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

KERALA.HEALTH

December 2025

HEALTH@PALAKKAD

KERALA.HEALTH

HEALTH@PALAKKAD

KERALA.HEALTH

Index

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)
E-mail : acskeralahealth1@gmail.com

141, 3rd Floor, North Block, Government Secretariat, Thiruvananthapuram Pin 695001 | 0471 2333241, 2333812, 2333610 | 0471 2333488
E: chiefminister@kerala.gov.in facebook.com/cmokerala twitter.com/cmokerala
Residence Cliff House | 0471 2318408, 2314853
www.keralacm.gov.in

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 Palakkad. 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 Palakkad.

I appreciate the works done by the District Medical Officer, District Project Manager and health functionaries of Palakkad 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@Palakkad** 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@Palakkad** will be a resource book for health functionaries, researchers, students as well as to people to understand the developments in health sector in Palakkad. 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 Rosh T V, DMO & DPM

i/c Palakkad, 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 Palakkad 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
വഞ്ചിയൂർ.പി.ഒ., തിരുവനന്തപുരം. പിൻ - 695035
ഫോൺ: 0471 2302490
വെബ്സൈറ്റ്: www.dhs.kerala.gov.in
ഇ-മെയിൽ: dhskerala@gmail.com

സന്ദേശം

സംസ്ഥാന ആരോഗ്യ വകുപ്പ് ജില്ലാ അടിസ്ഥാനത്തിൽ 2024 -25 വർഷത്തെ പ്രവർത്തനങ്ങൾ ക്രോഡീകരിച്ച 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
PALAKKAD DISTRICT- AN OVERVIEW

1.1 Introduction

The Palakkad district situated in the central part of Kerala state, is the largest among the 14 districts of the state. The city of Palakkad is the district headquarters. The district is bordered on the northwest by the Malappuram District, on the southwest by the Thrissur District, on the northeast by Nilgiris district and on the east by Coimbatore district of Tamil Nadu.

Palakkad is the gateway to Kerala due to the presence of the Palakkad Gap in the Western Ghats. The total area of the district is 4,480 km2 (1,730 sq mi) which is 11.5% of the state's total area making it the largest district in Kerala. The sex-ratio is 1067. The district has 5 taluks, 4 statutory towns, 17 census towns, 13 community development blocks and 91 panchayats. Palakkad is one of the least literate districts with a literacy rate of 89.3 percent. Scheduled Caste population is 14.4 percent, and 1.7 percent, Scheduled tribes. There are 3 forest divisions in the district viz. Palakkad, Mannarkkad and Nemmara and is the abode of the tribal population. Palakkad is one of the three large tribal population districts in the State. Palakkad is the 'Rice Bowl of Kerala' and agriculture is the main occupation.

Palakkad is the hottest and drought affected district in the State. Climatic changes have resulted in floods in the recent years. Most of the communicable diseases that bother the district are seasonal in nature.

Figure 1.1.1. District map

1.2. Administrative Division

There are two systems of administrative setup in the district—Revenue administration and Local Self Government. Under the revenue system, a district is divided into revenue divisions, taluks, and villages. However, for local administration, the district is divided into statutory towns and panchayats. For the implementation of development activities,

panchayats are grouped under Community Development Blocks. Therefore, all these units, namely taluks, villages, panchayats, panchayat wards, statutory towns, and community development blocks, have their own relevance and importance. This handbook contains data related to all these administrative units.

The district now consists of two revenue divisions—Ottappalam and Palakkad. The Ottappalam division comprises of Ottappalam and Mannarkkad taluks, which together include 66 villages, while the Palakkad division comprises of Palakkad, Chittur, and Alathur taluks, consisting of 90 villages. In total, there are five taluks and 156 villages in the district.

Under the Local Self Government system, the district is divided into four statutory towns and thirteen community development (CD) blocks, consisting of ninety-one panchayats. The distribution of Villages, Towns, CD Blocks and Panchayats in each Taluk are given below.

