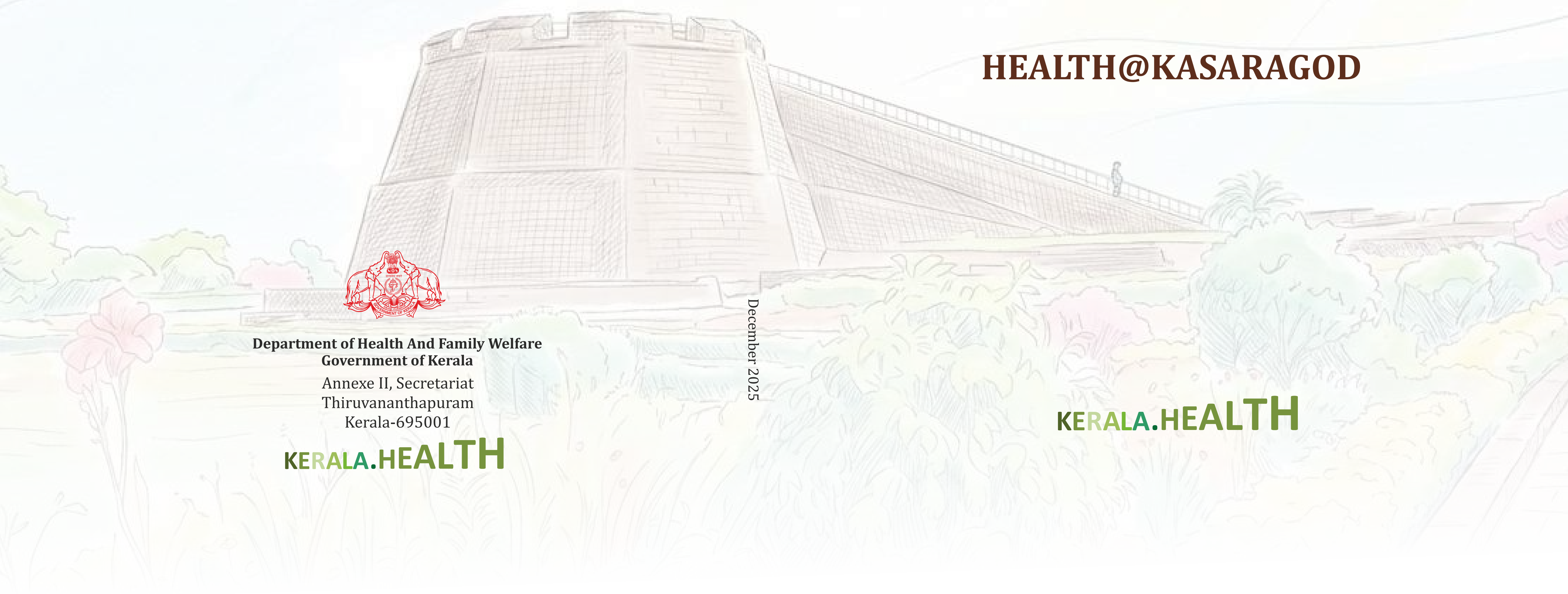
HEALTH@KASARAGOD

KERALA.HEALTH



December 2025

Department of Health And Family Welfare
Government of Kerala
Annexe II, Secretariat
Thiruvananthapuram
Kerala-695001

KERALA.HEALTH

HEALTH@KASARAGOD

KERALA.HEALTH

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Message

GOVERNMENT OF KERALA

Pinarayi Vijayan

CHIEF MINISTER

No. 1319/Press/CMO/25 | 24 December, 2025.

MESSAGE

The health and well-being of the people of Kerala remain the foremost priority of the Government of Kerala. Over the years, our State has achieved notable improvements in health outcomes through a strong public health system, a committed health workforce, and sustained community participation. Conscious investments across primary, secondary, and tertiary healthcare have been undertaken with the clear objective of reducing out-of-pocket expenditure and ensuring equitable access to quality health services for all.

At a time when emerging health challenges and changing disease patterns demand renewed focus, continuous strengthening of health planning and effective implementation of various programmes at the district level assume critical importance. In this context, district-specific strategies are essential to respond effectively to local needs while enhancing efficiency, equity, and responsiveness in service delivery.

The District Health Document stands as a comprehensive compilation of the district's health status, service delivery mechanisms, achievements, and priority areas. It reflects the collective efforts of the Health Department, local self-government institutions, and line departments in addressing social determinants of health. I am pleased to note that the Department is publishing all fourteen Health@District document series, providing valuable insights into programme implementation and developments in hospital infrastructure.

I appreciate the dedicated efforts of the Health Department in preparing this document. I am confident that this initiative will serve as a valuable guide for policymakers, administrators, researchers, and frontline health workers, and will contribute significantly to strengthening the district health system and advancing our goal of accessible, affordable, and quality healthcare for all. I wish every success to the endeavours of the Health Department.

Pinarayi Vijayan

The Addl. Chief Secretary (Health)
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Smt. Veena George

Minister for Health &
Family Welfare
and Woman & Child Welfare
Development
Government of Kerala

Message

The Government has taken decision to undertake strategic investment in primary, secondary and tertiary health care under the Aardram Mission and Navakerala Karma Padhathi.2. The department is taking various initiatives to improve health care services to people by improving infrastructure and by launching specific health service programs for all segments.

I am delighted to see that the Department has brought out a comprehensive compendium to give information regarding the various health initiatives undertaken in the district of Kasaragod. The book gives complete information about the various projects undertaken to improve infrastructure as well as the different programs under implementation to ensure efficient health care services to people.

It is informed to me that the department is taking steps to publish such books of all the districts annually. This initiative of documenting all the activities in the districts will give everyone information not only to health functionaries but also to people. I urge the health functionaries to use the data to study, analyse and based on the evidence take various interventions to improve the health care delivery in Kasaragod.

I appreciate the works done by the District Medical Officer, District Project Manager and health functionaries of Kasaragod and efforts taken by Directorate of Health Services and National Health Mission Kerala.

I wish a grand success to this initiative.

Veena George

Foreword

The Department of Health and Family Welfare has been taking various initiatives in Health Sector. They are ably supported by the line departments like Local Self Government Department, Revenue Department and others by working on social determinants of health. Health Science always demands well documented data regarding the outputs and outcomes. The foundation of Health Science is an evidence-based practice. In this back ground, the need for documenting a concise compilation of the efforts taken by all health functionaries and our partners was realized.

We have developed a template for the district health documentation and shared it with all the district functionaries to collate the information. It was a difficult task, but with continuous follow ups and coordination, the information was collected. The draft went through series of discussions including aesthetics of presentation and the draft was finalized.

The book **Health@Kasaragod** gives information regarding various initiatives such as infrastructure development, state plan and various State and Centrally sponsored schemes, national and state health programs. The book extensively covers the demographic data as well as the vital health statistics of the district. The output and outcome indicators will give all information regarding the efficacy of various programs and schemes implemented in the district.

The Department is in the process to publish Books of all the districts and it will be a Health@District encyclopaedia 2025 edition as a part of Nav Kerala Karma Padhati.2

We will focus on involving people at all levels and the officials of all departments to promote "Our Health is Our Responsibility" with the objective of improving preventive and promotive health to reduce morbidity and mortality and to build a healthy productive society.

I am confident that the book **Health@Kasaragod** will be a resource book for health functionaries, researchers, students as well as to people to understand the developments in health sector in Kasaragod. It will help to assess the progress against the benchmarks set and encourage all to strive to excel.

I take this opportunity to recognise the efforts taken by Smt. Prabha George, State Demographer and her team. All the data tables were validated and appropriate infographics were done properly. These set of documents, hopefully would encourage institutions to publish such informative books in future too. Dr Ramdas A V, DMO Kasaragod, Dr Arun P V, DPM Kasaragod and others have followed up to compile the information through a series of discussions and feedback. I appreciate the guidance given to the teams by Dr Vinay Goyal SMD NHM, and Dr Reena Director Health Services. I especially appreciate the work of many colleagues who tirelessly work in the field to achieve the result.

I would urge all the colleagues to study the information and to do data analysis for taking further actions to ensure progress in achieving the results. With shared vision and collective actions involving people at the grass roots, we will improve the health care delivery in Kasaragod district and all across the state.

Dr Rajan Khobragade IAS

Additional Chief Secretary
Health & Family Welfare and
AYUSH Department
Govt of Kerala.

Message

Department of Health and Family Welfare is publishing a book on Health @District encyclopedia, a comprehensive document that captures the current health landscape, priorities, and programmatic achievements across the district. This book reflects the continued commitment of State Health Department towards strengthening public health systems, ensuring equitable access, and advancing Kerala's long-standing legacy of excellence in health care. These strides have been made possible by the dedication of our health workforce, the support of local self-governments, and the active involvement of other line departments and communities.

The chapters highlight essential aspects of the district health system—including demographic and epidemiological patterns, health infrastructure, human resources, maternal and child health indicators, the burden of communicable and non-communicable diseases, tribal health challenges, and programmatic progress under National Health Mission.

This document is intended to serve not only as a repository of information, but as a strategic tool for planners, administrators, and public health professionals. It will support decision-making, foster inter-sectoral collaboration, and help monitor progress towards achieving the Sustainable Development Goals and Kerala's health sector priorities.

I extend my sincere appreciation to the district health team, programme officers, and all stakeholders, whose dedicated efforts have contributed to the preparation of this document. Their collective efforts continue to strengthen Team Kerala Health and propel us toward achieving the state's health priorities and the broader national vision.

Dr. Vinay Goyal IAS
State Mission Director
National Health Mission
Kerala

Message

ഡോ. റീന. കെ. ജെ
ആരോഗ്യവകുപ്പ് ഡയറക്ടർ

ആരോഗ്യവകുപ്പ് ഡയറക്ടറുടെ കാര്യാലയം
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സന്ദേശം

സംസ്ഥാന ആരോഗ്യ വകുപ്പ് ജില്ലാ അടിസ്ഥാനത്തിൽ 2024 -25 വർഷത്തെ പ്രവർത്തനങ്ങൾ ക്രോഡീകരിച്ച് പ്രസിദ്ധീകരിക്കുന്ന പ്രവർത്തനം പൂർത്തിയായിരിക്കുകയാണ്. 2024-25 വർഷം ജില്ലകൾ നടപ്പാക്കിയ പകർച്ചവ്യാധി പ്രതിരോധ നിയന്ത്രണ പ്രവർത്തനങ്ങൾ, ജീവിതശൈലി രോഗ നിയന്ത്രണ പദ്ധതി, മാതൃശിശു ആരോഗ്യ സംരക്ഷണം, മറ്റ് ദേശീയ പദ്ധതികൾ എന്നിവയുമായി ബന്ധപ്പെട്ട നടത്തിയ പ്രവർത്തനങ്ങൾ, ധന വിനിയോഗം, ജില്ലകളുടെ അടിസ്ഥാന വിവരങ്ങൾ,നിലവിലുള്ള ആരോഗ്യ സംവിധാനങ്ങൾ, ആരോഗ്യപ്രവർത്തകരുടെ എണ്ണം, അടിസ്ഥാന സൗകര്യങ്ങൾ എന്നിവ ഉൾപ്പെടുത്തി എല്ലാ ജില്ലകളും തയ്യാറാക്കി സംസ്ഥാനതലത്തിൽ പ്രസിദ്ധീകരിക്കുന്നത് അഭിനന്ദനാർഹമാണ്.

വിവിധ പദ്ധതികളുമായി ബന്ധപ്പെട്ട് ജില്ലകളുടെ പ്രവർത്തന പുരോഗതി വിലയിരുത്തുന്നതിനും വരും വർഷങ്ങളിലെ കർമ്മപദ്ധതി തയ്യാറാക്കുന്നതിനും ഇത് പ്രയോജനപ്രദമാകുന്നതാണ്. ഇതിനു പിന്നിൽ പ്രവർത്തിച്ച എല്ലാവരെയും അഭിനന്ദിക്കുന്നതോടൊപ്പം ഉദ്യമത്തിന് എല്ലാ ആശംസകളും നേരുന്നു.

ആത്മാർത്ഥതയോടെ,

ഡോ. റീന. കെ. ജെ

CHAPTER 1

KASARAGOD DISTRICT – AN OVERVIEW

1.1. Introduction

Source of data: Census of India 2011

Figure 1.1: Kasaragod district map

Kasaragod, the northernmost district of Kerala, aptly referred to as the ''Land of Seven Languages'', was formed on 24 May 1984 by separating it from the then Kannur District. It is bounded on the east by the Kodagu district of Karnataka, west by the Arabian Sea, north by the Dakshin Kannada District of Karnataka and South by Kannur District.

The district lies between latitudes 12°10’ N and 12°52’ N and experiences a warm and humid tropical climate influenced by both the south-west and north-east monsoons. Its geographical position, proximity to the sea, and topographical variations contribute to significant seasonal climatic changes.

Kasaragod is often considered as the crown of Kerala with a rich history of invasions and resistance, evident from its ancient forts, remaining of innovative culture of the modern stone age like ‘Chenkallarakal’, ‘Nannangatikal’, ‘Muniyarakal’, inscriptions of historical rulers and their practices, lush green highlands of Western Ghats, the fertile midlands and the district’s unique traditions and forms of worship. Kasaragod is also reputed for its practice of sharing the culture and languages.

Agriculture is the backbone of Kasaragod’s economy. Major crops include paddy, coconut, arecanut, cashew, pepper, banana, and rubber. With a coastline of 293 km, fisheries play a vital role in the local economy.

Kasaragod was known to the Arabs as *Harkwillia*. Many Arab travellers who visited Kerala between the 9th and the 14th centuries are believed to have visited Kasaragod as it was an important trade centre. *Duarte Borbosa*, a Portuguese traveller who visited Kumbla, near Kasaragod in 1514 recorded that was rice being exported for coir to Maldives.

Kasaragod was once part of the Kumbala Kingdom, which consisted of 64 Malayalam and Tulu villages. The Vijayanagara empire attacked and annexed Kasaragod from the Kolathiri Raja, with Nileshwaram serving as one of its capitals. During the decline of the Vijayanagara empire, the administration of this area was vested with Ikkeri Nayakas. Following the collapse of the Vijayanagara empire, *Venkappa Nayaka* declared independence for Ikkery. The forts at Kumbla, Chandragiri and Bekal were constructed or renovated by Shivappa Nayaka.

Although blessed with such a vast history of tradition, Kasaragod lags other districts in health infrastructure and is considered a high priority district for both the state and the country. The Endosulfan poisoning that occurred between 1978 and 2000 brought National and international attention to Kasaragod and the district is in the forefront for the fight against the use of chemical pesticides.

1.2 Administration

Table 1.2.1 Administration

Established	May 1984, 24
Headquarters	Kasaragod
Revenue Divisions	2
Parliament Constituencies	1
Assembly Constituencies	5
Taluk	4
Block	6
Panchayats	38
Municipality	3
Villages	129

The district of Kasaragod came into existence on 24th May 1984, marking a significant chapter in the administrative history of Kerala. The district headquarters is located at Kasaragod town, which functions as the nerve centre of governance and coordination.

Administratively, Kasaragod is divided into two revenue divisions and forms a part of one Parliament constituency. At the state level, it is represented through five Assembly constituencies, giving voice to the diverse communities of the district in the legislative process.

For ease of governance, the district is further subdivided into four taluks—Manjeshwaram, Kasaragod, Vellarikund, and Hosdurg. These taluks form the backbone of local administration, each catering to the needs of its people. Supporting this structure are six block panchayats, 38 grama panchayats, and three municipalities, which together ensure decentralized governance and people's participation in development. At the grassroots, the district is made up of 128 villages, each contributing to the cultural and economic vitality of Kasaragod.

This layered administrative setup not only reflects efficiency but also ensures that governance reaches every household, from the bustling towns to the quiet villages spread across the land.

1.2.1 Administrative Divisions in the District

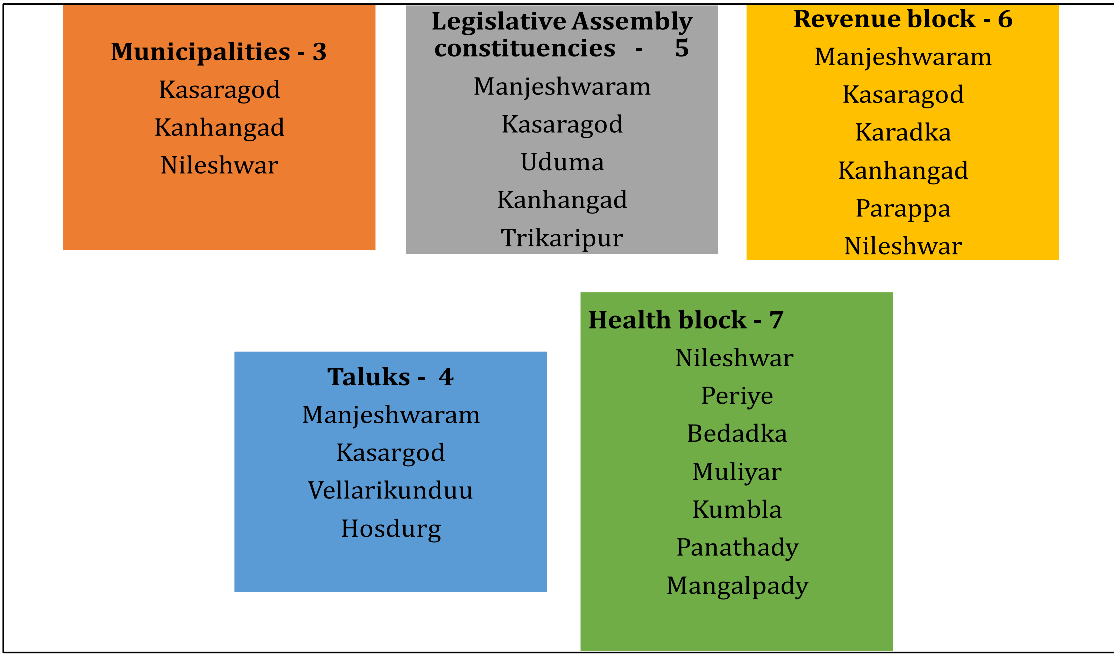


Figure 1.2.1 Administrative Divisions of Kasaragod District

The diagram highlights the different local governance and administrative units in the district. Kasaragod has 3 municipalities — Kasaragod, Kanhangad, and Nileshwar. There are 5 Legislative Assembly constituencies — Manjeshwar, Kasaragod, Uduma, Kanhangad, and Trikaripur. The district is divided into 6 revenue blocks — Manjeshwar, Kasaragod, Karadka, Kanhangad, Parappa, and Nileshwar. Additionally, there are 4 taluks — Manjeshwar, Kasaragod, Vellarikundu, and Hosdurg — and 7 health blocks — Nileshwar, Periye, Bedadka, Muliya, Kumbla, Panathady, and Mangalpady. This structure ensures efficient administrative functioning and decentralized governance across the district.

1.3 Demographic Profile of Kasaragod

Kasaragod, the northernmost district of Kerala, exhibits a diverse demographic pattern shaped by its geographic, cultural, and socio-economic characteristics. According to

Census 2011, the district has a population of 13.07 lakh, contributing about 3.9 percent to the total population of the state. The district is characterized by a relatively high population density, steady decadal growth, and a balanced rural–urban distribution. Kasaragod's population composition reflects a mix of various linguistic and cultural groups, adding to its social diversity. The demographic indicators such as sex ratio, literacy rate, and age structure provide important insights into the district's human resource potential and developmental status. This section presents an overview of key demographic features including population size, density, growth trends, age and sex distribution, literacy rate, and the share of vulnerable population groups based on Census 2011 data.

1.3.1 Population size and density

Table 1.3.1 Population Distribution of District (1901-2011)

Census Year	Total	Males	Females
1901	2,31,280	1,12,299	1,18,981
1911	2,47,467	1,20,526	1,26,941
1921	2,56,931	1,25,319	1,31,612
1931	3,02,043	1,48,055	1,53,988
1941	3,42,301	1,67,839	1,74,462
1951	4,11,031	2,00,927	2,10,104
1961	5,12,146	2,52,746	2,59,400
1971	6,83,020	3,41,859	3,41,161
1981	8,72,741	4,32,025	4,40,716
1991	10,71,508	5,28,803	5,42,705
2001	12,04,078	5,88,083	6,15,995
2011	13,07,375	6,28,613	6,78,762
Source of data: Census of India 2011			

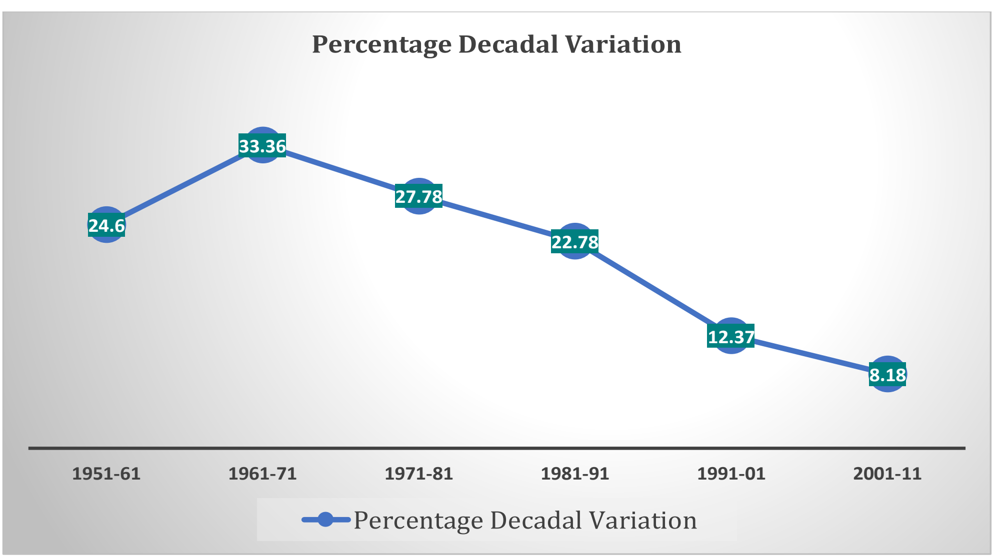
The census data from 1901 to 2011 reveal a steady increase in both the male and female population over the decades. In 1901, the district had **1,12,299 males** and **1,18,981 females**. By 2011, these numbers had risen to **6,28,613 males** and **6,78,762 females**, indicating a significant growth in total population over the century.