Table 1.2.1 Distribution of villages, Towns, Development Blocks and Panchayats as on 31.12.2009

Name of district/taluks	Total no. of villages	Rural area Wholly	Rural area Partly	Urban area Wholly	Urban area Partly	Statutory towns	Census towns	No. of CD blocks	No. of panchayats
Palakkad district	156	129	2	25	0	4	17	13	*91
Ottappalam Taluk	41	30	0	11	0	2	7	4	31
Mannarkkad Taluk	25	24	0	1	0	0	1	2	13
Palakkad Taluk	30	20	0	10	0	1	6	2	19

Chittur Taluk	30	26	2	2	0	1	2	3	16
Alathur Taluk	30	29	0	1	0	0	1	2	18
Source: Census 2011 *Panchayats spill over in more Taluks									

The administrative divisions of Palakkad district comprise of a total of 156 villages distributed among several taluks such as Ottappalam, Mannarkkad, Palakkad, Chittur, and Alathur, each with a mix of rural and urban areas. The region is organised into statutory towns, census towns, CD blocks, and numerous panchayats, reflecting a layered structure of governance that facilitates both local administration and rural development. This framework ensures effective decentralised planning and supports the diverse needs of the district's population through coordinated management at the taluk, town, and village level.

1.3. Demographic Details

Palakkad district comprises 156 fully inhabited villages and 21 towns, including 4 statutory and 17 census towns. The population as of 2025 stands at 2,809,934, with 1,359,478 males and 1,450,456 females, resulting in a sex ratio of 1,067 females per 1000 males. The district has a significant rural presence with 2,133,124 people residing in rural areas and 676,810 in urban areas—reflecting an urban population share of 24.09%. There are 636,211 normal households, 597 institutional households, and 412 houseless households across the area. Over the last decade, the population increased by 192,452, with rural and urban sex ratios at 1,068 and 1,063 respectively. Spanning 4,482 sq. km, the population density is 627 persons per sq. km. Literacy is high, with 89.31% overall, split into 93.10% for males and 85.79% for females. The district houses 403,833 Scheduled Castes and 48,972 Scheduled Tribes, demonstrating diversity within its demographic structure.

1.3.1 Population Size and Density

The total population is 28,09,934, comprising 13,59,478 males and 14,50,456 females. This indicates that females slightly outnumber males in the overall

population. Out of the total population, 21,33,124 people reside in rural areas. Among them, 10,31,466 are males and 11,01,658 are females. The rural population is therefore significantly higher than the urban population, and here too, females are more numerous than males.

The urban population is 6,76,810, with 3,28,012 males and 3,48,798 females. While smaller in comparison to the rural population, urban areas also show a higher number of females than males.

Between the years 2001 and 2011, the total population increased by 1,92,452 persons. Of this, 92,493 were males and 99,959 were females, suggesting that the female population grew at a slightly faster rate during the decade.

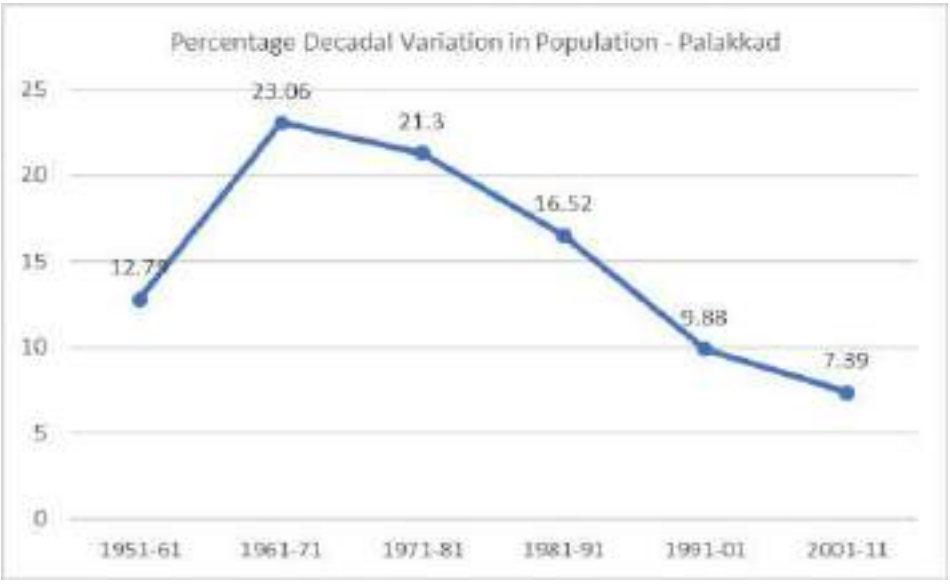
Table 1.3.1 Snapshot of population distribution of Palakkad district

Important Statistics		District
No. of Villages	Total	156
	Inhabited	156
	Uninhabited	-
No. of Towns	Statutory	4
	Census	17
	Total	21
No. of Households	Normal	6,36,211
	Institutional	597
	Houseless	412
Population	Total Persons	28,09,934
	Male	13,59,478

	Female	14,50,456
Rural	Total Persons	2133124
	Male	1031466
	Female	11,01,658
Urban	Total Persons	6,76,810
	Male	3,28,012
	Female	3,48,798
Decadal Population Growth 2001-2011	Persons	192,452
	Male	92,493
	Female	99,959
Percentage of Urban Population		24.09
Area in Sq. Km		4482
Density of Population (persons per 1 sq. Km		627
Sex Ratio (No of females per 1000 males	Total	1067
	Rural	1068
	Urban	1063
Literates	Total	2,239,492 (89.31%)
	Male	1,122,600 (93.10%)
	Female	1,116,892 (85.79%)
Scheduled Caste	Persons	403,833

	Male	197,451
	Female	206,382
Scheduled Tribe	Persons	48,972
	Male	24,314
	Female	24,658
Source: Census 2011 data		

Graph 1.3.1: Decadal Population Growth of District



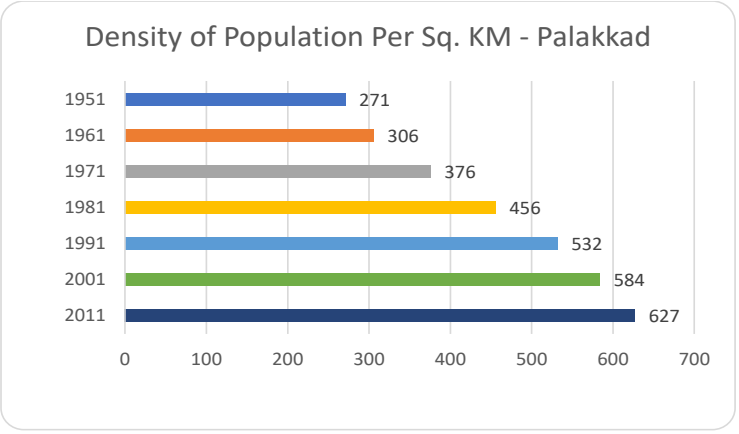
Source: Census 2011 data

The graph illustrates the changes in population growth rate of Palakkad District over six decades from **1951 to 2011**. During the decade **1961–71**, Palakkad recorded the **highest population growth** of **23.06 percent**, indicating a rapid rise in population during that period. The growth rate then **gradually declined** in the following decades — to **21.3 percent (1971–81)**, **16.52 percent (1981–91)**, **9.88 percent (1991–2001)**, and **7.39 percent (2001–2011)**.

Overall, the graph reveals a **steady downward trend** in population growth over time. This consistent decline reflects factors such as improved literacy, better healthcare, enhanced awareness of family planning, and socio-economic development in the district.

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

Graph 1.3.2. Density of Population per Sq. Km - Palakkad

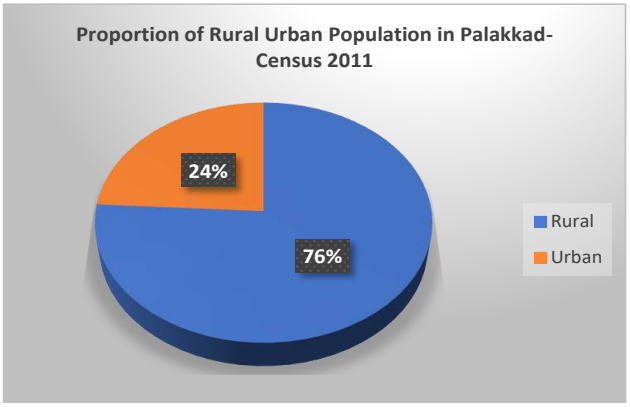


Source: Census 2011 data

The chart titled **"Density of Population per Sq. Km – Palakkad"** illustrates the progressive increase in population density from **1951 to 2011**. In **1951**, the district had a population density of **271 persons per sq. km**, which gradually rose over the decades. By **1961**, it increased to **306**, and further to **376** in **1971**. The upward trend continued, reaching **456** in **1981**, **532** in **1991**, and **584** in **2001**. By **2011**, the density reached **627 persons per sq. km**.