From 1901 to 1951, the population grew gradually, with the male population nearly doubling from 1.12 lakh to 2.00 lakh, and the female population rising from 1.18 lakh to 2.10 lakh. The post-1951 period witnessed accelerated growth, particularly between 1951 and 1981, reflecting improvements in healthcare, living standards, and overall socio-economic development.

Between 1971 and 2011, the population continued to rise steadily. The **female population consistently remained higher than the male population**, except in 1971, where a slight reversal occurred with males (3,41,859) outnumbering females (3,41,161). This indicates relatively balanced gender ratios throughout the period.

By 2011, the total population had increased more than fivefold compared to 1901, showing a strong demographic expansion. The steady rise in both male and female populations reflects long-term population growth trends influenced by better health facilities, lower mortality rates, and socio-economic progress.

Graph 1.3.1: Decadal Population Growth of District



Source: Census of India 2011

The chart illustrates the percentage decadal variation in population from 1951 to 2011, illustrating the changing pace of population growth across six consecutive census periods.

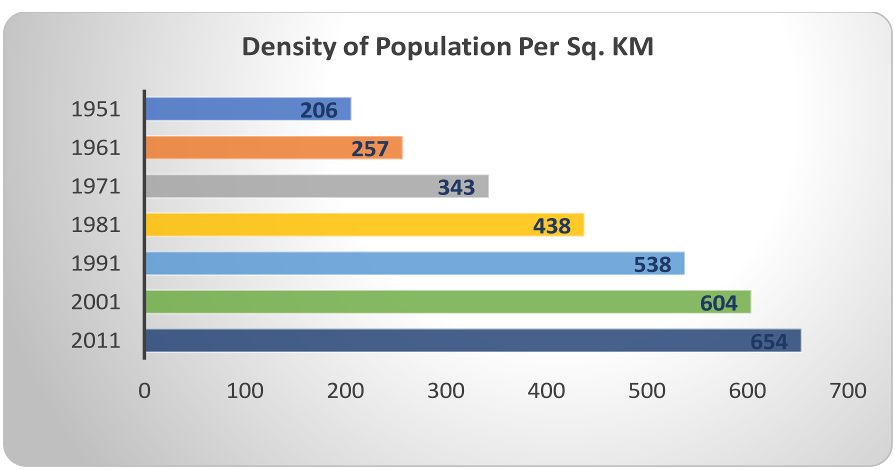
During the decade **1951–1961**, the district recorded a **24.6%** increase in population, marking a phase of moderate growth. The subsequent decade, **1961–1971**, witnessed the **highest decadal growth rate of 33.36%,** reflecting a period of rapid demographic expansion likely influenced by post-independence development initiatives, improved healthcare, and reduced mortality rates.

After 1971, however, the growth rate began to decline gradually. The **1971–1981** decade registered a growth of **27.78%,** followed by **22.78%** during **1981–1991**. This steady decline in growth rate reflects the onset of demographic transition, driven by increasing literacy, urbanisation and greater awareness of family planning.

In the following decades, the trend of deceleration continued sharply. The **1991–2001** period recorded a reduced growth of **12.37%,** and by **2001–2011**, the decadal variation further declined to **8.18%,** the slowest rate recorded in the period under review.

Overall, the graph highlights a **consistent downward trend in population growth rates** after 1971, suggesting a movement towards population stabilisation influenced by socio-economic progress, improved health facilities, and changing demographic behaviour.

Graph 1.3.2: Density of population per sq.km (1951 -2011)



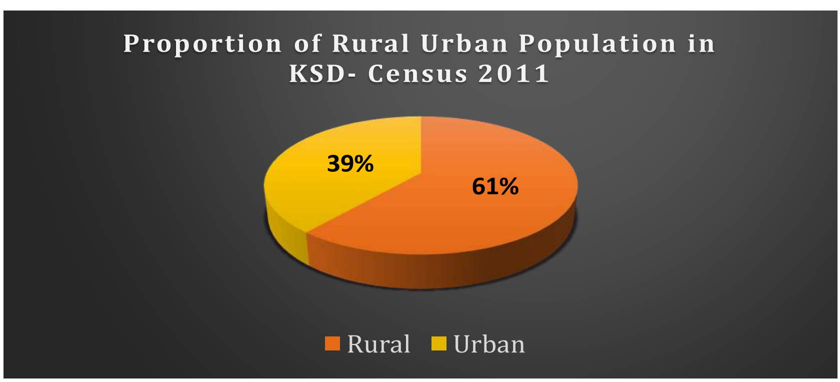
The chart illustrates the **trend in population density per square kilometre** from 1951 to 2011, highlighting the continuous increase in population concentration over the six decades.

In **1951**, the district recorded a population density of **206 persons per sq. km**, which gradually increased to **257 persons per sq. km** by **1961**, reflecting the onset of post-independence population growth. During the subsequent decades, population density continued to rise steadily — reaching **343 persons per sq. km** in **1971** and **438 persons per sq. km** in **1981**.

The trend persisted through the 1990s and 2000s, with density levels climbing to **538** and **604 persons per sq. km** in **1991** and **2001**, respectively. By **2011**, the district's population density had risen further to **654 persons per sq. km**, representing more than a **threefold increase** compared to 1951.

This consistent upward movement in population density reflects the combined impact of **natural population growth, declining mortality rates, and socio-economic development**. It also indicates **growing pressure on land and resources,** particularly in urban and semi-urban regions, as demographic expansion continues to exceed the spatial capacity of the district.

Graph 1.3.3: Rural - Urban Proportion in Population

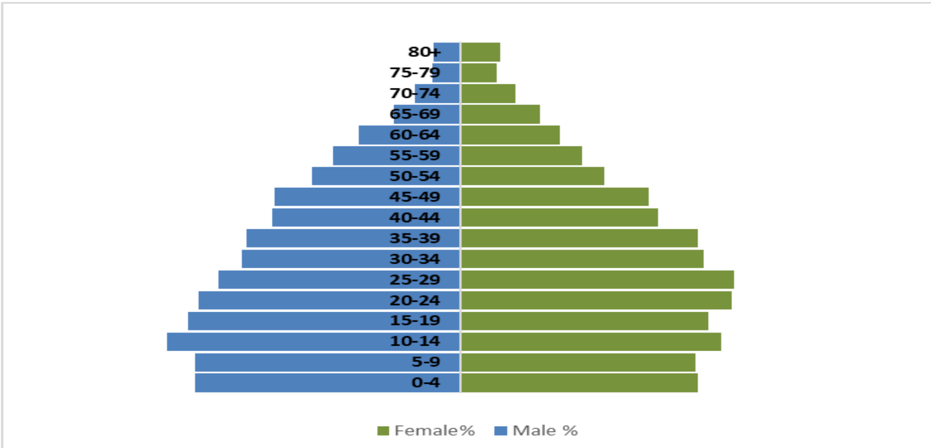


Source: Census of India, 2011

According to the 2011 Census, a majority (61%) of the population in Kasaragod District lived in rural areas, while 39% resided in urban areas. This indicates that the district had a predominantly rural demographic profile during that period.

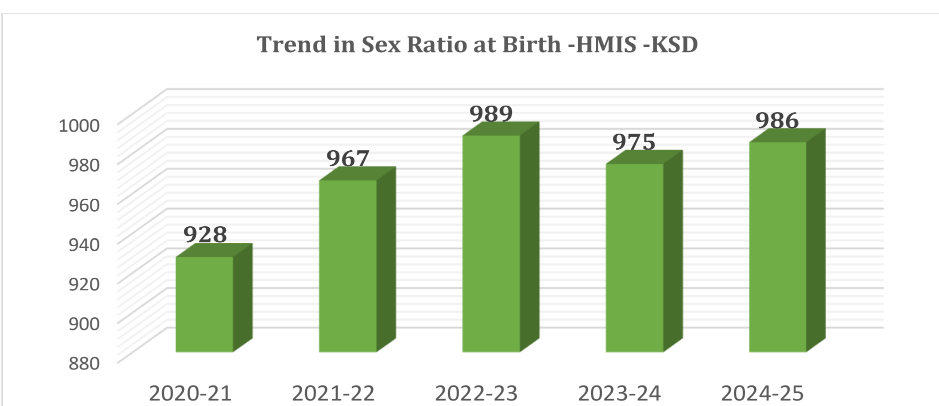
1.4 Age and sex distribution

Graph 1.4.1: Age and Sex Distribution of Population Based on Census 2011 Population



Graph 1.4.1 illustrates the age and sex distribution of the population based on the Census 2011 data. The population pyramid depicts the proportion of males and females in different age groups. The left-hand side of the pyramid represents males, while the right – hand side represents females. The graph has a broad base, indicating a large proportion of young people and a gradually tapering top, showing a smaller elderly population. This suggests that the population of Kasaragod District in 2011 was predominantly youthful, with a higher percentage of people in the younger age groups and fewer in the older age categories.

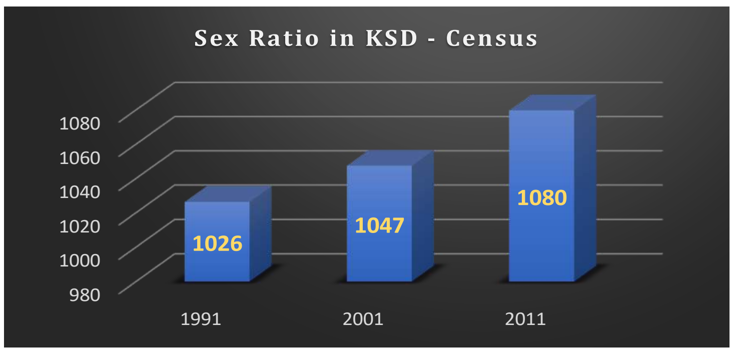
Graph 1.4.2: Sex Ratio at Birth.



Source: HMIS data

The graph illustrates the trend in sex ratio at birth in Kasaragod District (KSD) from 2020–21 to 2024–25 based on HMIS data. It indicates that the sex ratio has improved over the years. In 2020–21, the sex ratio was 928, which gradually increased to 967 in 2021–22, 989 in 2022–23, slightly declined to 975 in 2023–24, and again rose to 986 in 2024–25. This demonstrates a positive trend towards achieving a more balanced sex ratio at birth in KSD.

Table 1.4.3: Sex Ratio

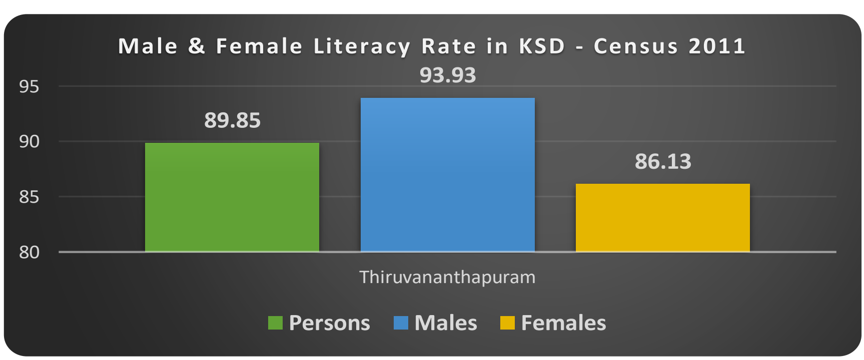


Source: Census of India

The graph illustrates the sex ratio in Kasaragod based on Census data for the years 1991, 2001, and 2011. It indicates a consistent increase over the years. The sex ratio stood at 1026 in 1991, 1047 in 2001, and 1080 in 2011. This demonstrates an overall improvement in the number of females per 1000 males in KSD.

1.5 Literacy rate

Graph 1.5.1 Literacy Rate Male, Female and all Based on the Census 2011 Data



Source: Census of India 2011

The graph shows the male and female literacy rates in Kasaragod based on Census 2011 data. The overall literacy rate is 93.85%, with male literacy at 95.93% and female literacy at 91.81%. This indicates a high literacy rate in the district, with a small gap between male and female literacy levels.

1.6 Vulnerable population groups

Table 1.6.1 SC/ST population of the district based on the census 2011 population

General	Male	6,28,413
	Female	6,78,762
	Total	13,07,375
Scheduled Castes	Male	26,385
	Female	26,898
	Total	53,283
Scheduled Tribes	Male	23,950
	Female	24,907
	Total	48,857
Source: Census of India 2011		

Table 1.6.1 presents the population of males and females among the General, Scheduled Caste (SC), and Scheduled Tribe (ST) categories in KSD based on the Census 2011 data. The General category records the highest population with 6,28,413 males and 6,78,762 females, totalling 13,07,375. Among the Scheduled Castes, there are 26,385 males and 26,898 females, making a total of 53,283. The Scheduled Tribe population comprises 23,950 males and 24,907 females, bringing the total to 48,857. This data highlights that females slightly outnumber males across all social categories in the district.

CHAPTER 2

KASARAGOD HEALTH DASHBOARD

District AT A GLANCE

Administrative Divisions

Thaluks –4

Villages – 129

Municipalities – 3

Corporations – 0

Block Panchayath- 6

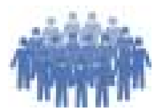
Grama Panchayath -38

Population

Population As per Census 2011 –1307375

Male – 628613

Female – 678763



Area

Total Area (Sq. K)–1992km²

Population Density (No per Sq K) – 654²

Decadal Population Growth Rate – 8.18%

Healthcare Infrastructure under DHS

District Level Hospitals

DH – 1

GH – 1

W&C – 1

3

Sub District Level Hospitals

THQH – 4

TH – 1

5

Community Health Centres

Total CHC – 6

Converted to FHC - 5

6

Primary Health Centres

Total PHC – 40

Converted to FHC – 39

40

Janakeeya Arogya Kendram

Janakeeya Arogya Kendram - 247

247

Other Institutions

School of Nursing – 1

Training Center –

PH Lab – 11

DVC Units – 1

Offset Press - 0

Blood Bank – 2

Public – 2

Private -0

Blood Storage Unit – 2

Reproductive, Maternal, and Child Health Services 2024-25

Pregnant Women Registration: 2024-25

21127

The number of pregnant women in the district shows a sharp decline post-COVID

Pregnant Women- Anaemia 2024-25

32%

32% pregnant women were identified as anaemic through VIVA testing.

Rising C-Section Rates in the district 2024-25

34.5%

Kerala continues to maintain a high C-section rate in both public and private sectors

Maternal Deaths 2024-25 -7

7

Total Maternal Deaths Reported in the District - 7

Preterm Births 2024-25-513

4.5%

The proportion of preterm births in the district – 4.5

Underweight Newborns 2024-25-1036

4.5%

The proportion of newborns weighing less than 2.5 kg in the district - 611

Delivery 2024-25-4 -13514

Institutional Delivery in the district – 13509

Public – 12595

Private – 914

Home Delivery 2024-25-15

Home Delivery Reported in the district – 15

No of Migrant Home Delivery - 4

Live Birth 2024-25- 13618

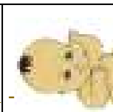
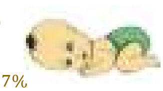
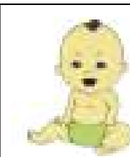
Total Live Birth Reported – 13718

Male – 6814

Female – 6804

Sex Ratio at Birth - 99.6-

CHILD IMMUNISATION 2024-25

% Birth Dose	6 Weeks Vaccines Coverage (%)	10 Weeks Vaccines Coverage (%)
Hep B0 -99 % **OPV 0 – 99 %** **BCG-100 %** 	OPV1 – 98% Pentavalent 1 - Rotavirus 1 – 98% PCV1 -98% IPV 1 - 98% 	OPV2 – 97 % Pentavalent2 –97% Rotavirus 2 – 97% 
% 14 Week Vaccines	**% Children Fully Immunized**	**MR 2 Coverage (%)**
OPV3 -97% Pentavalent 3 – 97% Rotavirus3 –97% IPV 2 - 19067 PCV2-19067 	MR1 – 97% FULLY IMMUNIZED (Children aged and <12 months)-96% 	**MR2 – 91%** 

Communicable diseases reported in the district 2024

Cases Reported

Dengue- 455

Malaria- 566

Chikungunya- 0

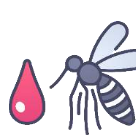
West Nile-0

Zika- 0

JE-0

0

Dengue Death



Cases Reported

Kala Azar-0

Scrub Typhus -20

Leptospirosis-64

2

Leptospirosis Death

Cases Reported

Cholera -3

Typhoid- 0

Acute Diarrheal Disease -29490

0

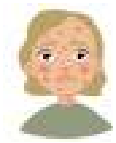
ADD Death

Communicable diseases reported in the District 2024

Chicken Pox Cases- 936 MPox Cases-0

4

Chicken Pox Death



Rabies Cases Reported- 0

Shigella cases-0

Amoebic Meningoencephalitis - 0

17

Rabies Death

Cases Reported

Hepatitis A - 270

Hepatitis B-20

Hepatitis C-5

Hepatitis E - 5

0

Hepatitis A Death

CHAPTER 3

HEALTH INFRASTRUCTURE PROFILE OF THE DISTRICT

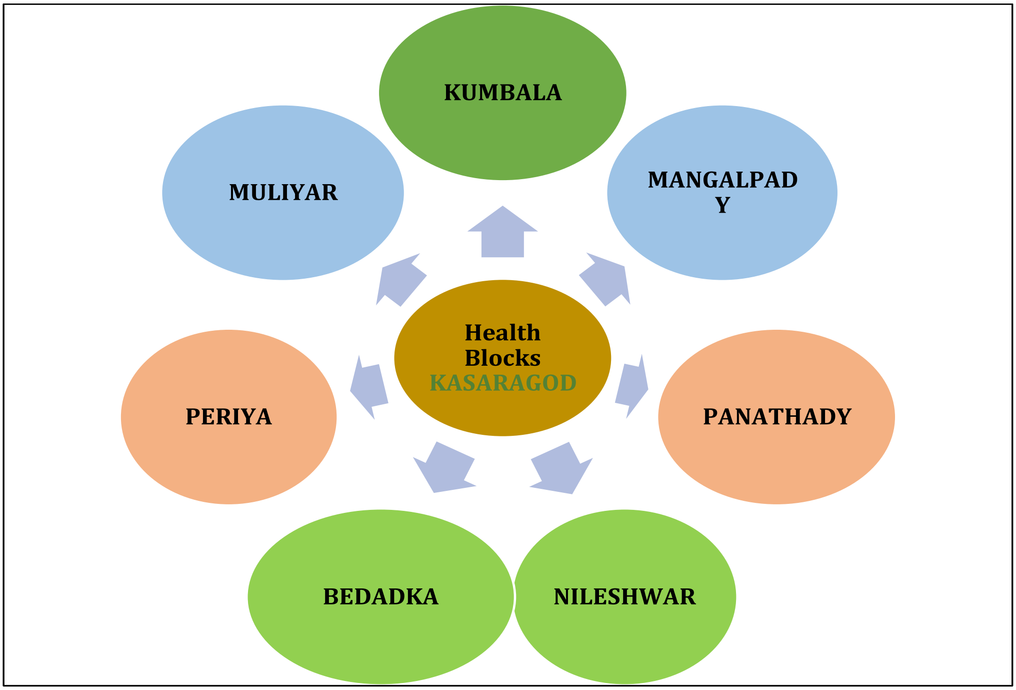


Figure 3.1 Health blocks in the district

In the district, health facilities are distributed across seven health blocks, covering different tiers of care. At the higher level, there are 3 District/General/Women & Children Hospitals and 5 Taluk Headquarters Hospitals, along with 6 Community Health Centres.

Primary-level care forms the bulk of the health system, with 40 Primary Health Centres (PHCs) and a large network of 247 Health & Wellness Centres (HWCs) ensuring community-level services. In addition, there are 3 Urban Primary Health Centres (UPHCs) and 9 Urban Health & Wellness Centres (UHWCs) providing care in urban areas.

Block-wise, Bedadka has a Taluk Hospital, 4 PHCs, and 32 HWCs, while Kumbala stands out with 2 CHCs, 8 PHCs, and 43 HWCs. Muliyar has a General Hospital, 1 CHC, 4 PHCs, and 25 HWCs, along with urban facilities (1 UPHC and 3 UHWCs). Mangalpady includes a Taluk Hospital, 1 CHC, 3 PHCs, and 24 HWCs. Panathady is served by a Taluk Hospital, 5 PHCs, and 36 HWCs. Nileshwar has the most extensive coverage, with 2 higher-level hospitals, 1 Taluk Hospital, 1 CHC, 12 PHCs, 61 HWCs, and urban facilities (1 UPHC and 3 UHWCs). Periya too has 2 higher-level hospitals, 1 CHC, 4 PHCs, 26 HWCs, along with 1 UPHC and 3 UHWCs.

Overall, the data highlights that while higher-level hospitals are limited in number, the health system is strongly rooted in a wide network of PHCs and HWCs, ensuring accessibility and outreach of basic health services across both rural and urban areas.

3.1 Details of Health Facilities in District

Table 3.1.1 Number of Health Facilities in District

Type of Facility	Numbers
24X7 PHC	1
24x7 PHC Converted to FHC	9
PHC	0
PHC Converted to FHC	30
UPHC	3
CHC	6
CHC Converted to FHC	0
TH	1
THQH	4
DH	1
GH	1
W&C	1
W&C (Specialty)	0
DTBC	1

General Dispensary	2
Health Clinic	0
Leprosy	0
MHC	0
Mobile Unit	2
Specialty (Leprosy)	0
Specialty (Others)	1
Specialty (TB)	0
TBC	0
JAK	247
UHWC	9
Grand Total	**319**

Table 3.1.1 provides an overview of the number and types of health facilities functioning in the district under the Directorate of Health Services (DHS). A total of 319 health facilities are operational across various levels of care.

The largest share is held by Janakeeya Arogya Kendram (JAK) centres (247), reflecting the extensive network of primary healthcare delivery points in the district. There are 30 Primary Health Centres (PHCs) converted to Family Health Centres (FHCs) and 9 former 24×7 PHCs upgraded to FHCs, indicating the district's focus on strengthening primary and comprehensive health services.

At the secondary level, there are 6 Community Health Centres (CHCs), 4 Taluk Headquarters Hospitals (THQHs), and one each of Taluk Hospital (TH), District Hospital (DH), General Hospital (GH), and Women & Children (W&C) Hospital, ensuring availability of advanced and referral care.

In addition, Urban Primary Health Centres (UPHC – 3), Urban Health & Wellness Centres (UHWC – 9), and Mobile Units (2) extend outreach and urban healthcare services. Specialized facilities such as the District TB Centre (DTBC) and other specialty centres (1) provide targeted disease control and specialized care.

Overall, the data indicates a comprehensive and well-distributed health infrastructure, with strong emphasis on primary healthcare, supported by secondary and specialty facilities to ensure accessible and continuous healthcare across the district.

3.2 Bed Strength in Different Health Facilities

The district has a well-structured and evenly distributed network of health institutions that provide services across various levels of care. There is one General Hospital with a sanctioned bed strength of 212 and one District Hospital with 400 beds, both situated in urban areas.

At the secondary care level, there are five Taluk Headquarters Hospitals with a total of 173 sanctioned beds, serving both urban and rural populations. The district also has seven Community Health Centres (CHCs/BFHCs) with a combined bed strength of 164 beds, primarily catering to urban areas.

Primary care services are provided through 39 Family Health Centres (FHCs) with a total of 144 beds, and a vast network of 247 Sub Centres, including 13 urban and 234 rural sub centres, ensuring the delivery of services at the grassroots level.

In addition, there are three Urban Primary Health Centres (UPHCs), nine Urban Health and Wellness Centres (UHWC), and a Women and Children (W&C) Hospital with 100 beds, located in the urban area. A Mobile Unit also operates to provide outreach services, especially in remote areas.

Overall, the district demonstrates a strong healthcare infrastructure with a balanced presence of urban and rural health facilities, effectively addressing diverse healthcare needs.

Table 3.2.1: Bed–Population, Doctor–Bed, and Doctor–Population Ratios in the District

Indicator	**Ratio**
The Bed - Population Ratio (based on Census 2011 population)	1,307,305 : 1,639
The Average Doctor - Bed Ratio	1,639: 324
The Doctor - Population Ratio (based on Census 2011 population)	1,307,305: 324
Source of data: Census 2011 Population	

The table shows the Bed–Population Ratio, Doctor–Bed Ratio, and Doctor–Population Ratio in the district based on the Census 2011 population data. The Bed–Population Ratio is 1,307,305:1,639, the average Doctor–Bed Ratio is 1,639:324, and the Doctor–Population Ratio is 1,307,305:324. These

figures reflect the availability of healthcare facilities and manpower in the district, indicating the proportion of medical resources to the total population.

3.3 Health Facilities in Rural and Urban Areas

The distribution of health facilities across rural and urban areas reflects the district's commitment to ensuring equitable and accessible healthcare services. With a predominantly rural population, a larger share of health institutions is in rural regions to strengthen the delivery of primary healthcare services. This network includes Sub Centres, Primary Health Centres, Community Health Centres, and higher-level hospitals, which together constitute a comprehensive healthcare system catering to the needs of both rural and urban communities.

Table 3.3.1 Distribution of Health Facilities in Rural and Urban Areas

Distribution of Health Facilities in Rural and Urban Areas			
Institutions	**R**	**U**	**Grand Total**
CHC	6	0	6
DH	0	2	2
DH(W&C)	0	1	1
PHC	39	1	40
SDH	4	1	5
Others	3	2	5
SC	234	13	247
Grand Total	286	20	306
Source of data: HMIS			

Table 3.3.1 shows the distribution of health facilities across rural and urban areas in the district. Out of a total of 306 health facilities, the majority (286 facilities, 93%) are in rural areas, while only 20 facilities (7%) are in urban areas, demonstrating that the health infrastructure is predominantly rural-oriented.

Among these, Sub Centres (247) form the largest share of facilities, followed by Primary Health Centres (PHCs) numbering 40, and Community Health Centres (CHCs) totalling 6. The district also has 5 Sub District Hospitals (SDHs), 1 District Hospital (DH), and 1 Women and Children (W&C) Hospital, mainly concentrated in urban locations to provide secondary and tertiary care services.

The presence of a higher number of Sub Centres and PHCs in rural areas highlights the district's focus on strengthening primary healthcare delivery and ensuring accessibility of basic health services to remote populations.

3.4 Health Facilities Converted to FHC

The Aardram Mission, launched by the Government of Kerala, aims to transform the public health delivery system by improving infrastructure, ensuring citizen-friendly services, and enhancing the quality of healthcare at all levels. A key component of this initiative is the conversion of Primary Health Centres (PHCs) and Community Health Centres (CHCs) into Family Health Centres (FHCs), which focus on comprehensive, continuous, and patient-centred care.

In the district, significant progress has been achieved under this mission through the upgradation of health facilities, modernization of Outpatient Departments (OPDs), and strengthening of service delivery mechanisms. The following sections present the status of Aardram implementation, the progress of FHC conversions, and the overall achievements under the programme.

Table 3.4.1 Total Number of Facilities Converted to FHC

Total Number of Facilities Converted to FHC				
24x7 PHC Converted to FHC	CHC Converted to FHC	PHC Converted to FHC	Grand Total	No of FHCs Construction Completed
9	0	30	39	36
Source: District Report				

Table 3.4.1 shows the status of health facilities converted to Family Health Centres (FHCs) in the district. A total of 39 facilities have been converted, comprising 9 former 24×7 PHCs and 30 PHCs. Out of these, construction of 36 FHCs has been completed, indicating substantial progress in upgrading primary healthcare infrastructure.

3.5 Delivery Points in the District

The district's health system comprises a network of public and private healthcare institutions that collectively ensure the delivery of preventive, promotive, and curative services to the population. These facilities function at various levels—ranging from primary care institutions such as PHCs and CHCs to secondary and tertiary care hospitals including District Hospitals and Women & Children Hospitals.

Understanding the distribution and type of healthcare facilities in the district is essential for assessing service availability, identifying resource gaps, and planning future health infrastructure development. The following section provides an overview of the existing health facilities in both the public and private sectors.

Table 3.5.1 Number of Delivery Points in the District

<table>
<tr><th>Type of Facility</th><th>Public</th><th>Private</th></tr>
<tr><td>CHC</td><td>0</td><td rowspan="4">33</td></tr>
<tr><td>SDH</td><td>0</td></tr>
<tr><td>DH/GH</td><td>2</td></tr>
<tr><td>W&C</td><td>1</td></tr>
<tr><td>Total</td><td>3</td><td>33</td></tr>
<tr><td colspan="3">Source: HMIS</td></tr>
</table>

Table 3.5.1 shows the distribution of delivery points across public and private health facilities in the district. There is a total of 36 delivery points, comprising 3 public and 33 private facilities.

Among public institutions, 2 are District/General Hospitals and 1 is a Women & Children Hospital, while the private sector is represented entirely by 33 CHCs functioning as delivery points.

This indicates that most institutional deliveries occur in private facilities, although public hospitals remain crucial centres for comprehensive maternal and child healthcare services.

3.6 Other Specialised Care Centres

Table 3.6.1 Number of Other Specialised Care Centres

Type of Health Facility	No. of Facility (31st March 2025)
NRC	0
DEIC	1
SNCU	2
NBSU	0
Physiotherapy Units	25
Dialysis Units	8
Cath Lab	1
Stroke Unit	1
Source: District Report	

3.7 NQAS Accredited Facilities

National Quality Assurance Standards have been developed keeping in the specific requirements for public health facilities as well global best practices. NQAS are currently available for District Hospitals, CHCs, PHCs and Urban PHCs. Standards are primarily meant for providers to assess their own quality for improvement through pre-defined standards and to bring up their facilities for certification. The National Quality Assurance Standards are broadly arranged under 8 "Areas of Concern"– Service Provision, Patient Rights, Inputs, Support Services, Clinical Care, Infection Control, Quality Management and Outcome. These standards are ISQUA accredited and meets global benchmarks in terms of comprehensiveness, objectivity, evidence, and rigor of development.

Table 3.7.1 NQAS Accredited Facilities as on 31st March 2025

Sl. No.	Facility Name	Year of NQAS accreditation
1	FHC Kayyur	2022-23
2	UPHC Pullikunnu Kasaragod	2022-23
3	FHC Karindalam	2022-23
4	FHC Bellur	2022-24
5	FHC Uduma	2022-23
6	CHC Panathady /Poodamkallu	2022-23
7	FHC Ennapara	2022-23
8	FHC Chittarikkal	2022-24
9	FHC Kumbadaje	2024-25
10	FHC Narkilakad	2024-25
11	FHC Padne	2024-25
12	FHC Valiyaparamba	2024-25
13	FHC Olat	2024-25
Source of data: District report		

The district has made notable progress in improving the quality of healthcare delivery through active participation in the NQAS programme. A total of 13 healthcare facilities have achieved NQAS accreditation between 2022–23 and 2024–25, demonstrating the district's commitment to maintaining high standards in service provision and patient care.

During the initial phase (2022–23), several Family Health Centres (FHCs) and Community Health Centres (CHCs) were accredited, including FHC Kayyur, FHC Karindalam, FHC

Uduma, CHC Panathady/Poodamkallu, and UPHC Pullikunnu Kasaragod. These facilities set the foundation for quality assurance initiatives within the district.

In 2022–24, two more facilities—FHC Bellur and FHC Chittarikkal—were successfully accredited, reflecting continued momentum in the district's quality improvement drive.

The latest phase**,** 2024–25, saw the accreditation of additional FHCs such as Kumbadaje, Narkilakad, Padne, Valiyaparamba, and Olat, indicating sustained efforts to expand NQAS coverage to more primary-level institutions.

CHAPTER 4

HEALTH HUMAN RESOURCE PROFILE OF THE DISTRICT

The availability and distribution of health human resources play a vital role in determining the efficiency and quality of healthcare delivery in a district. This chapter provides an overview of the health workforce status in Kasaragod district, including key indicators such as doctor–population ratio, bed–population ratio, and availability of medical officers. It also presents data on the sanctioned strength and category-wise distribution of health personnel under the Directorate of Health Services (DHS) and the National Health Mission (NHM). The analysis helps to assess existing human resource gaps and supports evidence-based planning for strengthening healthcare services in the district.

4.1 Health Human Resource – Major Indicators

Table 4.1.1: Bed–Population, Doctor–Bed, and Doctor–Population Ratios in the District

Indicator	Ratio
The Bed Population Ratio (based on Census 2011 population)	1:798
The Average Doctor Bed Ratio	1:5
Doctor Population Ratio (based on Census 2011 population)	1:4,037
Source of data: Census 2011 Population	

Based on the Census 2011 population, the bed–population ratio is 1:798, meaning one hospital bed is available for every 798 persons. This reflects a moderate level of inpatient care capacity in the district.

The doctor–bed ratio stands at 1:5, indicating one doctor for every five hospital beds. This shows that medical staffing levels are adequate in relation to existing infrastructure.

The doctor–population ratio is 1:4,037, suggesting one doctor is available for every 4,037 people. While this ratio is relatively satisfactory, further improvements are needed to ensure equitable access to healthcare services, particularly in rural and remote areas.

4.2 Availability of Medical Officers

Table 4.2.1: Details of Medical Officers Sanctioned under DHS in the District (As on 31/12/2025)

Category	Sanctioned
Administrative	
Additional Director	0
Deputy Director	3
Assistant Director	11
JAMO	1
General	
Assistant Surgeon	196
Assistant Surgeon Dental	8
Civil Surgeon	8
Civil Surgeon Dental	1
MO All	**228**

The Administrative Cadre consists of 15 doctors, including 11 Assistant Directors, 3 Deputy Directors, and 1 Junior Administrative Medical Officer. These officers are responsible for overall supervision, planning, and coordination of health services.

The General Cadre forms the largest segment, comprising 213 doctors. This includes 196 Assistant Surgeons, 8 Civil Surgeons, 8 Dental Assistant Surgeons, and 1 Dental Civil

Surgeon. This cadre plays a crucial role in delivering general and dental healthcare services at the primary and secondary levels.

Table 4.2.2: Number of Specialty and Super Specialty Doctors under DHS

Type	**Sanctioned**
Doctors (Speciality)	94
Anaesthesia	9
Blood Bank	2
Blood Bank/Clinical Lab/PH Lab	0
Dental	2
Dermatology & Venerology	2
ENT	4
Forensic Medicine	1
General Medicine	17
General Surgery	6
Microbiology	0
Obstetrics & Gynaecology	10
Ophthalmology	6
Orthopaedic Surgery	7
Paediatrics	12
PH Lab	0
Physical Medicine & Rehabilitation	3

Psychiatry	4
Radio Diagnosis/Radio Therapy	2
TB & Chest (Resp. Medicine)	7
Doctors (Super Speciality)	2
Cardiology	0
Nephrology	0
Neurology	2
UROLOGY	0

Table 4.2.2 presents the details of sanctioned posts for specialty and super specialty doctors under the Directorate of Health Services (DHS). Among the various medical specialties, General Medicine has the highest number of sanctioned posts (17), followed by Paediatrics (12) and Obstetrics & Gynaecology (10). Other key specialties such as Anaesthesia (9), Orthopedic Surgery (7), General Surgery (6), and Ophthalmology (6) also have significant representation.

Specialties like Forensic Medicine, Dermatology & Venerology, and Dental have a smaller number of sanctioned positions (1–2 each). Some categories, including Microbiology, PH Lab, Radio Diagnosis/Radio Therapy, and TB & Chest (Respiratory Medicine), currently do not have sanctioned posts listed.

For Super Specialty disciplines such as Cardiology, Nephrology, Neurology, and Urology, no sanctioned posts are reported under DHS at present.

Overall, the data indicates that the staffing pattern is concentrated in core clinical areas, particularly in General Medicine, Paediatrics, and Obstetrics & Gynaecology, reflecting the focus on essential healthcare services across the DHS system.

4.3 Sanctioned Strength of Health Personnel under DHS

Table 4.3.1: Category-wise Sanctioned Strength of Health Personnel under DHS

Category/Division	Sanctioned
Doctors (Administrative Cadre)	15
Doctors (General Cadre)	213
Doctors (Specialty)	94
Doctors (Super Specialty)	2
Nursing Service	426
JPHN To MCH Officer	297
JPHN/Nursing School	10
Dental	6
Lab (General)	66
Pharmacy & Medical Supply	104
Leprosy	1
Public Health	242
TB	4
Ophthalmology	15
Others	704
Grand Total	**2,199**

Table 4.3.1 presents the category-wise sanctioned strength of health personnel under the Directorate of Health Services (DHS), totalling 2,199 posts. The data indicates that the

'Others' category (704 posts) constitutes the largest segment, followed by Nursing Service (426 posts) and Public Health (242 posts).

Among medical personnel, there are 324 doctors in total — comprising 15 in the Administrative Cadre, 213 in the General Cadre, 94 in Specialty, and 2 in Super Specialty. Supporting divisions such as Pharmacy & Medical Supply (104) and Lab (General) (66) contribute to essential healthcare operations.

Smaller categories, including Ophthalmology (15), TB (4), and Leprosy (1), represent specialized services. The overall distribution reflects a comprehensive workforce structure that prioritizes nursing, public health, and core medical services within the DHS framework.

4.4 Health Human Resource under NHM

Table 4.4.1: Number of Health Personnel Working under NHM (As on 31/03/2025)

Category	In-position (as on 31march 2025)
Doctors	
Administrative Cadre	2
General Cadre	35
Specialty	8
AYUSH MO	37
Dental Specialist	1
Dental Surgeon	4
Ministerial Staff (AA, Jr. Supt, Typist, clerk etc.)	
District Accounts Manager	1

DEIC Manager	1
JC MIS	1
Consultant ABMO	1
JC D&C	1
Consultant AQAO	2
JC M&E	1
Consultant Engineer	2
DPRO	1
JC RBSK	1
Dist. ASHA Coordinator	1
Dist. Palliative Coordinator	1
Urban Health Coordinator	1
Accountant	11
Secretary	1
PROs	14
Data Manager IDSP	7
DEO	13
Office Assistant	1
Paramedical staff (HS, HI, JHI, JPHN, Nursing Asst. etc.)	
Staff Nurse	97
MLSP	204

Pharmacist	36
Physiotherapist	29
Ayurveda Therapist	1
RBSK Nurse/Urban JPHN	44
Audiologist	6
Audiometric Asst	1
Instructor for Hearing Impaired Children	1
Psychologist	3
Optometrist	5
Special Educator	2
Counsellor	16
Epidemiologist	5
Entomologist	0
VBD Consultant	1
Sr Dots plus Supervisor, NTEP	1
TB Supervisors (STS), NTEP	1
STLS, NTEP	1
JHI	5
TBHV, NTEP	2
Technical Staff (Leprosy officer, Biologist, LT, Dental Hygienist etc.	
Lab Technician	26

Other Technician	9
Others (Electrician, Driver, Housekeeper, Attender etc.)	
General Duty Attendant/ Hospital Worker	9
Peon	1
Total	**655**

As of 31 March 2025, a total of 655 personnel is working under the National Health Mission (NHM) in the district. The workforce includes 87 doctors, comprising administrative, general, specialty, AYUSH, and dental categories, ensuring a balanced mix of medical expertise.

A strong paramedical and technical workforce forms the backbone of service delivery, with 97 staff nurses, 204 MLSPs, 36 pharmacists, and 29 physiotherapists actively supporting healthcare functions at various levels.

The ministerial and administrative staff, numbering 62, play a key role in programme management, financial operations, and data monitoring, contributing to the efficient implementation of NHM initiatives.

In addition, technical and support staff such as lab technicians, counsellors, and attendants ensure smooth clinical and operational functions across institutions.

CHAPTER 5

MATERNAL AND CHILD HEALTH

The Maternal and Child Health Programme in Kasaragod district is dedicated to improving the health and well-being of mothers and children through targeted initiatives. The district implements PMSMA (Pradhan Mantri Surakshit Matritva Abhiyan), which offers free, high-quality antenatal care to all pregnant women on the 9th of each month, facilitating the early identification and management of high-risk pregnancies. Kasaragod actively promotes early ANC registration, ensuring that pregnant women receive timely and comprehensive antenatal check-ups. Immunisation is a central focus, with efforts to achieve complete vaccination coverage for both children and pregnant women, protecting them from preventable diseases. Additionally, the programme strongly encourages institutional deliveries, aiming to provide a safe childbirth experience and reduce both maternal and neonatal mortality. These coordinated efforts support district's progressive health indicators and contribute to sustainable improvements in maternal and child health throughout the district.