This steady rise indicates sustained population growth and expanding settlement patterns in the district. The trend reflects improvements in healthcare, living standard, and migration to urban and semi-urban areas within Palakkad, contributing to the sustained increase in population concentration over the six decades.

Graph 1.3.3 Proportion of Rural and Urban Population in Palakkad – Census 2011



Source: Census 2011 data

The pie chart titled **"Proportion of Rural and Urban Population in Palakkad – Census 2011"** depicts the distribution of population between rural and urban areas in the district. According to the 2011 Census, **76 percent** of Palakkad's population resides in **rural areas**, while **24 percent** lives in **urban areas**. This indicates that the district continues to have a predominantly rural character, with most people depending on agriculture and allied occupations. However, the urban share of 24 percent also highlights a gradual shift towards urbanization, influenced by the growth of towns, improved infrastructure, and the expansion of trade, industry, and services in recent decades.

1.4 Age and Sex Distribution

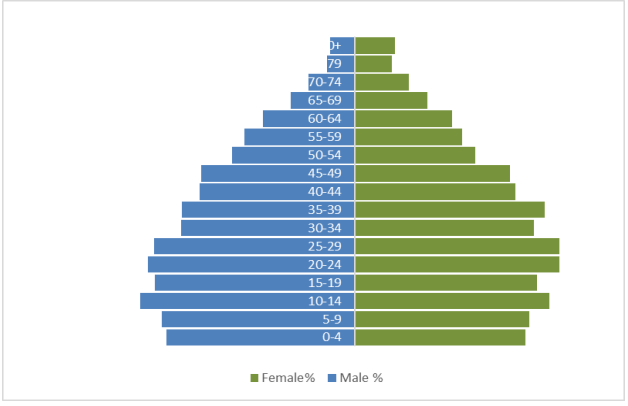
According to the Census of 2011, Palakkad district had a total population of **2,809,934**, comprising **1,359,478 males** and **1,450,456 females**, resulting in a **sex ratio of 1,067 females per 1,000 males**. This figure is higher than the State average and indicates a relatively balanced and favourable gender composition in the district. The **rural sex ratio** (1,068) is slightly higher than the **urban sex ratio** (1,063), reflecting a marginally greater female presence in rural areas.

The **child population (0–6 years)** stood at **302,297**, accounting for **10.76 percent** of the total population. Among this group, there were **153,696 boys** and **148,601 girls**, with a **child sex ratio of 967 girls per 1,000 boys**. This ratio, though high compared to

many parts of India, is lower than the overall sex ratio of the district, suggesting a mild gender imbalance in the younger age group. The child sex ratio in rural areas (969) was slightly better than in urban areas (959), indicating relatively more equitable gender distribution in rural communities.

The proportion of children below six years shows that the district's population structure is gradually **ageing and stabilizing**, consistent with the broader demographic transition seen in Kerala. The declining share of younger age groups, coupled with a high overall sex ratio, reflects **improvements in literacy, health care, and family welfare practices**. Palakkad's demographic profile thus presents a picture of a district in demographic maturity, marked by controlled fertility rates, enhanced life expectancy, and balanced gender representation, though continued attention to gender equity in younger age cohorts remains essential.