5.1 Pregnant Women Registration

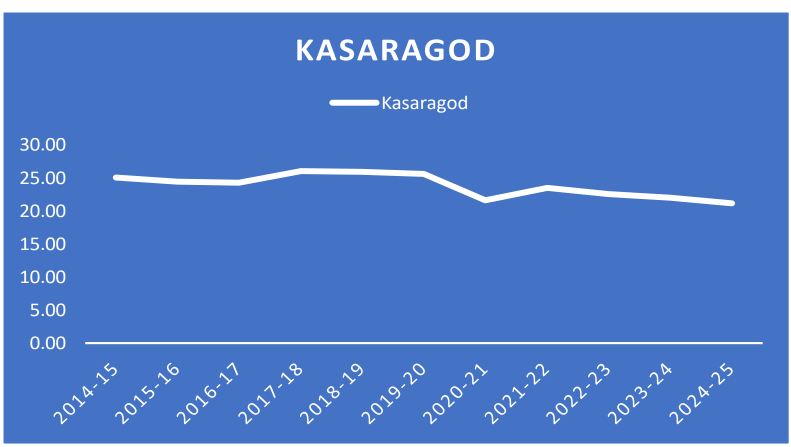
Table 5.1.1 Trend in Pregnant Women Registration in the District (2014-15 to 2024-25)

Period	Pregnant Women Registration (in thousands)
2014-15	25.02
2015-16	24.44
2016-17	24.20
2017-18	26.00
2018-19	25.87
2019-20	25.58

2020-21	21.58
2021-22	23.49
2022-23	22.50
2023-24	21.98
2024-25	21.13
Source: HMIS Portal	

The table shows the trend in pregnant women registration from 2014-15 to 2024-25 in the district. The data presents the number (in thousands) of pregnant women registrations across eleven years. The overall pattern indicates an initial, peaking in 2017-18 **(26.00 thousand),** followed by a **general decline,** reaching the lowest reported value in **2024-25** (21.13 thousand). This trend highlights the need for enhanced awareness and targeted interventions to improve early pregnancy registration rates. Overall, the data underscores the importance of continuous programme evaluation and strengthening maternal health initiatives.

Graph 5.1.1: Trend in Pregnant Women Registration in the District (2014-15 to 2024-25) in thousand.

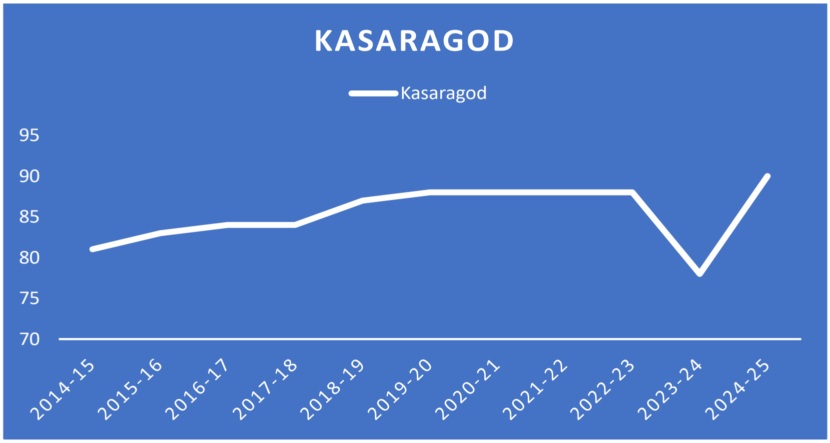


5.2 Early Initiation of Antenatal Care

Table 5.2.1 Trend in Percentage of First Trimester ANC Registration (2014-15 to 2024-25)

Period	ANC First Trimester Registration %
2014-15	81
2015-16	83
2016-17	84
2017-18	84
2018-19	87
2019-20	88
2020-21	88
2021-22	88
2022-23	88
2023-24	78
2024-25	90
Source: HMIS Portal	

Graph 5.2.1: Trend in Percentage of First Trimester ANC Registration (2014-15 to 2024-25)



This dataset represents the percentage of pregnant women registered for antenatal care (ANC) within the first trimester (first three months of pregnancy). The trend indicates a **steady improvement from 2014–15 to 2019–20**, followed by a **plateau at 88% that was sustained until 2022-23.** The data then shows a sharp drop to 78% in 2023–24, before a strong rebound to the highest recorded figure of 90% in 2024–25.

Early initiation of ANC is crucial for monitoring pregnancy and ensuring better maternal and foetal health outcomes. The general increase and the high figures in recent years reflect effective outreach, awareness, and service delivery improvements over the years. High first trimester registration rates are key indicators of progress in maternal healthcare programmes and contribute to reducing maternal and neonatal risks by facilitating timely interventions.

5.3 Immunization Status of Pregnant Women

Table 5.3.1: Td Immunization Status of Pregnant Women – 2024-25

	Number
No of PW registered for ANC	21127
No of PW given Td1	12959
No of PW given Td2	12173

No of PW given Td Booster	1252
Source: HMIS Portal	

The table shows the number of pregnant women in Kasaragod who were provided with different doses of the Td vaccine. While 21,127 women registered for ANC services, 12,959 women received the first dose of the vaccine, 12,173 received the second dose, and 1,252 received the Td booster. This data reflects the district's ongoing efforts in ensuring pregnant women are immunised against tetanus and diphtheria to safeguard both maternal and child health.

5.4 Abortion

Table 5.4.1: Trends in Spontaneous and Induced Abortions (2014-15 to 2024-25)

Period	Pregnant Woman	Total Abortions (spontaneous + Induced)	Spontaneous Abortions	Induced Abortions
2014-15	25021	897	874	23
2015-16	24437	928	913	15
2016-17	24204	1185	1173	12
2017-18	25998	1486	1029	457
2018-19	25869	1230	907	323
2019-20	25583	1190	813	377
2020-21	21581	940	703	237
2021-22	23485	1051	587	464
2022-23	22500	1160	579	581
2023-24	21977	1431	600	831
2024-25	21127	1702	686	1016
Source: HMIS Portal				

Total cases had a strong increase initially, but the numbers have been fluctuating with a significant drop in the most recent year. **Spontaneous cases** showed a rise until 2017, followed by a steady decline until 2021, with a slight increase afterward**. Induced cases** are low until 2016-17 and there is a massive spike in 2017-18 to 457. They drop significantly after 2017-18 before rising again. They show a strong, consistent rise only from 2021-22 (464) to 2024-25 (1016).

5.5 Family Planning

Table 5.5.1: Male and Female Sterilisations Reported in HMIS (2020-21to 2024-25)

Period	NSV	Laparoscopic sterilisations	Mini-lap sterilisations	PPS	PAS
2020-21	1	104	37	559	12
2021-22	5	87	39	628	6
2022-23	34	243	24	879	3
2023-24	26	205	53	802	50
2024-25	23	289	37	859	35
Source: HMIS Portal					

The NSV programme gained strong momentum from 2020-21, indicating successful awareness and acceptance efforts, but it has since declined significantly in the last two years (26 in 2023-24 and 23 in 2024-25). Laparoscopic sterilisations show a strong overall growth trend despite high fluctuation (e.g., a drop in 2021–22 and 2023–24), suggesting improved access to facilities and trained personnel over the period. Minilap sterilisation numbers continue to fluctuate widely, possibly due to preference for laparoscopy or other limiting factors like equipment or staffing. Post-partum sterilisation indicates growing uptake of sterilisation immediately after delivery — a positive sign of integrated maternal health services. Post Abortion Sterilisation (PAS) rise in recent years reflects improved counselling and availability of services.

Table 5.5.2: IUCD Insertions Reported in HMIS

(2020-21 to 2024-25)

Year	FP elements	IUCD Insertions
2020-21	IUCD	1173
	PPIUCD	93
	PAIUCD	15
2021-22	IUCD	1232
	PPIUCD	31
	PAIUCD	0
2022-23	IUCD	1757
	PPIUCD	38
	PAIUCD	0
2023-24	IUCD	1425
	PPIUCD	46
	PAIUCD	2
2024-25	IUCD	1250
	PPIUCD	61
	PAIUCD	1
Source: HMIS Portal		

IUCD insertion increased significantly from 1173 (2020–21) to a **peak of 1757 (2022–23),** followed by a **decline** to 1250(2024-25). It reflects strong service performance up to 2022–23, possibly due to focused IUCD promotion. PPIUCD shows an **initial sharp decline** from **93** in 2020–21 to 31 in 2021–22, followed by a **subsequent steady growth** from 2021-22 to reach **61** in 2024–25. Despite an initial fall in 2021–22, steady growth since then indicates improved integration of FP counselling in maternity services. PAIUCD is **declining** from 15 (2020–21) to 1 (2024–25). The low and decreasing figures suggest limited uptake post-abortion, likely due to service delivery constraints or inadequate counselling.

Table 5.5.3: Distribution of Family Planning Commodities (Public Sector) Reported in HMIS (2020-21 to 2024-25)

Period	Number of Combined Oral Pill cycles distributed	Number of Condom pieces distributed	Number of Centchroman (weekly) pill strips distributed	Number of Emergency Contraceptive Pills (ECP) given
2020-21	4011	11915	74	146
2021-22	5027	44769	700	107
2022-23	6803	90361	370	49
2023-24	7854	71317	564	129
2024-25	7777	91294	582	127
Source: HMIS Portal				

Between **2020–21 and 2024–25,** the distribution of family planning commodities in the public sector has shown an **overall positive trend:**

- The **supply and utilization** of **condoms and oral pills** have increased markedly, highlighting marked progress in short-term contraceptive use.
- **Centchroman** and **ECP** usage patterns remain relatively low but stable, showing moderate community acceptance.
- The data overall suggests **strengthened family planning logistics, outreach, and service delivery,** with room for further IEC (Information, Education, and Communication) efforts to expand awareness of less commonly used methods.

5.6 Delivery

Table 5.6.1: Trend in Total Deliveries (2020-21 to 2024-25)

Period	Pub	Pvt	Home Delivery	All
2020-21	16189	28391	14	44594
2021-22	15671	27549	20	43240
2022-23	15589	27937	22	43548
2023-24	13525	27201	24	40750
2024-25	11205	25513	24	36742
Source: HMIS Portal				

Table 5.6.1 presents the trend in total deliveries from 2020-21 to 2024-25, categorized by place of delivery—public health facilities, private facilities, and home deliveries. Total reported deliveries under HMIS show a **gradual, persistent downward trend** across all facility types:

- **Public institutional deliveries** have reduced significantly, indicating a possible shift toward private healthcare or a declining fertility rate.
- **Private sector deliveries** continue to contribute the **major share** of total institutional births.
- **Home deliveries** remain **very low**, underscoring sustained progress toward safe, facility-based childbirth.

Overall, while the **institutional delivery rate remains high,** the **total number of reported deliveries** has been consistently declining. This suggests a need for continuous monitoring, improved data reporting, and enhanced public facility utilization initiatives

Table 5.6.2: Institutional Deliveries (2020-21 to 2024-25)

Period	Pub	Pvt	Home Delivery	All	%
2020-21	4482	13902	16	18400	0.08696
2021-22	4177	14999	28	19204	0.1458
2022-23	4009	13912	22	17943	0.12261
2023-24	3322	12354	10	15686	0.06375
2024-25	2853	10656	15	13524	0.11091
Source: HMIS Portal					

Table 5.6.2 shows the trend in home and institutional deliveries from 2020-21 to 2024-25. Total deliveries declined from 18400 in 2020-21 to 13524 in 2024-25. Institutional deliveries (combined public and private) form the vast majority, while home deliveries remain minimal, though showing a slight increase in proportion from 0.08696% to 0.11091% over the same period. This minor rise in home deliveries demands attention to ensure safe practices are maintained. Rising institutional deliveries correlate with improved maternal and new-born outcomes, driven by programmes promoting facility births and skilled attendance. Geographic, socio-economic, and awareness factors affect access to institutional delivery. Continued focus on reducing barriers like distance and improving antenatal care support can further reduce home deliveries and improve maternal health equity.

5.7 Caesarean Section Deliveries

Table 5.7.1: C-Section Rate in Public and Private Hospitals

(2020-21 to 2024-25)

Period	Pub	Pvt	All
2020-21	29.38	28.87	28.99

2021-22	29.90	27.11	27.72
2022-23	33.23	30.31	30.96
2023-24	32.72	33.75	33.53
2024-25	32.95	34.90	34.49
Source: HMIS Portal			

C- section delivery in public sector shows gradual increase from **29.38% (2020–21)** to **32.95% (2024–25).** This indicates a rising rate of C-sections in public hospitals, possibly due to better availability of emergency obstetric care, increased identification of high-risk pregnancies, or a shift in patient preference. In private sector **consistent increase** from **28.87% to 34.90%. it shows** a sharper rise, suggesting growing elective or non-medical C-sections and higher intervention rates. The overall C-section rate has steadily increased, surpassing the WHO's recommended limit of 10–15%, highlighting a trend toward over-medicalization of childbirth in both sectors.

5.8 Maternal Deaths

Table 5.8.1: Trend of Maternal Deaths (2014-15 to 2024-25)

Period	Maternal deaths
2014-15	6
2015-16	12
2016-17	8
2017-18	8
2018-19	6
2019-20	10
2020-21	11
2021-22	13

2022-23	12
2023-24	17
2024-25	7
Source: HMIS Portal	

Over the **11-year period (2014–15 to 2024–25),** maternal deaths reported under HMIS show a **fluctuating but overall controlled trend.** The **highest number (17)** occurred in **2023–24,** which may be linked to post-pandemic effects, high-risk pregnancies, or reporting improvements. A **subsequent decline to 7 in 2024–25** suggests improvement in maternal care services, timely referrals, and better monitoring mechanisms. Despite fluctuations, the **long-term trend remains stable,** indicating that while maternal health outcomes have improved, **continued vigilance and quality maternal care interventions** remain essential to sustain reductions in mortality.

5.9 Childbirth

Table 5.9.1: Trend of Live Births by Gender – (in thousands) (2014-15 to 2024-25)

Period	Male	Female	Total
2014-15	11.233	10.575	21.808
2015-16	10.742	9.819	20.561
2016-17	9.844	9.301	19.145
2017-18	10.485	9.814	20.299
2018-19	10.11	9.81	19.92
2019-20	9.374	8.777	18.151
2020-21	9.57	8.881	18.451
2021-22	9.821	9.492	19.313
2022-23	9.093	8.993	18.086

2023-24	7.98	7.779	15.759
2024-25	6.814	6.804	13.618
Source: HMIS Portal			

The period 2014–15 to 2024–25 witnessed a **steady decline in live births** for both genders, with total births reducing by nearly **8.19 thousand.** Despite the fall in total numbers, the **sex ratio at birth improved remarkably,** moving towards gender balance. Overall, the data reflect a **positive demographic shift—**lower fertility, healthier maternal outcomes, and more equitable gender outcomes.

5.10 Infant Mortality

Table 5.10.1: Number of Neonatal Deaths Reported

(2014-15 to 2024-25)

Period	Neonatal Death
2014-15	125
2015-16	97
206-17	125
2017-18	108
2018-19	86
2019-20	93
2020-21	82
2021-22	94
2022-23	100
2023-24	88
2024-25	89
Source: District Report	

Table 5.10.1 presents the number of neonatal deaths reported annually from 2014–15 to 2024–25. The data indicate a general declining trend in neonatal mortality over the years, from 125 deaths in 2014–15 to 89 deaths in 2024–25. Although there are minor fluctuations in certain years, the overall pattern reflects improvement in neonatal health outcomes and healthcare services over the decade.

Table 5.10.2: Number of Infant Deaths Reported

(2014-15 to 2024-25)

Period	Infant Death
2014-15	184
2015-16	161
2016-17	193
2017-18	186
2018-19	149
2019-20	150
2020-21	127
2021-22	129
2022-23	153
2023-24	142
2024-25	132
Source: District Report	

Table 5.10.2 s presents the number of infant deaths reported from 2014-15 to 2024-25. It shows that 184 **deaths in 2014–15 to 132 deaths in 2024–25**, showing an **overall decline of about 28.3%** over the decade. This suggests gradual improvement in infant health care, maternal care, and public health initiatives.

Table 5.10.3: Number of child death reported

(2021-22 to 2024-25)

Period	2021-22	2022-23	2023-24	2024-25
Child Death	139	163	159	158
Source: District Report				

Table 5.10.3 shows the number of child deaths reported between 2021–22 and 2024–25 (covering children generally aged 1 to 5 years). The number of deaths increased initially from 139 in 2021–22 to 163 in 2022–23, followed by a slight stabilization and minor decrease in the subsequent two years (158 in 2024–25). The short-term trend shows a concerning rise in the early years of the period, warranting further investigation into the causes of mortality in this age group and the effectiveness of child survival programmes.

Table 5.10.4: Infant and Neonatal Mortality Rates

(2019-20 to 2024-25)

Period	Infant and Neonatal Mortality Rates	
2019-20	IMR	8
	NMR	5
2020-21	IMR	7
	NMR	4
2021-22	IMR	7
	NMR	5
2022-23	IMR	8
	NMR	6
2023-24	IMR	9
	NMR	6

2024-25	IMR	10
	NMR	7
Source: Monthly District Death Reports and HMIS Live Birth Data		

The table presents the Infant Mortality Rate (IMR) and Neonatal Mortality Rate (NMR) over a six-year period from **2019–20 to 2024–25**. **IMR** refers to the number of infant deaths (under 1 year of age) per 1,000 live births. **NMR** refers to the number of neonatal deaths (within the first 28 days of life) per 1,000 live births.

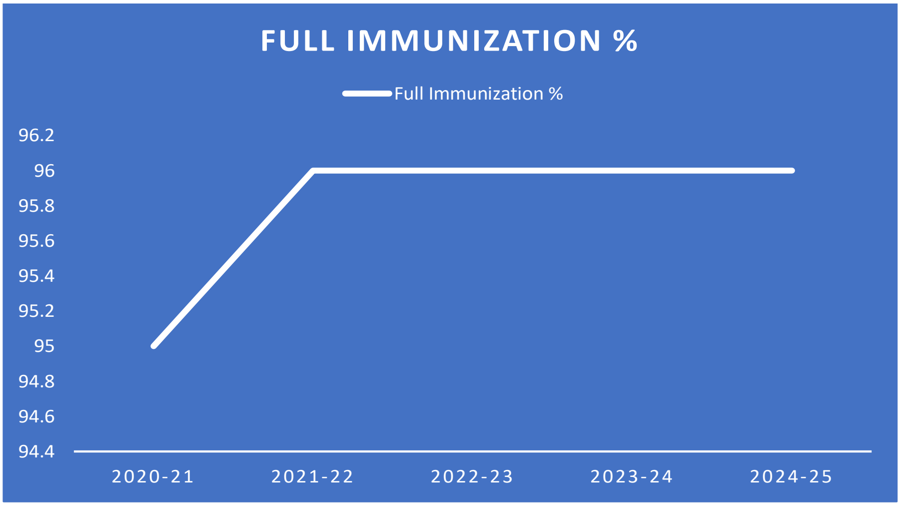
The **initial decline (2019–21)** reflects successful interventions in maternal and child health services. However, the **rising trend from 2021–22 to 2024–25** indicates **emerging challenges—**possibly due to factors such as post-pandemic healthcare strain, gaps in neonatal care, or variations in data reporting and quality of prenatal services. The increase in both IMR and NMR highlights the need for **targeted interventions** focusing on new-born care, maternal health, and early postnatal monitoring.

5.11. Child Immunisation

Table 5.11.1: Child immunisation

Period	Full Immunisation %
2020-21	95
2021-22	96
2022-23	96
2023-24	96
2024-25	96
Source: RCH Portal	

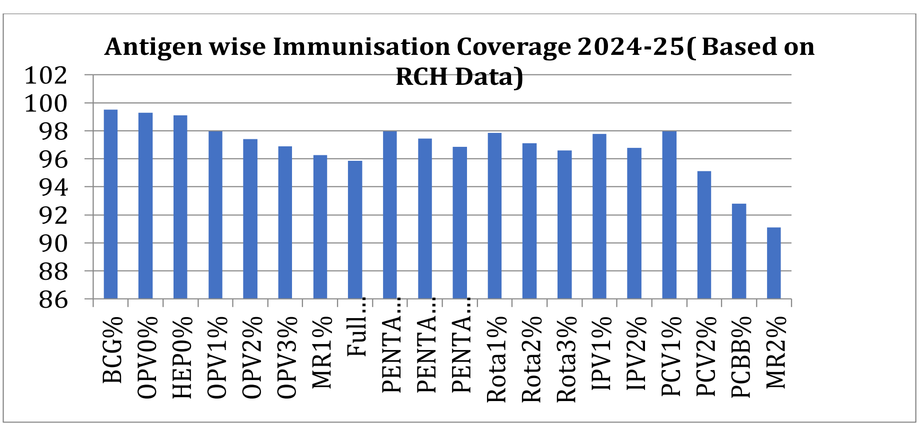
Graph 5.11.1: Trend in Percentage of Children Fully Immunised



Source: RCH Portal

The table presents data on the percentage of children who received full immunisation over a five-year period, from 2020–21 to 2024–25. The data indicate a consistently high immunisation coverage rate throughout the period. In 2020–21, the full immunisation rate was **95%**, which slightly increased to **96%** in 2021–22. From 2021–22 onward, the rate remained steady at **96%** through 2024–25. This stability suggests that the immunisation programme has maintained strong performance and near-universal coverage over the past several years.

Graph 5.11.2: Antigen-wise Immunisation Coverage



Source: RCH Data

The graph titled **"Antigen wise Immunisation Coverage 2024–25 (Based on RCH Data)"** presents the coverage percentages of various vaccines administered under the national immunisation programme. The data indicates **high immunisation coverage** across most antigens, showing the effectiveness of the ongoing immunisation efforts under the RCH programme. Coverage rates range from about **86% to 99%,** reflecting a **strong but slightly uneven performance** among different vaccines.

CHAPTER 6

COMMUNICABLE AND NON-COMMUNICABLE DISEASES

6.1. Disease Burden Overview: Common Communicable Diseases

The communicable disease profile in Kasaragod district shows **burden of major communicable diseases** reported in the year **2024**. It includes vector-borne diseases, water-borne diseases, zoonotic diseases, and viral infections. The table presents the **incidence of major communicable diseases reported in the year 2024.** It highlights the number of confirmed cases for a range of infectious diseases, including vector-borne, water-borne, zoonotic, and viral infections.

In Kasaragod district **Acute Diarrheal Disease** shows the highest number of reported cases (29,490), indicating a major public health concern related to sanitation and water quality. Other diseases with notable case counts include **Chicken Pox (936 cases), Dengue Fever (455 cases), Hepatitis A (270 cases), Influenza (H1N1, H3N2) with 55 cases**, and **Leptospirosis (64 cases).**

Table 6.1.1. Trend of communicable diseases in the district

Disease	2024	2023	2022	2021	2020
Dengue Fever: Confirmed	455	295	227	429	117
Malaria	40	29	17	27	31
Chikungunya	0	0	0	7	0
Acute Encephalitis Syndrome	3	1	0	0	0
Japanese Encephalitis (JE)	0	0	0	0	0
Leptospirosis: Confirmed	64	65	57	78	3

Hepatitis - A: Confirmed	270	58	0	0	2
Hepatitis - B	20	13	7	0	1
Hepatitis - C	5	5	0	0	0
Hepatitis - E	1	0	0	0	0
Cholera	3	0	0	0	0
Typhoid	0	2	5	0	0
Acute Diarrheal Disease	29490	28767	20838	12712	15648
Shigella	0	0	6	0	0
Scrub Typhus	20	9	4	1	0
Kala Azar	0	0	0	0	0
Kyasanur Forest Disease	0	0	0	0	0
Influenza (H1N1, H3N2, Infl A, Infl B)	55	55	9	0	1
Rabies: Confirmed	0	0	0	1	0
Zika	0	0	0	0	0
West Nile	0	0	0	0	0
Nipah	0	0	0	0	0
Chicken Pox	936	1501	350	112	480

In contrast, several diseases such as **Chikungunya, Japanese Encephalitis, Typhoid, Kala Azar, Kyasanur Forest Disease, Zika, West Nile, and Nipah** reported **no cases** during the year.

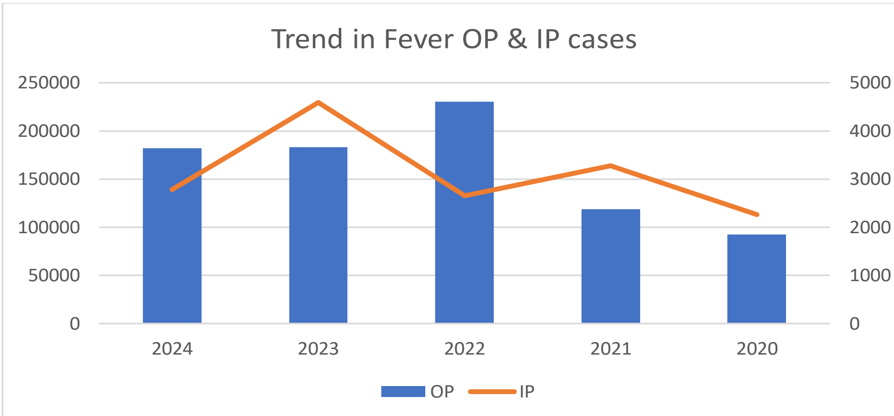
6.1.1 Fever case - Cases Reported

Table 6.1.1.1 Trend in Fever Outpatient and Inpatient Cases

2024	OP	181994
	IP	2785
2023	OP	183187
	IP	4591
2022	OP	230107
	IP	2652
2021	OP	118504
	IP	3281
2020	OP	92443
	IP	2263

The trend of Fever Outpatient and Inpatients shows that there is a fluctuating trend over the years in OP cases. The number of OP cases increased significantly from **118,504 in 2021** to **230,107 in 2022,** then slightly declined in **2023 (183,187)** and remained stable in **2024 (181,994).** IP cases show an irregular pattern, with the highest count in **2023 (4,591)** and the lowest in **2022 (2,652).** The trend of fever showing Outpatient (OP) and Inpatient (IP) cases from 2021 to 2024. OP cases peaked in 2022, followed by a slight decline. IP cases fluctuated, with the highest in 2023.

Graph 6.1.1.1: Trend in Fever Outpatient and Inpatient Cases Reported from All Health Facilities (2020–2024)



The chart highlights that **OP cases consistently far exceed IP cases,** indicating a higher reliance on outpatient care. The dual visualization effectively captures both the volume and variability in healthcare utilization across the years.

6.1.2 Trend in Top Five Reported Communicable Diseases in the District

Table 6.1.2.1: Top Five Communicable Diseases in the District (2020-2024)

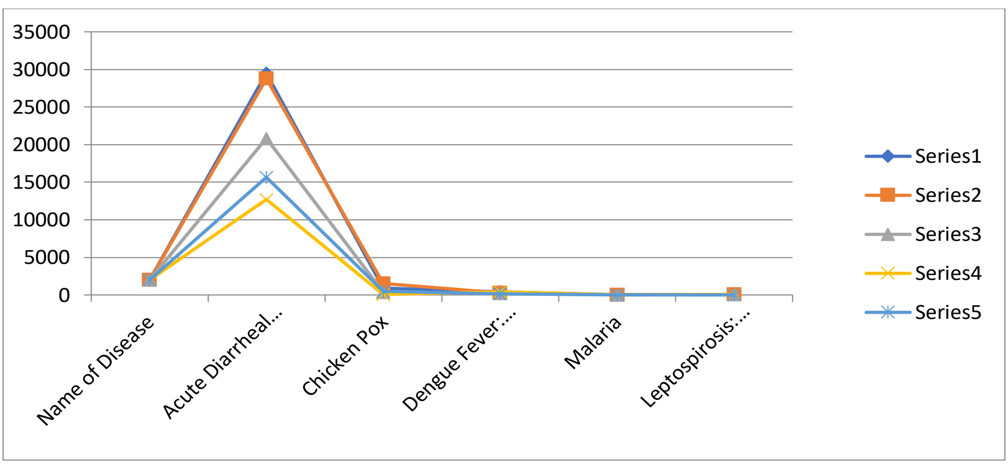
Sl. No	Name of Diseases	2024	2023	2022	2021	2020
1	Acute Diarrheal Disease	29490	28767	20838	12712	15648
2	Chicken Pox	936	1501	350	112	480
3	Dengue Fever: Confirmed	455	295	227	429	117
4	Malaria	40	29	17	27	31
5	Leptospirosis: Confirmed	64	65	57	78	3

This table presents the five most reported communicable diseases in the district over a five-year period, from **2020 to 2024.** The data highlights both the **burden of diseases** and the **trends in incidence** over time. **Acute Diarrheal Disease** dominates the district's communicable disease profile, representing the **largest and fastest-growing threat. Dengue and Leptospirosis** show **rising or fluctuating patterns,** signalling **environmental and climatic influences** on disease dynamics.

Malaria control remains a **public health success,** while **Chicken Pox** reflects **cyclical outbreaks** requiring vaccination vigilance.

The general trend underscores a **shift toward higher incidence of waterborne and vector-borne diseases,** likely due to **urbanization, climate change, and sanitation challenges.**

Graph 6.1.2.1 Trend of top five communicable Diseases in the district



6.2. Burden of Non-Communicable Diseases in the District

Table 6.2.1 Major Noncommunicable Diseases

Disease	2023-24	2024-25
	No of Cases	No of Cases
Accidental injuries	24414	26205
Cancers		

Cancer Cervix	73	70
Breast Cancer	167	204
Lung Cancer	67	235
Oral Cancer	430	496
Rheumatic fever	54	205
Hypertension	31177	32570
Ischemic Heart disease	2547	3890
Congenital Heart disease	430	1140
Others	3001	4388
Diabetes		
Type 1	2506	4699
Type 2	25049	27971
Cerebrovascular Disorders	1431	2743
Chronic neurological disorders	98	1476
Others	3236	4694
Obesity	126	653
Psychic disorders	376	597
Common Mental disorders	4537	9534
Severe mental disorders	376	850
Road Traffic Accident	6217	2752
Snake bite	133	285

Almost all NCD categories show an increase in cases from 2023–24 to 2024–25. This indicates either better reporting/diagnosis or a genuine rise in disease burden. Accidental injuries rose from 24,414 → 26,205 (+7.3%). Road traffic accidents, however, dropped sharply from 6,217 → 2,752 (–55.7%). Indicates improved road safety measures or underreporting in 2024–25. Snake bites increased from 133 → 285 (+114%), possibly due to environmental/rural exposure factors. Cervical cancer slightly declined (73 → 70, –4%). Breast cancer increased significantly (167 → 204, +22%). Lung cancer more than tripled (67 → 235, +251%). Oral cancer also rose (430 → 496, +15%). Lifestyle factors (tobacco, pollution, late detection) are driving higher cancer burden. Hypertension continues to dominate with very high prevalence (31,177 → 32,570, +4.5%). Ischemic heart disease rose markedly (2,547 → 3,890, +53%). Congenital heart disease almost tripled (430 → 1,140, +165%). Other cardiac cases increased too (3,001 → 4,388, +46%). Cardio-metabolic diseases are a major health challenge in the district. Type 1 diabetes has nearly doubled (2,506 → 4,699, +87%). Type 2 diabetes increased (25,049 → 27,971, +11.7%). Alarming rise, especially in Type 1 diabetes, may need further validation or indicate improved detection. Cerebrovascular disorders (stroke-related) doubled (1,431 → 2,743, +92%). Chronic neurological disorders skyrocketed (98 → 1,476, +1,406%). Possible better reporting, aging population, or higher lifestyle-related risk factors. Common mental disorders more than doubled (4,537 → 9,534, +110%). Severe mental disorders also rose (376 → 850, +126%). Psychic disorders (376 → 597, +59%) and obesity (126 → 653, +418%) show sharp increases. Growing recognition and diagnosis of mental health & lifestyle diseases.

Cancers, cardiovascular diseases, diabetes, and mental health conditions are all rising, signaling an urgent need for preventive & screening programmes. Road traffic accidents show improvement, but accidental injuries overall are still rising. Obesity, diabetes, and hypertension form the backbone of the NCD burden → strong link to lifestyle changes. Mental health cases doubled, indicating rising awareness or increasing stress-related illnesses.

CHAPTER 7

CRITICAL OBSERVATIONS IN NFHS 5 DATA AND APPROPRIATE INTERVENTIONS NEEDED

7.1 Comparison of NFHS-4 and NFHS-5 Data and Comparison with State Status

Table 7.1.1 Comparison of NFHS-4 and NFHS-5 Data

Indicators	NFHS-5 (2019-20)	NFHS-4 (2015-16)
Population and Household Profile	**Total**	**Total**
1. Female population age 6 years and above who ever attended school (%)	90.8	88.8
2. Population below age 15 years (%)	24.1	22.5
3. Sex ratio of the total population (females per 1,000 males)	1,134	1,041
4. Sex ratio at birth for children born in the last five years (females per 1,000 males)	984	981
5. Children under age 5 years whose birth was registered with the civil authority (%)	99.1	98.4
6. Deaths in the last 3 years registered with the civil authority (%)	95.5	NA
7. Population living in households with electricity (%)	99.5	99.1
8. Population living in households with an improved drinking-water source[1] (%)	93.2	92.7

9. Population living in households that use an improved sanitation facility[2] (%)	98.9	98
10. Households using clean fuel for cooking[3] (%)	73.5	52.9
11. Households using iodized salt (%)	99.6	94.2
12. Households with any usual member covered under a health insurance/financing scheme (%)	44	37.5
13. Children age 5 years who attended pre-primary school during the school year 2019-20 (%)	9.6	NA
Characteristics of Women (age 15-49 years)		
14. Women who are literate[4] (%)	95.9	NA
15. Women with 10 or more years of schooling (%)	68.3	61.9
Marriage and Fertility		
16. Women age 20-24 years married before age 18 years (%)	4.7	4
17. Births in the 5 years preceding the survey that are third or higher order (%)	1.4	0.5
18. Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	3.7	3.3

19. Women age 15-24 years who use hygienic methods of protection during their menstrual period[5] (%)	93.9	92.8
Current Use of Family Planning Methods (currently married women age 15–49 years)		
20. Any method[6] (%)	56.4	42.6
21. Any modern method[6] (%)	46.6	37.5
22. Female sterilisation (%)	39	34.2
23. Male sterilisation (%)	0.2	0
24. IUD/PPIUD (%)	2.4	1.4
25. Pill (%)	0	0.2
26. Condom (%)	3.5	1.6
27. Injectables (%)	0	0.2
Unmet Need for Family Planning (currently married women age 15–49 years)		
28. Total unmet need[7] (%)	12.5	15.2
29. Unmet need for spacing[7] (%)	6.4	10.4
Quality of Family Planning Services		
30. Health worker ever talked to female non-users about family planning (%)	23.9	25.2
31. Current users ever told about side effects of current method[8] (%)	69.1	59.4

Indicators	NFHS-5 (2019-20)	NFHS-4 (2015-16)
Maternal and Child Health	**Total**	**Total**
Maternity Care (for last birth in the 5 years before the survey)		
32. Mothers who had an antenatal check-up in the first trimester (%)	97.4	95.9
33. Mothers who had at least 4 antenatal care visits (%)	91.2	90.9
34. Mothers whose last birth was protected against neonatal tetanus[9] (%)	99.2	97.9
35. Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	89.4	72.2
36. Mothers who consumed iron folic acid for 180 days or more when they were pregnant (%)	83.7	54.6
37. Registered pregnancies for which the mother received a Mother and Child Protection (MCP) card (%)	92.8	87.1
38. Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel member within 2 days of delivery (%)	95	88

39. Average out-of-pocket expenditure per delivery in a public health facility (Rs.)	3,778	6,659
40. Children born at home who were taken to a health facility for a check-up within 24 hours of birth (%)	*	*
41. Children who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel member within 2 days of delivery (%)	95.9	na
Delivery Care (for births in the 5 years before the survey)		
42. Institutional births (%)	100	100
43. Institutional births in public facility (%)	29.9	28.5
44. Home births that were conducted by skilled health personnel[10] (%)	0	0
45. Births attended by skilled health personnel[10] (%)	100	100
46. Births delivered by caesarean section (%)	28.8	26.3
47. Births in a private health facility that were delivered by caesarean section (%)	28.9	28.4
48. Births in a public health facility that were delivered by caesarean section (%)	28.4	21.1

Child Vaccinations and Vitamin A Supplementation		
49. Children age 12-23 months fully vaccinated based on information from either vaccination card or mother's recall[11] (%)	92.5	91.8
50. Children age 12-23 months fully vaccinated based on information from vaccination card only[12] (%)	98	93.4
51. Children age 12-23 months who have received BCG (%)	98.6	98
52. Children age 12-23 months who have received 3 doses of polio vaccine[13] (%)	94.4	93.8
53. Children age 12-23 months who have received 3 doses of Penta or DPT vaccine (%)	96.6	93.5
54. Children age 12-23 months who have received the first dose of measles-containing vaccine (MCV) (%)	97.3	93.5
55. Children age 24-35 months who have received a second dose of measles-containing vaccine (MCV) (%)	9.3	NA
56. Children age 12-23 months who have received 3 doses of rotavirus vaccine[14] (%)	24.7	NA
57. Children age 12-23 months who have received 3 doses of Penta or hepatitis B vaccine (%)	95.3	90

58. Children age 9-35 months who received a vitamin A dose in the last 6 months (%)	83.4	68.5
59. Children age 12-23 months who received most of their vaccinations in a public health facility (%)	88.3	80.7
60. Children age 12-23 months who received most of their vaccinations in a private health facility (%)	11.7	19.3
Treatment of Childhood Diseases (children under age 5 years)		
61. Prevalence of diarrhoea in the 2 weeks preceding the survey (%)	1.9	6.7
62. Children with diarrhoea in the 2 weeks preceding the survey who received oral rehydration salts (ORS) (%)	*	*
63. Children with diarrhoea in the 2 weeks preceding the survey who received zinc (%)	*	*
64. Children with diarrhoea in the 2 weeks preceding the survey taken to a health facility or health provider (%)	*	*
65. Prevalence of symptoms of acute respiratory infection (ARI) in the 2 weeks preceding the survey (%)	0.3	1.2

66. Children with fever or symptoms of ARI in the 2 weeks preceding the survey taken to a health facility or health provider (%)	(97)	*
Indicators	**NFHS-5 (2019-20)**	**NFHS-4 (2015-16)**
Child Feeding Practices and Nutritional Status of Children	**Total**	**Total**
67. Children under age 3 years breastfed within one hour of birth[15] (%)	86.1	59.8
68. Children under age 6 months exclusively breastfed[16] (%)	(68.2)	*
69. Children age 6-8 months receiving solid or semi-solid food and breastmilk[16] (%)	*	*
70. Breastfeeding children age 6-23 months receiving an adequate diet[16, 17] (%)	9.4	25.2
71. Non-breastfeeding children age 6-23 months receiving an adequate diet[16, 17] (%)	*	*
72. Total children age 6-23 months receiving an adequate diet[16, 17] (%)	12.2	28.3
73. Children under 5 years who are stunted (height-for-age)[18] (%)	25.3	18.7

74. Children under 5 years who are wasted (weight-for-height)[18] (%)	12.6	9.7
75. Children under 5 years who are severely wasted (weight-for-height)[19] (%)	5.7	3.2
76. Children under 5 years who are underweight (weight-for-age)[18] (%)	21.4	13.9
77. Children under 5 years who are overweight (weight-for-height)[20] (%)	1.6	0.4
Nutritional Status of Women (age 15-49 years)		
78. Women whose Body Mass Index (BMI) is below normal (BMI <18.5 kg/m^2)[21] (%)	9.4	13
79. Women who are overweight or obese (BMI ≥25.0 kg/m^2)[21] (%)	28.4	27.5
80. Women who have high risk waist-to-hip ratio (≥0.85) (%)	76.8	NA
Anaemia among Children and Women		
81. Children age 6-59 months who are anaemic (<11.0 g/dl)[22] (%)	34.3	37.7
82. Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl)[22] (%)	35.6	35
83. Pregnant women age 15-49 years who are anaemic (<11.0 g/dl)[22] (%)	27.3	35.6

84. All women age 15-49 years who are anaemic[22] (%)	35.4	35
85. All women age 15-19 years who are anaemic[22] (%)	39.6	28.6
Blood Sugar Level among Adults (age 15 years and above)		
Women		
86. Blood sugar level - high (141-160 mg/dl)[23] (%)	8.1	NA
87. Blood sugar level - very high (>160 mg/dl)[23] (%)	10.2	NA
88. Blood sugar level - high or very high (>140 mg/dl) or taking medicine to control blood sugar level[23] (%)	20.4	NA
Men		
89. Blood sugar level - high (141-160 mg/dl)[23] (%)	10	NA
90. Blood sugar level - very high (>160 mg/dl)[23] (%)	10.2	NA
91. Blood sugar level - high or very high (>140 mg/dl) or taking medicine to control blood sugar level[23] (%)	22.3	NA
Hypertension among Adults (age 15 years and above)		
Women		

92. Mildly elevated blood pressure (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	13.5	NA
93. Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100mm of Hg) (%)	5.3	NA
94. Elevated blood pressure (Systolic ≥140 mm of Hg and/or Diastolic ≥90 mm of Hg) or taking medicine to control blood pressure (%)	26.1	NA
Men		
95. Mildly elevated blood pressure (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	15.9	NA
96. Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100mm of Hg) (%)	4.6	NA
97. Elevated blood pressure (Systolic ≥140 mm of Hg and/or Diastolic ≥90 mm of Hg) or taking medicine to control blood pressure (%)	26	NA
Screening for Cancer among Women (age 30-49 years)		
98. Ever undergone a screening test for cervical cancer (%)	3.5	NA
99. Ever undergone a breast examination for breast cancer (%)	1.7	NA

100. Ever undergone an oral cavity examination for oral cancer (%)	0.6	NA
Tobacco Use and Alcohol Consumption among Adults (age 15 years and above)		
101. Women age 15 years and above who use any kind of tobacco (%)	3.5	NA
102. Men age 15 years and above who use any kind of tobacco (%)	14.2	NA
103. Women age 15 years and above who consume alcohol (%)	0.1	NA
104. Men age 15 years and above who consume alcohol (%)	14.9	NA
Source NFHS 4&5 report		

The comparison between NFHS-5 and NFHS-4 highlights significant progress in key health and social indicators, along with emerging areas requiring focused intervention.