Graph 1.4.1 Age and sex distribution of Population based on Census 2011 population

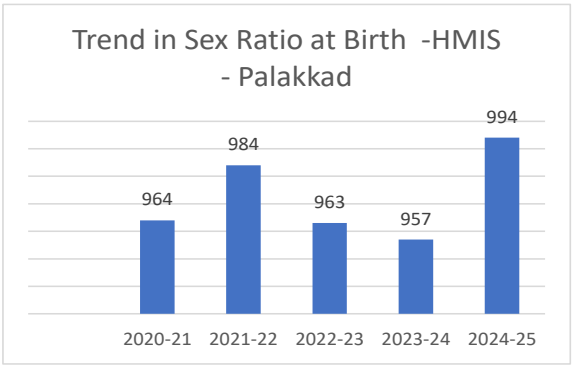


Source: Census 2011 data

This population pyramid illustrates an expansive or rapid-growth population structure, characteristic of a population with a high birth rate and a relatively low life expectancy. The pyramid has a very broad base, particularly noticeable in the 0-4 to 15-19 age groups, indicating a large proportion of children and adolescents. The longest bars, suggesting the largest cohorts, are found around the 10-14 and 25-29 age ranges for both males and females. The pyramid then tapers rapidly towards the top, with a significantly smaller percentage of individuals in the older age brackets, such as 70-74

and 79+. This shape signifies that many people will soon enter their reproductive and working years, leading to a high potential for continued population growth. The distribution between Male % (blue) and Female % (green) is balanced across most age groups, showing no major sex imbalances in the population. Overall, this is the profile of a young population facing high future growth momentum and a significant dependent population (children).

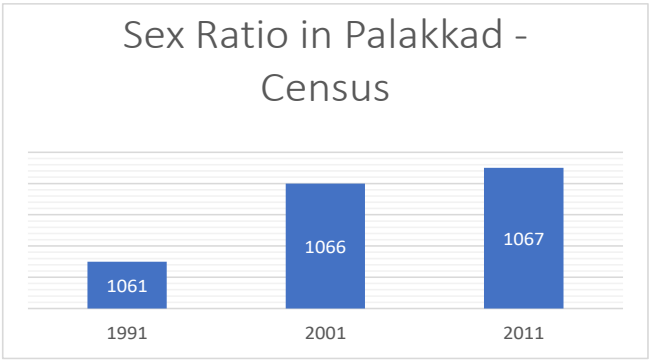
Graph 1.4.2 Sex Ratio at Birth



Source: Health Management Information System (HMIS)data

This bar chart displays the Trend in Sex Ratio at Birth (SRB) for Palakkad District. The Sex Ratio at Birth is typically defined as the number of female births per 1,000 male births. The data shows fluctuations over the five-year period. Starting at 964 in 2020-21, the ratio saw a notable increase to its peak of 984 in 2021-22, indicating an improvement towards a more balanced ratio. This positive trend was followed by two years of decline, with the SRB dropping to 963 in 2022-23 and further to 957 in 2023-24, the lowest point shown in the series. However, the most recent data point for 2024-25 shows a significant rebound and a new peak of 994. This final year's ratio of 994 is very close to the natural biological range (which is typically around 950-980 depending on the country, but often targeted as 980-1000 for policy purposes), suggesting a substantial improvement in the sex ratio at birth in Palakkad during the last reported year.

Graph 1.4.3 Sex Ratio

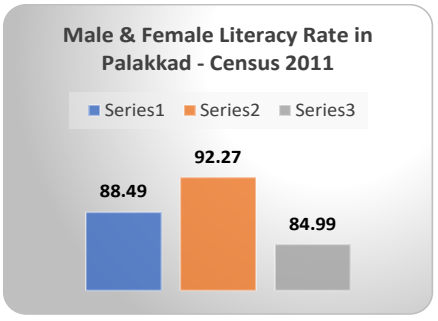


Source: Census 2011 data

This bar chart illustrates the Sex Ratio of the total population in Palakkad as recorded in the Census over three decades: 1991, 2001, and 2011. The Sex Ratio is traditionally defined as the number of females per 1,000 males. The data shows a consistently high sex ratio (i.e., more females than males) that has steadily increased across the twenty-year span. In 1991, the ratio was **1061** females per 1,000 males. This increased significantly in the subsequent decade to **1066 i**n the 2001 Census. The upward trend continued, though at a slower pace, reaching **1067** in the latest available census data from 2011. The overall trend indicates a population in Palakkad where females consistently outnumber males, and this difference has modestly widened over the period from 1991 to 2011.