Key Improvements:

- **Education and Gender Balance:** Female literacy and school attendance have improved (90.8% vs 88.8%), and the **sex ratio** increased substantially from **1,041 to 1,134**, reflecting better gender equity.
- **Infrastructure and Basic Amenities:** Nearly universal access to electricity (99.5%) and improved sanitation (98.9%) indicates strengthened living standards. The rise in households using **clean cooking fuel (73.5% vs 52.9%)** marks a major environmental and health gain.
- **Maternal and Child Health:** Antenatal and postnatal care coverage remains high, with notable improvement in **iron-folic acid supplementation (83.7% vs 54.6%)**. Institutional deliveries and immunisation coverage continue to be near universal, showcasing robust maternal and child health services.

Areas of Concern:

- **Child Nutrition:** Despite good service coverage, nutritional outcomes have declined — **stunting (25.3%)** and **underweight prevalence (21.4%)** have increased, indicating dietary and care-related gaps.
- **Anaemia:** Anaemia persists among women (35.4%) and children (34.3%), showing minimal progress, necessitating strengthened iron supplementation, diet diversification, and anaemia control programmes.
- **Lifestyle Diseases:** High prevalence of **hypertension (26%)** and **high blood sugar (20–22%)** among adult points to rising non-communicable diseases (NCDs), requiring preventive screening, lifestyle modification campaigns, and NCD management services.

Strengths:

The district demonstrates strong performance in **maternal care, immunisation, sanitation, and gender balance,** supported by effective health system coverage and awareness.

Focus Areas for Improvement:

- Targeted **nutrition interventions** for children and women.
- Strengthening **anaemia and NCD prevention programmes**.
- Enhancing **awareness and screening** for cancers and lifestyle diseases.
- Promoting **balanced diets and physical activity** through community-level initiatives.

Overall, the district shows **steady health system progress**, with the need to pivot towards **nutrition-sensitive and NCD-focused strategies** to sustain long-term health gains.

CHAPTER 8

DISTRICT MENTAL HEALTH PROGRAMME

District Mental Health Programme (DMHP) is a community - based mental health initiative providing mental health services across Kasaragod district. The programme was started in 2009 under **Institute of Mental Health and Neurosciences (IMHANS),** Calicut**.** DMHP functioned under **National Health Mission (NHM)** from April 2017 to May 2018 and is currently under the **Directorate of Health Services (DHS)**. At present, **19 outreach clinics** are conducted every month, offering mental health services to more than **1,500 patients.** The programme focuses heavily on continuity of care through regular follow-up services, along with community detection and support.

8.1 DMHP Outreach clinics -2024 -25

A total of **23,591** cases were recorded across DMHP outpatient clinics during 2024–25. New cases comprised **474 (2%),** while **23,117 (98%)** were follow-up cases, indicating strong retention and sustained care. The highest number of cases were recorded in July (2008), September (2018), December (2007), February (2046). Lowest cases in January (1985), November (1876), April (1894). New cases range between 24 (Jan) to 52 (June). There is a stable monthly patient load of ~1900–2050 cases. Follow-ups dominate (98%), indicates good patient retention & regular monitoring. New case detection is relatively low, may reflect under-diagnosis, stigma, or limited outreach in the community. Seasonal variation is minimal, no sharp spikes, which suggests mental health service demand is steady year-round. Average monthly caseload ≈ 1,965 cases, showing consistent program utilization. Need to increase awareness & screening to bring in more new cases. Current load shows the program has strong follow-up adherence, which is a positive indicator of continuity of care. Could explore community outreach in low new-case months (e.g., January, April) to boost detection.

Table 8.1.1 DMHP outreach clinics in 2024-25

Month	2024-25		
	New	Follow Up	Total Case
April	34	1860	1894
May	44	1913	1957
June	52	1951	2003
July	36	1972	2008
August	40	1930	1970
September	37	1981	2018
October	44	1915	1959
November	45	1831	1876
December	41	1966	2007
January	24	1961	1985
February	38	2008	2046
March	39	1829	1868
Total	**474**	**23117**	**23591**

8.2 Post Flood activities & Training programs- 2024-25

A total of **58 training sessions** were conducted in 2024-25, involving **2,285 participants**. The most significant initiatives included SMA Training (**21 sessions**, 830 participants) and **ASWASAM** Training (**15 sessions**, 583 participants).

Table 8.2.1 Post flood activities and training

SL. No	Training	No of training conducted	No of Participants
1	Jeeva Raksha (Suicide Prevention Training)	10	465
2	ASWASAM TRAINING	15	583
3	SMA Training	21	830
4	Stress Management	10	272
5	Training for DH Staff	1	60
6	Training for ASHAs, Kudumbasree workers, Care givers	1	75

8.3 IECs Programme conducted

Total IEC programs conducted were 5 and total participants were 532. Average reach per program is nearly 106 participants. Largest participation in World Mental Health Day (160 participants) and most frequent activity is School Mental Health programs (2 sessions, 197 participants)

IEC activities reached >500 people, but frequency is limited (only 5 events). Expanding school-based programs could greatly increase long-term impact. But participation in IEC is modest compared to training (2,285 trainees). Greater community-level mass campaigns could bridge the awareness gap. Linking Suicide Prevention Day efforts with Jeeva Raksha trainings (already strong) could create a sustainable suicide prevention network.

Table 8.3.1 IECs conducted under DMHP and participants

Sl.No	IEC	No. of IEC conducted	No. of Participants
1	Suicide Prevention Day	1	65
2	Alzheimer's Day	1	110
3	World Mental Health Day	1	160
4	School Mental Health	2	197

8.4 DMHP Targeted Interventions

1	Total No of Palliative Visit	104
2	Total No of Drop out Visit	67

8.4.1 Sampoorna Manasika Aarogyam (SMA)

Sampoorna Manasika Aarogyam is a programme for finding the undetected mental health cases in the community by involving community level health workers. SMA implemented in 21 Family Health Centres (FHCs). Conducted 63 mental health camps, detecting 562 new cases. 389 follow-up cases handled, showing an active care system. 951 total cases (new + follow-up) caseload addressed. A total of 834 psychoeducation sessions indicates a strong focus on awareness. Counselling (105 sessions) were comparatively lower, indicating scope for more structured counselling interventions. Total number of palliative visits is 104 and 67 dropout visits show proactive home/community-level care.

Table 8.4.1 DMHP target 2024-25

Sl.No	Sampoorna Manasika Aarogyam (SMA)	Total
1	Total No of FHCs Where SMA Implemented (2024-25)	21

2	Total No. of camps conducted	63
3	Total Number of New Case	562
4	Follow up	389
5	Total Case	951
6	Total No of Palliative Visit	104
7	Total No of Drop out Visit	67
8	Total No. of Psycho Education given	834
9	Total No. of Counselling given	105

8.4.2 Amma Manas

The **Amma Manas** initiative is a maternal mental-health programme launched by the **Kerala Department of Health & Family Welfare** in collaboration with the **National Mental Health Programme**. Its focus is on early screening, identification, and management of mental-health issues among women during pregnancy and the postnatal period. In districts such as Kasaragod, this programme forms part of the broader district mental-health system, integrating with primary and community health services so that pregnant women and new mothers are assessed for distress, depression, anxiety, and other conditions, and linked to care. During 2024–25, **two Amma Manas training sessions** were conducted for **90 participants**.

Key components include:

- Training of Junior Public Health Nurses (JPHN) and Maternal-care staff in mental-health screening.
- Embedding screening during antenatal and immunisation visits to mothers and linking with the District Mental Health Programme for specialised referrals.
- Support through public-health infrastructure in districts like Kasaragod, enabling early detection and timely intervention.

CHAPTER 9

TRIBAL HEALTH PROGRAMME

Kasaragod district has approximately **83,000 Scheduled Tribe (ST) residents**, making it the second-largest tribal population in Kerala after Wayanad. Majority of this Scheduled Tribe population resides in seven panchayats such as Kodom-Belur, Kallar, Panathady, Kinanoor-Karinthalam, West Eleri, East Eleri and Balal. These communities are largely located in remote, hilly, and underdeveloped regions of the Western Ghats, making accessibility to healthcare facilities difficult. Residents often travel long distances to reach primary health centres for basic medical services. Most of the residents are of Korangar, Malakkudi, Mavilar, Koppalar and Malavattu community. In the identified panchayats, a significant number of people require regular medical care, including those suffering from chronic illnesses such as cancer and kidney disease.

9.1 Tribal Population Distribution

The table (9.1.1) shows the distribution of Scheduled Tribe (ST) population in seven panchayats of Kasaragod district. A total of 10,661 tribal families comprising 38,638 individuals reside in these areas. The highest tribal population is recorded in Panathady (7,864) followed by Kodom-Belur (7,176) and Balal (6,846) panchayats. The major tribal communities include Koraga, Mavilar, Koppalar and Malavattu who mostly inhabit hilly and remote regions along the Western Ghats. Due to difficult terrain and distance from healthcare facilities, many tribal residents face challenges in accessing regular and specialized medical care.

Table 9.1.1 Tribal Population Distribution in Kasaragod District

Sl.no	Panchayath	Families	Population
1	East Eleri	660	2588
2	West Eleri	1390	5175
3	Kinanoor - karinthalam	1010	3579
4	Balal	1990	6846
5	Panathady	2165	7864

6	Kallar	1449	5410
7	Kodom Belur	1997	7176
	Total	**10661**	**38638**

9.2 Health Interventions for Scheduled Tribes

Tribal mobile camp

- Conducted under the Health Services Department
- Staffed by a Medical officer, medicines, Nurse etc
- Average 21 medical camps per month.
- Average OP - 900 per month

Free medicines for Scheduled tribe

- Provided through **Samagra Suraksha Arogya Padhathi**
- Annual allocation: **Rs.50 lakhs per district**
- Funds allotted by ST department

9.3 Other Welfare Schemes for ST population

The government provides various schemes focusing on Maternal and Child Health, institutional delivery, and reducing financial barriers:

- **Janani Janmaraksha Scheme** – Financial assistance of Rs.18,000 per mother, promoting safe pregnancy and institutional delivery, implemented through the Tribal Department.
- **Provision of Tribal Staff Nurse** – A dedicated staff nurse is posted in tribal areas by the Tribal Department for Maternal and Child Health support.
- **Financial Assistance for Institutional Delivery** - Available to all women regardless of age and number of children for delivering in the government institutions (except pay ward). Also applicable to BPL/SC/ST women regardless of age and number of children for delivering in private accredited health facilities. Rs. 700.
- **Financial Assistance for Home Delivery** – Rs. 500 available only for BPL women who prefer to deliver home regardless of age and number of children.

CHAPTER 10

FINANCIAL ALLOCATION AND UTILIZATION

Over the past four years, funding for the health sector in Kasaragod has been sourced primarily from DHS Plan funds and National Health Mission (NHM) allocations. A total of Rs.586.09 lakhs was allocated from **DHS Plan funds** between 2022 and 2025, of which Rs.477.88 lakhs was utilized, indicating an overall utilization rate of **around 81.5%.** Utilization was relatively low in 2022 and 2024 but improved notably in 2025, where nearly **90%** of the allocated funds were spent. In contrast, **NHM funding** showed consistent and efficient utilization, with Rs.115.22 crore allocated and Rs.115.09 crore (almost 100%) utilized across all four years. This indicates strong financial absorption under NHM, while DHS Plan funds require further strengthening of planning and implementation mechanisms to ensure full utilization.

Table 10.1: Financial allocation and utilization for the last four years

Source		DHS- Plan (in Lakhs)	NHM (in Crores)
2022	**Allocation**	126.37	26.91
	Utilisation	96.08	26.78
2023	**Allocation**	215.87	30.24
	Utilisation	170.09	30.24
2024	**Allocation**	111.41	24.54
	Utilisation	92.35	24.54
2025	**Allocation**	132.44	33.53
	Utilisation	119.36	33.53
Total	**Allocation**	586.09	115.22
	Utilisation	477.88	115.09

CHAPTER 11

NHM ACTIVITIES IN THE DISTRICT

In **Kasaragod district**, NHM activities were initiated soon after the national launch, marking a major step toward improving healthcare infrastructure and service delivery. At the time, the district faced unique challenges due to its **geographical diversity, tribal and coastal population**, and **uneven distribution of health facilities.** The NHM intervention helped bridge these gaps by focusing on primary healthcare and maternal-child health services through the existing **Primary Health Centres (PHCs), Community Health Centres (CHCs)**, and **Sub-Centres (SCs).**

During the **initial phase (2005–2012),** major emphasis was laid on strengthening healthcare institutions at the grassroots level. Infrastructure development, provision of essential drugs and equipment, and recruitment of additional health personnel under NHM helped improve service availability. The introduction of the **Accredited Social Health Activist (ASHA)** programme brought about a significant change in community-level health awareness and outreach, particularly in remote and tribal areas such as **Vellarikkundu, Manjeshwar, and Balal.**

The district also witnessed improvements in **maternal and child health indicators**, with a rise in institutional deliveries and immunization coverage. Various **national health programmes**—such as those for tuberculosis (RNTCP), leprosy (NLEP), malaria (NVBDCP), and HIV/AIDS (NACP)—were implemented under the NHM framework, ensuring better disease control and surveillance.

A major milestone in Kerala's health sector reform was the launch of the **Aardram Mission** in 2017, under which PHCs across the state were transformed into **Family Health Centres (FHCs)**. Kasaragod embraced this initiative enthusiastically, upgrading several PHCs into FHCs to offer comprehensive, patient-friendly, and continuous care services. These FHCs now provide extended OP hours, laboratory and pharmacy facilities, preventive health care, and health education initiatives, embodying the spirit of the NHM's holistic approach.

In recent years, NHM Kasaragod has further expanded its scope to include **non-communicable disease (NCD) prevention, mental health services**, and **adolescent health programmes.** During the **COVID-19 pandemic**, NHM played a crucial role in the district's health response by facilitating testing, vaccination drives, and community surveillance activities, demonstrating its resilience and adaptability.

At present, NHM Kasaragod continues to play a pivotal role in strengthening the district's healthcare system. It coordinates various national and state health programmes, supports infrastructure development, and ensures human resource availability across all levels of care. The mission remains committed to achieving **universal health coverage** and ensuring that every citizen of Kasaragod has access to quality, equitable, and sustainable healthcare services.

11.1 Rashtriya Bal Swasthya Karyakram (RBSK) & Arogya Kiranam (AK)

The **Rashtriya Bal Swasthya Karyakram (RBSK)** and the **Arogya Kiranam Programme** are two major child health initiatives functioning in Kasaragod district, both aiming to ensure comprehensive health coverage for children and adolescents. While RBSK is a **national-level programme** implemented under the **National Health Mission (NHM)**, Arogya Kiranam is a **state initiative of the Government of Kerala**, designed to extend financial and medical support for children suffering from serious or chronic illnesses.

The **RBSK programme** primarily focuses on the **early identification and intervention** of health conditions among children and adolescents up to 18 years of age. It targets four main categories of health issues known as the **4Ds** — *Defects at birth, Deficiencies, Diseases,* and *Developmental delays including disabilities*. Screening activities are carried out by **Mobile Health Teams (MHTs)** at schools, Anganwadis, and community levels. Children identified with potential health conditions are referred to the **District Early Intervention Centre (DEIC)** at the District Hospital for further evaluation and management. In Kasaragod, RBSK has achieved extensive coverage, particularly in rural and coastal areas, leading to significant improvements in the early detection of developmental and health disorders among children.

On the other hand, the **Arogya Kiranam Programme** complements RBSK by focusing on the **treatment and care aspect**. It provides **completely free medical care and diagnostic services** to children below 18 years of age who are suffering from **serious, chronic, or life-threatening illnesses.** This includes conditions such as congenital heart diseases, cancers, kidney disorders, metabolic abnormalities, and other major health issues that often require prolonged or specialized medical intervention. The programme is implemented through **government hospitals**, ensuring **cashless treatment,** and reducing the financial burden on families, especially those from economically weaker sections.

Together, RBSK and Arogya Kiranam form a **continuum of child health services** in Kasaragod district — from **screening and early identification (RBSK)** to **treatment and rehabilitation (Arogya Kiranam)**. RBSK identifies and refers children with health issues, while Arogya Kiranam ensures that those diagnosed with severe illnesses receive comprehensive treatment without financial constraints.

11.1.1 Treatment expenditure of RBSK-AK

Table 11.1.1 shows the treatment expenditure under RBSK, RKSK, and AK for the years 2022–23 to 2024–25. During 2022–23, the total expenditure was ₹18,648,224, of which ₹16,852,270 was under RBSK, ₹1,793,393 under RKSK, and ₹2,561 under AK. In 2023–24, the total expenditure declined to ₹9,044,576, mainly due to a reduction in spending under both RBSK and RKSK. However, in 2024–25, the expenditure again increased to ₹12,240,262, indicating a revival in program activities.

Over the three-year period, the cumulative expenditure amounted to ₹39,933,062, with RBSK contributing the largest share of ₹36,273,564, followed by RKSK with ₹3,656,937, and a minimal amount under AK. The data reflects fluctuations in annual expenditure, with an overall emphasis on RBSK-related treatment services.

Table 11.1.1 Treatment expenditure of RBSK-AK

Year	RBSK	RKSK	AK	Total
2022-23	16852270	1793393	2561	18648224
2023-24	7693307	1351269	0	9044576
2024-25	11727987	512275	0	12240262
Total	36273564	3656937	2561	39933062

11.2 Newborn Screening (Visible Birth Defect-VBD Screening)

Newborn screening in Kasaragod district was initiated in May 2017 as part of the RBSK program under the National Health Mission (NHM). The objective is early identification and intervention for conditions that could lead to neonatal morbidity or mortality.

The screening is conducted for newborns delivered in public health institutions, focusing on the early detection of congenital and metabolic disorders. The screening includes the following four key indicators:

1. Visible Birth Defect Screening
    - A physical examination of the newborn is performed within the first 24 hours of life.
    - It helps identify any visible structural or external birth defects early on.
2. Pulse Oximetry Screening
    - Conducted within 24–48 hours of birth to monitor the baby's oxygen saturation levels.
    - It acts as a first-line screening tool for detecting congenital heart disease (CHD).
3. OAE Screening (Otoacoustic Emissions)
    - Performed after 48 hours of birth to screen for hearing impairments.
    - Enables early identification and intervention for hearing loss.
4. IEM Screening (Inborn Errors of Metabolism)
    - Done within 48 hours of birth to detect metabolic disorders.
    - Aims to reduce Infant Mortality Rate (IMR) by early diagnosis and treatment of metabolic conditions.

Table 11.2.1 shows that under RBSK, screening indicators have shown a gradual decline over the last four years, in line with the reduction in total live births. Total live births decreased from 3,867 in 2021–22 to 2,854 in 2024–25, and corresponding declines were observed across all screening parameters including VBD, Pulse oximetry, OAE, and IEM. For instance, Pulse oximetry coverage fell from 3,672 in 2021–22 to 2,771 in 2024–25, while OAE screening reduced from 3,368 to 1,673 during the same period. Despite this decline, the proportion of newborns screened remains close to total live births, reflecting consistent coverage though on a reducing cohort size. Strengthening follow-up and ensuring 100% coverage in all screening modalities will be important for sustaining early detection efforts under RBSK.

Table 11.2.1 :Screening under RBSK

Indicators	2021-22	2022-23	2023-24	2024-25
Total live birth	3867	4032	3301	2854
VBD	3804	3979	3281	2786
Pulse oximetry	3672	3928	3258	2771
OAE	3368	3964	3120	1673
IEM	3804	3963	3257	2782

11.3 District Early Intervention Centre (DEIC):

District Early Intervention Centre (DEIC) – Early Childhood Disability Management and Intervention

Govt.District Hospital, Kanhangad

The District Early Intervention Centre (DEIC) is a key component of the Rashtriya Bal Swasthya Karyakram (RBSK) under the National Health Mission (NHM). It plays a crucial role in the early identification, intervention, and management of developmental delays and disabilities in children from birth to 18 years of age.

The primary objective of DEIC is to provide comprehensive care and rehabilitation services for children diagnosed with any of the 4Ds:

- Defects at birth
- Deficiencies
- Diseases
- Developmental delays including disabilities

Each DEIC functions as a referral and follow-up center for children identified during health screenings conducted at the community level, Anganwadis, and schools. These centres are typically located within district hospitals.

The DEIC multidisciplinary team includes:

- Medical Officer
- Paediatrician
- Dentist
- Dental Hygienist
- Psychologist
- Physiotherapist
- Audiologist & Speech Therapist
- Optometrist
- Special Educator
- Lab Technician
- Staff Nurse

Key Services Provided by DEICs:

- Comprehensive developmental assessments
- Therapy services (Speech, Psychological, Physiotherapy, Optometry, and Special Education)
- Nutritional support
- Counselling for parents and caregivers
- Follow-up and referral to higher centers when needed
- Hridyam Cases registration and follow up

DEICs act as a centralized hub to ensure early and effective intervention, significantly improving the quality of life of children with special needs.