1.5 Literacy Rate

Graph 1.5.1 Literacy rate male, female and all based on the census 2011 data



Source:

This bar chart depicts the Male and Female Literacy Rates in Palakkad based on the Census 2011 data. It presents three indicators - the overall literacy rate, the male literacy rate, and the female literacy rate. The overall literacy rate in Palakkad stands at 88.49%. When disaggregated by sex, the data reveals a notable gender gap in literacy. The Male literacy rate is higher at 92.27%, while the Female literacy rate is significantly lower at 84.99%. The difference of 7.28 percentage indicates that, although literacy levels are generally high in the district, males were more literate than females in 2011.

1.6. Vulnerable population group

Tribal data:

Attappady, situated in the eastern part of Palakkad district, is known for it's rich cultural diversity and vibrant indigenous communities. The area is predominantly inhabited by three major tribal groups: the **Irula, Muduka,** and **Kurumba**. According to the latest available data, the region consists of a total of **193 tribal colonies**, spread across various parts of Attappady. As of the latest census, the total population of Attappady stands at 33,361. (table 1.6.1). This population is distributed across the three tribal groups in the following manner:

1. **Irula Tribe:** The largest group in Attappady, the Irula tribe resides in 147 colonies, with a total of 9,370 families. The male population in this community is recorded at 12,976, while the female population is 13,560, bringing the total population of the Irula tribe to 26,536.
2. **Muduka Tribe:** The Muduka tribe, with 27 colonies, comprises 1,195 families. The male population is 1,908, while the female population is 2,104, resulting in a total of 4,012 people in the Muduka community.
3. **Kurumba Tribe:** The smallest of the three communities, the Kurumba tribe resides in 19 colonies, with 743 families. The male population here is 1,393, and the female population stands at 1,420, totaling 2,813 people.

In total, Attappady is home to 11,308 families, comprising 16,277 males and 17,084 females. The data indicates a slightly higher female population, suggesting a favourable gender balance within the tribal communities.

Attappady's population is an embodiment of the rich traditions and culture of the indigenous tribes of Kerala. Despite facing various challenges in terms of development

and access to resources, these communities continue to preserve their unique heritage and way of life. The data offers a glimpse into the diverse and evolving demographic landscape of the region.

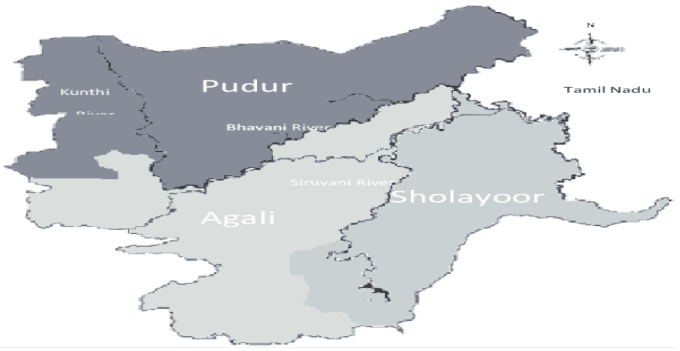


Fig.1.61. Attappady

Table 1.6.1. Snapshot of Attappady population detail

Snapshot of Attappady Population Details					
Caste	**No. of Colonies**	**Total family**	**Male**	**Female**	**Total Population**
Irula	147	9370	12976	13560	26536
Muduka	27	1195	1908	2104	4012
Kurumba	19	743	1393	1420	2813
Total	193	11308	16277	17084	33361
Source: Census 2011 data					

1.6.1. Panchayat wise Tribal population data:

The distribution of the tribal population in three key panchayats: Agali, Pudur, and Sholayur which is provided in **tables 1.6.2,1.6.3,1.6.4**

1. **Agali Panchayat:** Agali, one of the largest panchayats in Attappady, is home to a significant number of tribal families. Agali has 73 colonies, with the following breakdown. The Irula community is the largest in Agali, residing in 52 colonies. There are 3,513 families, with a male population of 4,943 and a female population of 5,133, totaling 10,076 people. The Muduka tribe has 21 colonies, with 835 families. The male population stands at 1,336, and the female population at 1,462, resulting in a total of 2,798 people. Although there are no distinct colonies for the Kurumba tribe, they have a presence in Agali with 36 families. The male population is 70, and the female population is 98, bringing the total to 168.In total, Agali Panchayat has 4,384 families, with a male population of 6,349 and a female population of 6,693, giving it a total population of 13,042
2. **Pudur Panchayat:** Pudur, another panchayat in Attappady, has a slightly smaller tribal population compared to Agali. It contains 67 colonies and is home to a diverse mix of tribes. The Irula tribe is also the dominant group in Pudur, with 43 colonies and 2,536 families. The male population is 3,348, and the female population is 3,617, totaling 6,965 people. The Muduka community resides in 5 colonies, with 323 families. The male population is 532, and the female population is 590, resulting in a total of 1,122 people. The Kurumba tribe is present in 19 colonies, with 707 families. The male population is 1,323, and the female population is 1,322, making up a total of 2,645 people. Pudur's total population stands at 10,732, with 5,203 males and 5,529 females.
3. **Sholayur Panchayat:** Sholayur, though smaller in terms of tribal population compared to Agali and Pudur, still holds a significant presence of the Irula and Muduka tribes. The panchayat contains 53 colonies. The Irula tribe is found in 52 colonies, with 3,321 families. There are 4,685 males and 4,810 females, giving a total population of 9,495. The Muduka tribe has 1 colony, with 37 families. The male population is 40, and the female population is 52, making a total of 92 people. The Kurumba tribe has no recorded population in Sholayur. Sholayur's population

consists of 3,358 families, with 4,725 males and 4,862 females, leading to a total population of 9,587.

The tribal population in Attappady's panchayats reflects the diverse cultural landscape of the region. The Irula tribe is the largest group across all three panchayats, with the Muduka and Kurumba tribes also contributing to the region's demographic diversity. Agali, Pudur, and Sholayur each have distinct populations, with Agali being the most populous and Sholayur the smallest. Despite the differences in population size, the tribal communities in these panchayats maintain their unique cultural identities while contributing to the broader social fabric of Attappady.

Table 1.6.2. Agali Panchayat

Caste	No. of Colonies	Total Family	Male	Female	Total Population
Irula	52	3513	4943	5133	10076
Muduka	21	835	1336	1462	2798
Kurumba	0	36	70	98	168
Total	73	4384	6349	6693	13042
*Source: census 2011 data					

Table 1.6.3. Pudur Panchayat

Caste	No. of Colonies	Total family	Male	Female	Total Population
Irula	43	2536	3348	3617	6965
Muduka	5	323	532	590	1122
Kurumba	19	707	1323	1322	2645
Total	67	3566	5203	5529	10732
*Source: census 2011 data					

Table.1.6.4. Sholayur panchayat

Caste	No.Of Colonies	Total family	Male	Female	Total Population
Irula	52	3321	4685	4810	9495
Muduka	1	37	40	52	92
Kurumba	0	0	0	0	0
Total	53	3358	4725	4862	9587
**Source: census 2011 data*					

1.6.2. Population of PVTG Communities in Attappady:

The Attappady region of Palakkad, is home to several villages that are predominantly inhabited by the Kurumba tribe, a Particularly Vulnerable Tribal Group (PVTG). Below is a detailed breakdown of the population and family statistics for these communities (table 1.6.5).

Table 1.6.5. Particularly vulnerable Tribal Group Attappady

PVTG - ATTAPADI							
Sl.No	Name of Ooru	Grama Panchayath	Cast	No.of family	Population(PVTG)		Total
					Male	Female	
1	MeleAnavai	Pudur	Kurumba	63	88	106	194
2	ThazheAnavai	Pudur	Kurumba	65	143	120	263
3	ThazheThudukki	Pudur	Kurumba	47	89	90	179
4	MeleThudukki	Pudur	Kurumba	46	89	85	174
5	Galasi	Pudur	Kurumba	14	34	24	58