Table 11.3.1 shows that new cases ranged between 609 – 981 per year. Peak in 2022–23 (981 cases). Lowest in 2023–24 (609 cases).

Much higher follow-up cases than new cases each year. Peak in 2023–24 (5313 follow-ups). Indicates good continuity of care and patient tracking. once children are registered, they remain under consistent DEIC follow-up.

"DEIC services show consistent new case detection (600–980 annually) with a strong emphasis on follow-up care, follow-up cases consistently outnumber new registrations, peaking in 2023–24."

Table 11.3.1 DEIC Service Delivery

Financial Year	New cases	Follow Up cases
2021-22	649	3527
2022-23	981	3103
2023-24	609	5313
2024-25	809	3987

11.4 Hridyam:

A unique initiative by the Government of Kerala to support children with Congenital Heart Disease (CHD). This can be used as web-based registry for CHD cases across Kerala, monitoring the progress of program envisaged for management of children with CHD, identify the bottlenecks for implementing the protocols established at any point, and understand the case status and response time for systems in place and ultimately the outcome of the program.

Key Features of the Hridyam Program:

1. Objective:

   To identify, treat, and manage congenital heart diseases in children from birth through adolescence. The focus is on early detection, timely intervention, and ongoing care.

2. Screening and Early Detection:

- Newborns are screened at birth using pulse oximetry to detect possible CHDs.
- Paediatricians and trained healthcare workers identify signs of CHDs during regular checkups.

3. Web-based Monitoring:

- The program uses a centralized digital platform to track suspected cases, referrals, treatments, and outcomes.
- This enables better coordination between hospitals and healthcare providers.

4. Treatment:

- Children diagnosed with CHD are provided free treatment, including surgery, through empanelled government and private hospitals.

5. Awareness & Training:

- Training is given to doctors, nurses, and healthcare staff to ensure early identification.
- Public awareness campaigns educate families on symptoms and the importance of early intervention.

6. Success and Impact:

- Hridyam has gained national recognition as a model public health initiative.
- Thousands of children have received life-saving treatment under the scheme.

Table 11.4.1 provides an overview of the Hridyam programme in Kasaragod district.

Table 11.4.1 Hridyam status

Hridyam Statistics in Kasaragod	
Total Cases registered	1129
Surgery done	413

11.5 Mobile Intervention Unit (MIU)

Anuyatra (MIU) – A Comprehensive Disability Management Initiative

Anuyatra, through the Mobile Intervention Unit (MIU), is a comprehensive lifecycle approach for disability management. The main objective is to transform Kerala into a disabled-friendly state. This initiative is a joint venture of the National Health Mission (NHM), the Department of Social Security Mission, and the Health Department.

MIUs have been launched across the state, including one in Kasaragod, with the aim of strengthening the outreach programs of District Early Intervention Centers (DEICs). These mobile units operate under NHM as a parallel arrangement to the DEICs, ensuring greater accessibility and coverage.

Each MIU team typically includes:

- Psychologist
- Physiotherapist
- Special Educator
- Speech Therapist
- Developmental Therapist

These professionals work collaboratively to provide early detection, intervention, and rehabilitation services to children and individuals with disabilities in remote and underserved areas.

Table 11.5.1: MIU Service in the district

Year	New cases	Follow up cases
2021-22	30	2712
2022-23	247	2545
2023-24	210	6210
2024-25	295	2708

The table(**Table 11.5.1**) presents details of the services provided by the Mobile Intervention Unit (MIU) in Kasaragod district over the last four years. A steady number of new and follow-up cases have been reported, indicating continuous outreach and rehabilitation efforts. In 2024–25, the MIU handled 295 new cases and 2,708 follow-up cases, showing sustained engagement with beneficiaries. The rise in the number of cases in previous years, especially in 2023–24, reflects the unit's expanding coverage and improved accessibility of services for children and individuals with developmental disabilities across the district.

The Mobile Intervention Unit (MIU) services in Kasaragod district show a steady increase in new cases detected over the years, along with consistently high numbers of follow-up cases. New cases were very low in 2021–22 (30 cases), Increased sharply in 2022–23 (247 cases), Slight dip in 2023–24 (210 cases), Again improved in 2024–25 (295 cases). This reflects strengthening outreach and early identification of children requiring interventions. Follow-up cases remain high each year (ranging between 2,545 – 6,210). The peak was in 2023–24 with 6,210 follow-ups, indicating strong continuity of care and active patient tracking during that year. The consistently high follow-up load demonstrates that once children are enrolled, they are systematically monitored and provided.

Table 11.5.2 shows the structured weekly schedule which enables equitable service delivery across multiple blocks, ensuring access in both rural and semi-urban areas.

Table 11.5.2 MIU Services Weekly Schedule – Kasaragod District

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
CHC Periya	FHC Narkilakkad	FHC Kayyur	TH Bedadka	TH Mangalpady	UPHC Kasaragod

11.6 Mobile Health Team (MHT):

Shalabham is a new initiative deployed under the Rashtriya Bal Swasthya Karyakram (RBSK) to provide healthcare services in remote areas of the district. The Shalabham team examines children to identify various health issues including malnutrition, birth defects, developmental delays, childhood diseases, and more.

The team consists of specially trained doctors and RBSK nurses, who are equipped to diagnose and support early interventions. Children identified with health problems are ensured access to advanced treatment as part of the initiative.

11.7 Rashtriya Kishor Swasthya Karyakram (RKSK):

The Ministry of Health & Family Welfare has launched Rashtriya Kishor Swasthya Karyakram for adolescents, in the age group of 10-19 years, which would target their nutrition, reproductive health and substance abuse, among other issues. The key principle of this program is adolescent participation and leadership, Equity and inclusion, Gender Equity and strategic partnerships with other sectors and stakeholders.

In Kasaragod,AH program is mainly functioning through 9 adolescent friendly health centers. Centers are placed in in all health blocks.OnMonday,Tuesday,Friday, and Saturday from 9 AM TO 4pm the counselling services are provided in all the above-mentioned centers,rest 2 days the services are through field visit.

Table 11.7.1 RBSK Services Achievement

Year	New Cases	Follow up Cases
2021-22	2226	624
2022-23	1837	936
2023-24	13213	2156
2024-25	11908	2042

11.8 Peer Educators Programme -SDC (Student Doctor Cadet)

The table (**Table 11.8.1)** shows the selection and training details of Peer Educators under the Student Doctor Cadet (SDC) Programme in Kasaragod district. A total of 600 peer educators were selected during 2017–18 and 2018–19, with 540 and 570 trained, respectively. After a brief gap during 2020–22, the programme was revived, and the number of trained peer educators gradually increased 632 in 2023–24 and 579 in 2024–25. The consistent training of peer educators highlights the district's efforts to strengthen adolescent health awareness and leadership among students.

Table 11.8.1 Peer Educators Programme -SDC (Student Doctor Cadet)

Year	Total Peer Educators selected	Trained
2017-2018	600	540
2018-2019	600	570
2019-2020	600	600
2020-2021	0	0
2021-2022	0	0
2022-2023	823	632
2023-2024	600	579
2024-2025	600	574

11.9 Weekly Iron Folic Supplementation Program (WIFS)

Coverage remained above **97%** across all five years. Reflects **efficient implementation**, strong coordination, and high community acceptance. Achievement indicates inclusion of out-of-school adolescents and possible improvements in outreach and enumeration processes. Target population reduced from **184,325 (2020–21)** to **161,770 (2024–25),** yet coverage rates remained consistently high and suggests robust tracking and delivery systems. Number of participating schools increased from **705 to 723**(Table 11.9.1)Demonstrates **program sustainability** within schools and administrative commitment to scaling up. Minimal year-on-year fluctuation in performance. Indicates a **well-integrated program structure** with continued support from stakeholders.

Table 11.9.1 WIFS program status

Year	Target population	Total covered	% Achievement	No. of school program initiated
2020-21	184325	181200	98.30	705

2021-22	178658	175560	98.27	708
2022-23	175100	172205	98.35	716
2023-24	169040	168100	99.44	721
2024-25	161770	158060	97.71	723

11.10 Family Planning

The family planning program in the district has shown steady improvement in sterilization services along with sustained uptake of contraceptive methods, although certain categories show fluctuations. **Table 11.10.1** shows that laparoscopic (Lapro) cases rose significantly from just 46 in 2020–21 to 205 in 2022–23, followed by a slight decline to 192 in 2024–25. NSV (No-Scalpel Vasectomy) cases increased from 2 in 2020–21 to 35 in 2022–23, but slightly reduced in the following years (29 in 2023–24, 24 in 2024–25). This reflects improved adoption of permanent methods, with higher male participation than earlier, though sustainability remains a challenge. Condoms (CC): Usage showed a sharp rise between 2020–21 (10,505) and 2023–24 (95,632), before slightly dropping to 87,913 in 2024–25. Oral Pills (OP): Gradually increased from 3,868 in 2020–21 to a peak of 8,562 in 2023–24 but fell again to 7,463 in 2024–25. IUCD insertions declined over time from 1,270 in 2020–21 to 1,107 in 2024–25, showing reduced preference for this method. The district has made significant progress in sterilization services, especially laparoscopic cases. Condom and oral pill distribution indicates wide community-level acceptance of spacing methods

Table 11.10.1 Family Planning services

Year	No. of Lapro Cases	No. of NSV Cases	CC	OP	IUCD
2020-21	46	2	10505	3868	1270
2021-22	143	20	54154	7695	2284
2022-23	205	35	91233	8098	1150
2023-24	184	29	95632	8562	1256
2024-25	192	24	87913	7463	1107

11.11 Biomedical Equipment Maintenance Program (BEMP)

Under BEMP, 6 out of 7 institutions in the district are covered, with a total of 5,518 biomedical assets registered. During the reporting period, 3,383 service calls were raised, out of which 3,358 were rectified, leaving only 25 pending cases. This translates to a 99% rectification rate, highlighting the efficiency of the biomedical equipment maintenance system as shown in **Table 11.11.1**. The very high response rate ensures minimal downtime of critical medical equipment, thereby supporting uninterrupted healthcare delivery. Continued focus on covering the remaining institution and sustaining timely rectification of calls will further strengthen the program. All 8 institutions were AERB approved.

Table 11.11.1 BEMP program status

Description	Total Call Registered	Total Call rectified	Pending calls	Percentage of rectified calls
Total Institution under BEMP - 67 Total Asset - 5518	3383	3358	25	99%

11.12 Procurement of Equipment at State level through KMSCL – NHM

Table 11.12.1 summarises the equipment procurement undertaken through the Kerala Medical Services Corporation Ltd. (KMSCL). A total amount of ₹1,17,02,020 was sanctioned for the year 2024-25, funded by the State NHM.

Table 11.12.1 Equipment Procurement through KMSCL

Year	Details	Sanctioned Amount (Rs)	Status
2024-2025	NHM ROP 24-25	11702020	Funding from State NHM, Some Equipment Supply Still Pending

11.13 Accredited Social Health Activist (ASHA)

- ASHA Training: 10th Module completed
- AYUSH training - 4 batch training completed for the selected 158 ASHAs.
- SHAILI mobile app training for ASHAs completed.
- Monthly ASHA meetings are conducted every month at NHM Conference Hall. One ASHA

from each health institution of Kasaragod district will serve as a participant.

In the meeting, programme officers give refresher training on national programmes.

11.14 National Programme for Palliative Care (NPPC)

The Palliative Care Program in Kasaragod is a vital health initiative implemented under the National Health Mission (NHM) to provide comprehensive care and support to patients suffering from chronic, debilitating, or life-limiting illnesses. The program focuses on relieving pain, managing symptoms, and improving the quality of life of patients and their families through a compassionate, community-based approach.

In Kasaragod, palliative care services are delivered through a network of government hospitals, Family Health Centres (FHCs), and Primary Health Centres (PHCs), supported by trained healthcare professionals and volunteers. The program also emphasizes home-based care, ensuring that patients receive continuous medical and emotional support within their communities.

Overall, the palliative care initiative in Kasaragod reflects the district's commitment to providing holistic and humane healthcare, addressing not only the physical but also the psychological and social needs of patients.

- NNPC Programme achieved in Panathady and Bellur
- Running Lymphedema clinic in 4 secondary units
- CHC Cheruvathur
- CHC Periye
- CHC Muliyar
- CHC Panathady

- Morphine Available in 7 institutions
- TH Trikkarippur
- TH Nileshwar
- DH Kanhangad
- DH Kasaragod
- CHC Cheruvathur
- CHC Panathady
- CHC Periye
- Training centre activities
- 10 days foundation course for doctors
- 10 days foundation course for Physiotherapist
- 45 days training for Staff Nurses
- 4 months training for ANMs
- 5 days training for care home care givers
- 3 days training for health professionals
- 3 days training for Volunteers

11.15 Endosulfan Victims Rehabilitation Project Kasaragod

Endosulfan, a highly toxic organochlorine pesticide, was sprayed in the cashew plantations in Kasaragod district from 1978, till 2001 regularly three times every year. The aerial spraying of Endosulfan was undertaken to contain the menace of the tea mosquito bug.

Reports of its effect on health and environment started appearing in print and electronic media from 1997 onwards. This became a burning issue in the State and attracted the attention of the public and government during early 2000. Many Government and private agencies studied the issue in detail. Some of them are an Expert Committee from Kerala Agricultural University, under the Chairmanship of Dr. Abdul Salam, a Government Committee under the Chairmanship of Dr. Achuthan, Expert team from National Institute of Occupational Health, ICMR Ahmedabad and Thanal-Non-Governmental Organization.

The Government of Kerala also appointed a Committee with Dr. P.K. Sivaraman, Additional Director of Health Services (Public Health) as Chairman and members from various related departments to study the health-related issues of Endosulfan affected areas.

Diseases like congenital anomalies, Mental retardation, Cancer, and Infertility were found to be more in the affected area. Specialist Medical camps organized at Vani Nagar also showed a higher number of people with Central Nervous System anomalies and Skeletal problems. Laboratory investigations done by the National Institute of Occupational Health also showed high levels of Endosulfan in the Serum of people, water, soil, and vegetation. The World Health Organization (WHO) points out in its literature on Endosulfan about the chances of occurrence of health hazards due to short term and long-term exposure to Endosulfan among human beings. Since the Committees could not find any other reason that could explain the health hazards seen in the Endosulfan sprayed area, it was attributed to the aerial spraying of Endosulfan.

A special cell was formed in 2006-07 under the auspices of Kasaragod District Panchayat to coordinate and implement various activities. The cell, which was formed with Kasaragod District Panchayat President as Chairman and District Collector as Convener, started functioning in February 2007. In the year 2006-07, the state government allocated 50 lakhs. The operation was launched in 2010 to identify the victims of endosulfan in various parts of the district. As per the government order issued on 4th April 2013, the operation of the Endosulfan Victims Relief Remediation Cell that was functioning earlier was cancelled and a new district level cell was formed under the chairmanship of the State Agriculture Minister. The said cell is currently functioning. In addition, a special cell at the officer level under the leadership of the Deputy Collector is functioning in the Kasaragod Collectorate.

Background

In Kasaragod district, 11 grama panchayats have been declared as endosulfan affected panchayats by govt of Kerala. 38 specialist medical camps were conducted in the district at various places during 2010 to 2017 and a total 6727 patients were identified as endosulfan victims in Kasaragod district.

11 Grama Panchayats declared affected in 2010.

Spraying caused severe health issues — congenital anomalies, cerebral palsy, epilepsy, deformities, chronic illnesses.38 medical camps (2010–2017) held to identify victims. 6727 victims identified.

The National Health Mission has been providing the following services given to endosulfan victims since 2011.

1. Comprehensive medical treatment includes specialty and super specialty treatment through 16 empanelled hospitals
2. Free medicine, medical supplies, and diapers supply through health institutions
3. Mobile medical unit for doorstep delivery of medical services
4. Physiotherapy services through 11 panchayath physiotherapy centers
5. Home based palliative service through staff nurse
6. Vehicle support in 11 affected panchayath and two ambulance services to GH and Panathady Hospital.

Medical and Palliative Services Provided to Endosulfan Victims in Kasaragod

Medical Services:

The medical services provided to Endosulfan victims in Kasaragod have been a part of a larger rehabilitation initiative funded by the National Health Mission (NHM), Kerala, since 2011. These services include specialized treatment at empanelled hospitals, the provision of medical supplies, physiotherapy, and mobile medical units to cater to the rural and remote populations. NHM ceased to provide funds from 2022-23. The state is providing the services from 2022-23.

Specialized Medical Care:

- Empanelled Hospitals: The NHM has empanelled 16 hospitals, both public and private, to provide comprehensive medical care, including specialized and super-specialized treatments for Endosulfan victims. These hospitals were listed as per (G.O.(Rt). No.1186/13/H&FWD dated 02.04.2013). The hospitals are presently providing all the services free of cost to endosulfan victims.

Medical Supplies:

- Free Medicines: Essential medicines are provided free of charge through local health institutions. Additional medicines were purchased and provided through Neethi Medicals. But the medicines were not provided after March 31, 2023, due to the lack of funds. Funds were allotted for the same through Kasaragod development package via order no. G.O (Rt) No 434|2022 /PSEA Dated Thiruvananthapuram dt 18-11-2022. The funds for reimbursing purchases from Neethi medical stores of F.Y 2023-24 are being allotted through the social security mission department. As the funds for F.Y 2024-25 are not available, some Neethi medicines are not ready to provide medicines.

Mobile Medical Units:

- Doorstep Medical Services: A mobile medical unit has been operating in Kasaragod, ensuring that medical services are delivered directly to the homes of endosulfan victims. It was provided by NHM. The mobile medical unit ceased its operation in December 2023 due to lack of funds in NHM.

Physiotherapy Services:

- Panchayat Based Physiotherapy: Physiotherapy services are provided at 11 panchayat-level centres, where trained physiotherapists assist Endosulfan victims with mobility and physical rehabilitation. These services aim to help victims regain or maintain functionality, which is essential given the physical disabilities of many of the victims. The physiotherapists were providing home-based services previously. But it is not provided at present as the free mobility service has ceased in the district.

Dialysis and Specialized Medical Units:

- Dialysis Services: 2 dialysis beds are exclusively reserved for endosulfan victims in GH Kasaragod. The victims have already been given preference for dialysis in all the institutions.

Cardiology and Neurology Services:

- Cardiology: The District Hospital Kanhangad has a fully functional cath lab, and two cardiologists are appointed to treat endosulfan victims suffering from cardiovascular complications. The department is conducting all state-of-the-art interventional cardiology procedures.

- Neurology: Specialist neurologists are available at the District Hospital Kasaragod and General Hospital Kanhangad to provide care for victims experiencing neurological disorders, including seizures, cognitive impairment, and motor dysfunction. Both the hospitals are provided with EEG facility.

Palliative Services:

- Palliative care is a critical component of the rehabilitation process for Endosulfan victims. The focus of palliative care is on providing comfort, managing pain, and ensuring that patients receive the necessary support during their final years.

Home-Based Palliative Care:

- Endosulfan Staff Nurse Home Care: NHM-appointed staff nurses have been providing home-based palliative as well as specialized care services to bedridden victims. These nurses administer pain management, assist with mobility, and provide general care to improve the quality of life for patients.

Primary and Secondary Palliative Care:

- Care at Health Institutions: In addition to home-based care, doorstep primary and secondary palliative services are provided at secondary healthcare institutions, such as the District Hospital and General Hospitals, where patients can receive in-patient palliative care.

Vehicle Support for Transportation:

- Vehicle Support: Until April 30, 2023, vehicle support was provided to 11 panchayats to transport Endosulfan victims to healthcare facilities. Additionally, two ambulances were deployed to transport victims for critical treatments such as dialysis. However, due to the lack of funds, vehicle support was discontinued after April 30, 2023, affecting the accessibility of healthcare services for remote communities.

11.16 Janani Suraksha Yojana (JSY)

Table 11.6.1 shows that in 2020–21, 3,419 rural and 628 urban beneficiaries availed JSY benefits, with an expenditure of ₹27.6 lakhs. Coverage declined in 2021–22 to 2,025 rural and 229 urban beneficiaries, with ₹15.6 lakhs spent. A sharp increase was noted in 2022–23, with 5,274 rural and 1,280 urban

beneficiaries supported, incurring ₹44.5 lakhs. Subsequently, beneficiary numbers again reduced to 2,305 rural and 170 urbans in 2023–24, and further to 1,827 rural and 173 urbans in 2024–25, with an expenditure of only ₹13.8 lakhs. This trend indicates fluctuating utilization of JSY benefits, possibly

linked to variations in institutional deliveries, awareness levels, and migration patterns. While the program continues to provide critical financial support, the declining trend in recent years highlights the need to strengthen awareness, particularly in rural areas, to ensure sustained uptake.

Table 11.16.1 JSY - Beneficiaries and Expenditure

Year	Rural	Urban	Expenditure
2020-21	3419	628	27,60,700
2021-22	2025	229	15,66,200
2022-23	5274	1280	44,54,600
2023-24	2305	170	20,98,600
2024-25	1827	173	1382700

11.17 Janani Shishu Suraksha Karyakaram (JSSK)

The JSSK scheme has ensured free services and financial protection for pregnant women and newborns in the district. In 2020–21, 15,492 pregnant women and 2,349 Mathruyanam beneficiaries availed services, with an expenditure of ₹119.3 lakhs. Beneficiary numbers increased in 2021–22 to 17,597 pregnant women and 1,985 Mathruyanam, with a higher expenditure of ₹139.6 lakhs. A sharp rise was observed in 2022–23, when 37,407 pregnant women and 2,551 Mathruyanam beneficiaries were covered, with ₹109.4 lakhs spent. However, utilization reduced in 2023–24 with 24,301 pregnant women and 1,645 Mathruyanam, and expenditure dropped to ₹76.7 lakhs.

In 2024–25, coverage stood at 21,348 pregnant women and 1,465 Mathruyanam, but expenditure increased to ₹173.9 lakhs, suggesting higher per-beneficiary support costs(**Table 11.17.1**).Overall, the scheme demonstrates strong reach, though fluctuations highlight the need for sustained service delivery and consistent utilisation.

Table 11.17.1 JSSK - Beneficiaries and Expenditure

Year	Category	Beneficiaries	Expenditure
2020-21	Pregnant Women Mathruyanam	15492 2349	119,33,795
2021-22	Pregnant Women Mathruyanam	17597 1985	139,63,369,
2022-23	Pregnant Women Mathruyanam	37407 2551	109,39,588
2023-24	Pregnant Women Mathruyanam	24301 1645	76,74,295
2024-25	Pregnant Women Mathruyanam	21348 1465	173,92,929

CHAPTER 12

NATIONAL URBAN HEALTH MISSION (NUHM)

The NUHM will meet health needs of the urban poor, particularly the slum dwellers by making available to them essential primary health care services.

Table 12.1 summarizes the status of community processes implemented under the National Urban Health Mission (NUHM).

Table 12.1 NUHM program status

Community process	Approved	In position
No. of Mahila Arogya Samithi (MAS) constituted	46	46
No. of MAS Accounts opened	46	46
No. of MAS trainings/ orientations held	46	46
No. of ASHAs	59	59
No. of UHNDs held in 2024-25 with frequency (Weekly, Monthly, Quarterly)	373	373
No. of special outreach medical camps		
a. 2023-24	12	12
b. 2024-25	0 (Not in ROP for 2024-25)	0 (Not in ROP for 2024-25)
Population and households assigned per ASHA	1500	1500
Population and households assigned per JPHN	7400	7400
NGO Support in Community process if any	NIL	NIL

12.1 Institutional level activities:

Average OP (Per Day): **144**

Average Lab (Per Day): **36**

Table 12.1.1 outlines the service delivery achievements under the National Urban Health Mission (NUHM) for the year 2024–25.

Table 12.1.1 NUHM service Delivery status

ITEMS	2024-25
Total OP	129640 (UPHC & UHWC)
Total NCD	53903
Total Lab	32321
Total Outreach labour camps	0 (Not in ROP for 24-25)

CHAPTER 13

NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME

NTEP aim to strengthen diagnosis, treatment, and prevention efforts, accelerating progress toward a TB-free India.

13.1 Components of NTEP

The National Tuberculosis Elimination Program (NTEP) in Kasaragod district functions under the guidelines of the Government of India's national initiative to eliminate TB by 2025. The program aims to achieve early diagnosis, effective treatment, prevention of transmission, and reduction of TB burden in the district.

In Kasaragod, NTEP is implemented through the District TB Centre (DTC), operating under the District Medical Officer (Health). The district's TB control activities are integrated with the general health system, ensuring collaboration with primary health centres, community health centres, taluk hospitals, and private healthcare institutions.

Key components of NTEP in Kasaragod include:

Active Case Finding (ACF): Periodic screening of high-risk populations for early detection.

Nikshay Sampark and Nikshay Poshan: Ensuring patient tracking and nutritional support.

Drug-Resistant TB (DR-TB) Management: Diagnosis and treatment through advanced facilities like CBNAAT/Truenat labs.

Public–Private Mix (PPM): Engaging private practitioners for notification and treatment adherence.

Community Awareness and IEC Activities: Promoting awareness to reduce stigma and ensure community participation.

The NTEP follows the National Strategic Plan (2017-2025), focusing on four key actions:

Detect – Treat – Prevent – Build (DTPB) to control and eliminate TB in India.

13.2 Programme Implementation

NTEP is being implemented under the aegis of the National Health Mission. In Kasaragod District, A Separate wing Under DMO is working for implementation of NTEP. A District TB Centre and 3 TB Units and 20 DMCs are working in this district.

13.3 Progress in the Tuberculosis Eradication in the District - CB-NAAT Testing

Table 13.3 CB _NAAT Testing

Year	No. of tests conducted	Positive cases	Percentage
2020-21	1173	71	6
2021-22	3151	140	4
2022-23	5182	418	8
2023-24	3536	250	7
2024-25	5718	327	6

Under the National Tuberculosis Elimination Programme (NTEP), CB-NAAT testing capacity in Kasaragod has improved considerably over the past five years. The number of tests conducted. The district has significantly expanded TB diagnostic services, ensuring early detection and timely treatment. While positivity peaked in 2022–23, subsequent years indicate stabilization, which is a positive sign for TB control efforts. Sustained surveillance, follow-up of high-risk groups, and effective treatment adherence will be critical for achieving TB elimination targets

13.4 Fund allocation for NTEP

Table 13.4 Fund allocation for NTEP

Sl. No	Year	Amount (in lakhs)
1	2020-21	74.55
2	2021-22	85.50
3	2022-23	344.95
4	2023-24	102.46
5	2024-25	114.08

CHAPTER 14

NATIONAL AIDS CONTROL PROGRAM IMPLEMENTATION IN DISTRICT

14.1 NACP service facilities in Kasaragod District

NACP has the following service facilities operational in Kasaragod District

Table 14.1 NACP Service centre

Name of HIV service centers	No. of HIV Service centers
Targeted interventions	4
Integrated counselling and testing centers	3
Designated STI & RTI clinic	1
ART Centre	1
Link ART	0
Blood Banks (Government)	2
Blood Banks (Private)	0

Table 14.1 lists various centres such as targeted interventions (4), ICTCs (3), STI/RTI clinic (1), ART centre (1), and government blood banks (2), indicating the district's comprehensive HIV prevention and care network.

14.2 Targeted Intervention projects in Kasaragod District

Table 14.2 Targeted Intervention Project

Indicator	FSW	Migrant	MSM	TG	Truckers
Total No. of TI Projects	1	1	1 (composite-MSM & TG)	1 (composite-MSM & TG)	1

The table14.2 indicates that Kasaragod district has a network of HIV-related service facilities that include counselling, testing, treatment, and blood safety services under the

National AIDS Control Programme. The district has 4 targeted intervention projects and 3 ICTCs functioning actively, along with one ART centre and one STI/RTI clinic.

14.3 Testing of General Clients (at ICTCs in district) - SIMS Data

Table 14.3 ICTC Achievement

	General Clients April 2024 - March 2025			
	ICTC	TOTAL	General clients positive	% Positive
GH ICTC	6956	6956	20	0.29%
DH ICTC	9451	9451	8	0.08 %
Mangalpady ICTC	5122	5122	4	0.08%

The table titled "14.3 Testing of General Clients (at ICTCs in district) – SIMS Data" presents data on HIV testing among general clients in Kasaragod district for the period April 2024 to March 2025. It includes information from three Integrated Counselling and Testing Centres (ICTCs) — GH ICTC, DH ICTC, and Mangalpady ICTC. GH ICTC tested 6,956 clients, of whom 20 (0.29%) were found positive. DH ICTC tested 9,451 clients, identifying 8 (0.08%) positives. Mangalpady ICTC tested 5,122 clients, with 4 (0.08%) positives. Overall, the data indicates that while a significant number of clients were tested, the HIV positivity rate remains very low, reflecting effective awareness and prevention activities under the National AIDS Control Programme in the district.

14.4 Prevention of Parent to Child Transmission of HIV (ANC)

Table 14.4 Prevention of Parent to Child Transmission of HIV (ANC)

District Kasaragod	ICTC	Total	ANC positive
GH ICTC	2642	2642	0
DH ICTC	1533	1533	1
Mangalpady ICTC	1017	1017	0

In Kasaragod district, a total of 5,192 individuals were tested for HIV across three Integrated Counselling and Testing Centres (ICTCs) — GH ICTC, DH ICTC, and Mangalpady ICTC. Among these, only one antenatal case tested positive, reported from the District Hospital ICTC. Both GH ICTC and Mangalpady ICTC recorded no positive cases.

This indicates a very low HIV positivity rate (0.019%) among the antenatal population in the district, reflecting effective preventive measures, awareness programs, and access to maternal health services. Continued routine HIV screening during antenatal check-ups is essential for maintaining low transmission rates and ensuring early detection. Strengthening counselling, partner testing, and follow-up services will further enhance maternal and child health outcomes under the National AIDS Control Programme (NACP).

14.5 Blood Collection

Table 14.5 Blood Collection

Year	No of Blood Units Collected
2024-2025	12994

12994 units of blood collected in the year 2024- 2025.

Annexures

ANNEXURE 1

Details of medical health institutions

Details of PHC

Name of Institution	PHC Vellarikkundu	PHC Meenja	PHC Vaninagar	PHC Bandadka	PHC Karichery	PHC Konnakakd
No of bed	12	0	2	0	0	0
OT	0	0	0	0	0	0
ICU/CCU	0	0	0	0	0	0
Ventilator	0	0	0	0	0	0
CT scanner	0	0	0	0	0	0
MRI Scanner	0	0	0	0	0	0
US Scanner	0	0	0	0	0	0
TMT	0	0	0	0	0	0
ECHO	0	0	0	0	0	0
EEG	0	0	0	0	0	0
ECG	1	0	0	0	0	0
Angiogram	0	0	0	0	0	0

Angioplasty	0	0	0	0	0	0
Xray	0	0	0	0	0	0
Laser ray	0	0	0	0	0	0
Blood bank	0	0	0	0	0	0
clinical lab	1	0	0	1	0	1
pharmacy	1	1	1	1	1	1
ambulance	1	0	0	0	0	0
ICU ambulance	0	0	0	0	0	0

Details of CHC

Name of Institution	CHC Cheruvathur	CHC Badiadka	CHC Muliyar	CHC Kumbla	CHC Manjeshwar	CHC Periye
No of bed	24	30	12	30	24	12
OT	0	0	0	0	0	0
ICU/CCU	0	0	0	0	0	0
Ventilator	0	0	0	0	0	0
CT scanner	0	0	0	0	0	0
MRI scanner	0	0	0	0	0	0
US Scanner	0	0	0	0	0	0
TMT		0	0	0	0	0
ECHO	0	0	0	0	0	0
EEG	0	0	0	0	0	0
ECG	1	0	1	1	0	2
Angiogram	0	0	0	0	0	0
Angioplasty	0	0	0	0	0	0
Xray	1(Dental)	0	0	0	0	1
Laser ray	0	0	0	0	0	0
Blood bank	0	0	0	0	0	0
clinical lab	1	1	1	1	1	1
pharmacy	1	1	1	1	1	1
ambulance	1	1	1	1	0	1
ICU ambulance	0		0	0	0	0

Details of FHC, DH, GH, THQH

Sl.no	Name of Institution	No of bed	OT	ICU/CCU	Ventilator	CT scanner	MRI scanner	US Scanner	TMT	ECHO	EEG	ECG	Angiogram	Angioplasty	Xray	Laserray	Blood bank	clinical lab	pharmacy	ambulance	ICU ambulance
1	TH Poodamkallu	35	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	1	1	0
2	TH TRIKARIPUR	42	1	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	1	1	0
3	THQH Bedadka	24	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1	0
4	TH Mangalpady	24	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	1	1	0
5	THQH Nileshwar	42	0	0	0	0	0	0	0	0	0	5	0	0	1	0	0	1	1	1	0
6	GH	212	9	8	13	1	0	0	0	0	0	1	0	0	1	1	1	1	1	1	0
7	DH	364	4	3	YES	YES	0		YES	YES	1	YES	YES	YES	YES		YES	YES	YES	YES	0
8	W&C	75	3	0	0	0	0	0	0	0	0	yes	0	0	0	0	0	Yes	Yes	Yes	0
9	FHC Panathur	24	0	0	0	0	0	0	0	0	0	yes	0	0	0	0	0	yes	yes	yes	0

10	FHC Ennappara	0	0	0	0	0	0	0	0	0	0	yes	0	0	0	0	0	yes	yes	no	0
11	FHC madikai	0	0	0	0	0	0	0	0	0	0	yes	0	0	0	0	0	yes	yes	no	0
12	FHC Kayyur	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1	0
13	FHC Olat	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1	0
14	FHC Valiyaparamba	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1	0
15	FHC Thuruthi	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
16	FHC Padne	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
17	FHC Udumbunthala	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
18	FHC Mavilakadapuram	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
19	FHC Perla	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
20	FHC Bellure	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
21	FHC Kumbadaje	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0

22	FHC Chattanchal	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
23	FHC Uduma	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1(108)	0
24	FHC Kalanad	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
25	FHC Chengala	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
26	FHC Adoor	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
27	FHC Mulleriya	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1	0
28	FHC Mogralputhur	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
29	FHC Arikady	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes	Yes	No	0
30	FHC Madhur	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes	Yes	No	0
31	FHC Puthige	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes	Yes	No	0
32	FHC Angadimogar	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No	Yes	No	0
33	FHC Bayar	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	
34	FHC Vorkady	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
35	FHC Karindalam	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	1	1	0	0

36	FHC Narkilakkad	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	1	1	1	0
37	FHC Thaikadappuram	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1(108)	0
38	FHC Moucode	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
39	FHC Chittarikkal	9	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
40	FHC Anandasram	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
41	FHC Ajanur	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0
42	FHC Pallikkare	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0

ANNEXURE 2

HEALTH INITIATIVES – KASARAGOD

Brain Health Initiatives

The Brain Health Initiative in Kasaragod is a public health approach to neurological disorders, including diseases such as headache, dementia, stroke, epilepsy, head injuries, and other neurological conditions. It is a district-level pilot project launched in collaboration with the district administration and supported by the District Collector. The initiative aims to establish a comprehensive, collaborative, and sustainable model for neurological healthcare within the public health system. Kasaragod is recognized as the first block in India to implement this initiative.

A specialised outpatient clinic (OP) at DH Kanhangad HUB Hospital has been allotted ₹19 lakh for the project. The BHI coordinator will oversee and coordinate the further progress of the programme.

Leprosy initiatives

Battle

Basic awareness against testing, treating leprosy elimination.

Knowledge attitude & practice evaluation among public & professional groups.

Hope

Focussed intervention among person affected with leprosy

Under-reporting of leprosy due to stigma.

Incidence of new cases not being reported as other notifiable communicable diseases.

Viva Campaign – Pilicode becomes the first panchayath to complete screening

The Viva Campaign, implemented by the State Health Department, is a community-driven intervention against anaemia or malnutrition. The initiative aims to identify and provide treatment for anaemia among women at an early stage. Women aged 15 to 59 are subjected to haemoglobin testing as part of this program. Pilicode Grama Panchayat has successfully implemented the project with meticulous planning and timely execution, achieving 100% completion of anaemia screening, making it the first panchayat in the district to do so.

A ceremony to honour the health workers involved in this achievement was held at the Kalikkadavu Karakkakavu Auditorium. District Panchayat President Baby Balakrishnan inaugurated the event. Block Panchayat President Madhavan Maniyara presented mementos to the health workers. The event was presided over by Grama Panchayat President P.P. Prasanna Kumari, with District Medical Officer Dr. A.V. Ramdas as the chief guest.

Known for exemplary initiatives in sanitation and energy conservation in the past, Pilicode Grama Panchayat continues its comprehensive public health interventions through the Viva Campaign.

In the Panchayat, there are 8,453 women aged 15 to 59. The campaign was designed to test all of them for haemoglobin levels and provide treatment to those identified as anaemic. A broad-based committee was formed at the Panchayat level, with the Grama Panchayat President as Chairperson and the Medical Officer as Convener, involving elected representatives, health workers, and volunteers. At the ward level, sanitation and nutrition committees were tasked with implementing the initiative. Each ward formed "Viva Neighbourhood Assemblies," focusing on 50 houses, to conduct awareness programs and organize timely haemoglobin testing camps in collaboration with local clubs and organizations.

Camps were even held during the night for the convenience of residents. Within a month, haemoglobin testing was completed for 8,318 out of 8,453 women, and a study report was prepared. Iron tablets were provided through the Olat Family Health Centre for those diagnosed with anaemia, along with follow-up tests to ensure ongoing care.

As part of efforts to become an anaemia-free panchayat, the next steps include collaboration with the Agriculture Department to implement the "Vegetable Kitchen Garden" project aimed at improving nutritional security.

IEC-BCC: As part of intensifying IEC- BCC activities and to prepare innovative and district-specific IEC- BCC activities, the district IEC wing has conducted a systematic gap analysis study.

Findings - High immunisation resistance prevails in the northern side of the district due to the following reasons:

1) Vaccines include forbidden ingredients
2) Vaccines contain harmful substances
3) Vaccines remain as a conspiracy against a particular community

4) Fear of AEFI

5) Fake and anti- vaccine messages circulate through social media

Kolayakootam

For addressing these factors, to overcome the resistance, the district team has organized a community event named "Kolaayakkoottam'.

Features of Kolaayakkootam

A) One of the effective mid media IEC- BCC activities

B) A good platform for focus group discussion & panel discussion ensuring the active involvement of specialty doctors, district level health team members, elected representatives, officials of other line departments, voluntary organizations, and local clubs.

C) A community event including heterogeneous groups such as lactating mothers, adolescent groups, working women etc.

After conducting an impact study of specific IEC events, misconceptions on vaccination have been reduced and the vaccination status has been improved.

"Ignorance denied me vaccination as a child. The polio-stricken leg I now carry is the result of that negligence. So, let us never forget to vaccinate our children."

When Hakeem, a young man, spoke these words before a gathering at a homestead in Manjeshwaram, the crowd listened in silence. The event, titled “Kolayakkoottam” (Homestead Gathering), was a vibrant health dialogue organized as part of the Mission Indradhanush, a nationwide immunization campaign. The initiative was led by the Kasaragod District Medical Office (Health) and the National Health Mission in collaboration with Manjeshwaram CHC (Community Health Centre).

The discussion was enriched with active participation and focused on educating those who had denied vaccination to their children due to superstitions and misconceptions. Health workers explained the scientific basis of vaccinations and the dangers of preventable diseases resulting from vaccine refusal. The session concluded with attendees gaining a deeper understanding of immunization and its importance.

Some parents who had previously hesitated to vaccinate their children due to misinformation declared during the gathering, "We will vaccinate our children." This realization among the participants made the event truly meaningful. Health workers also announced the establishment of special vaccination camps at Hosabettu Kadappuram to ensure comprehensive coverage.

The Kolayakkoottam turned into a cultural celebration with traditional duff muttu performances and songs, creating a festive atmosphere. The attendees were served traditional dishes like tapioca, fish curry, and black tea, evoking the nostalgic flavours of the past.

This heartfelt health dialogue was a step towards dispelling myths, fostering awareness, and ensuring the well-being of children in the community.

ANNEXURE 3

Images of Health Facilities in Kasaragod District

Government Medical College Kasaragod

District Hospital Kanhangad

General Hospital, Kasaragod

Women and Child Hospital Kanhangad

Taluk Hospital Poodamkallu

Taluk Hospital Bedaduka

Taluk Hospital Trikaripur

FHC Periye

FHC Perla

FHC Chengala

FHC Chattanchal

FHC Ennappara

FHC Kayyur

FHC Panathur

FHC Thuruthi

HEALTH AND WELLNESS CENTERS

UHWC Cherappuram

FWC Pavoor

ANNEXURE 4

IEC Activities

Kolayakkoottam (A Community Celebration of Health)

Bandadka tribal Unnathi (Nikshay Shivir TB, Ashwamedham NLEP, NCD) | Aarikkadi, Pilicode (Waterborne diseases, NLEP, Immunisation) | Vengatt, (Waterborne diseases - 'Edda Neer' Campaign)

Kolayakkoottam (A Community Celebration of Health)

Manjeshwar (Mission Indradhanush immunisation drive) | Padanna (NCD, Lifestyle diseases) | Kutti vayal Cheruvathoor (Anemia viva campaign)

Kolayakkoottam (A Community Celebration of Health)

Ennappara (Immunisation, MR Vaccination, CD, NCD, NPPCD, NPCBVI, NLEP, NTEP)

Kaavunjira, Cheruvathur (Aarogyam Anandam Cancer Screening)

Posters, leaflets, press releases...

Photos of Endosulfan camps conducted in the district

AYUSH ASHA Training and meeting at NHM Conference Hall:




District level training for palliative volunteers in connection with palliative care day observation.

Class taken by a paraplegia patient for BCCPN students

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