6	Kadukumanna	Pudur	Kurumba	62	115	116	231
7	Kinattukkara	Pudur	Kurumba	21	38	41	79
8	Thadikkundu	Pudur	Kurumba	44	89	104	193
9	Murugala	Pudur	Kurumba	14	33	34	67
10	Palappada	Pudur	Kurumba	4	5	6	11
11	Gottiyarkkandi	Pudur	Kurumba	73	142	123	265
12	Anakkatty	Pudur	Kurumba	13	18	24	42
13	Kurukkathikkalu	Pudur	Kurumba	54	113	97	210
14	Pazhayoor	Pudur	Kurumba	23	39	59	98
15	MeleBhoothayar	Pudur	Kurumba	35	50	57	107
16	ThazheBoothayar	Pudur	Kurumba	52	89	92	181
17	Edavani	Pudur	Kurumba	43	88	89	177
18	Melemoolakombu	Pudur	Kurumba	24	40	36	76
19	Ooradam	Pudur	Kurumba	18	21	19	40
Total				**715**	**1323**	**1322**	**2645**
Source: Census 2011 data							

CHAPTER 2

PALAKKAD - HEALTH DASHBOARD

2.1. Palakkad District at a glance

District AT A GLANCE

Administrative Divisions

Thaluks –5
Villages – 156
Municipalities – 7
Corporations – 0
Block Panchayath- 13
Grama Panchayath -91

Population

Population As per Census 2011 – 2,809,934
Male – 1,450,456
Female – 1,450,456

Area

Total Area (Sq. K) - 4482 Sq.km

Population Density (No per Sq K) - 627

Decadal Population Growth Rate - 192,452

Healthcare Infrastructure under DHS

District Level Hospitals

DH – 1
GH – 0
W&C – 1

2

Sub District Level Hospitals

THQH – 6
TH – 1

7

Community Health Centres

Total CHC – 19
Converted to FHC - 3

19

Primary Health Centres

Total PHC – 76
Converted to FHC – 64

76

Janakeeya Arogya Kendram

Janakeeya Arogya Kendram

-504

504

Other Institutions

School of Nursing – 1
Training Center – 2
PH Lab – 0
DVC Units – 1
Offset Press - 1

Blood Bank – 11
Public – 2
Private -9
Blood Storage Unit – 11

Reproductive, Maternal, and Child Health Services 2024-25

Pregnant Women Registration: 2024-25

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

30305

Pregnant Women- Anaemia 2024-25

45% pregnant women were identified as anaemic through VIVA testing.

45%

Rising C-Section Rates in the district 2024-25

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

30.7%

Maternal Deaths 2024-25

Preterm Births 2024-25

Underweight Newborns 2024-25

11

Total Maternal Deaths Reported in the District - 11

4.97%

The proportion of preterm births in the district – 4.97%

16.32%

The proportion of new-borns weighing less than 2.5 kg in the district – 16.32%

Delivery 2024-25

Institutional Deliver in the district – 23584

Public – 5526

Private – 18018

Home Delivery 2024-25

Home Delivery Reported in the district – 15

No of Migrant Home Delivery - 5

Live Birth 2024-25

Total Live Birth Reported – 23697

Male –12100

Female –11597

Sex Ratio at Birth - 958

CHILD IMMUNIZATION 2024-25

% Birth Dose

Hep B0 –98
OPV 0 – 99
BCG- 100

6 Weeks Vaccines Coverage (%)

OPV1 - 98
Pentavalent 1 - 98
Rotavirus 1 - 98
PCV1 - 98
IPV 1 -98

10 Weeks Vaccines Coverage (%)

OPV2 - 97
Pentavalent 2 -97
Rotavirus 2 - 97

% 14 Week Vaccines

OPV3 - Pentavale
Rotavirus
IPV 2 - 97
PCV2-96

% Children Fully Immunized

MR1 - 97
FULLY IMMUNIZED -96 (children aged between 9 and <12 months)

MR 2 Coverage (%)

MR2 - 96

Communicable diseases reported in the District 2024

Cases Reported
Dengue- 1303
Malaria- 54
Chikungunya- 1
West Nile- 1
Zika- 0
JE- 0

16
Dengue Death

Cases Reported
Kala Azar-0
Scrub Typhus - 26
Leptospirosis- 235

30
Leptospirosis Death

Cases Reported
Cholera - 5
Typhoid- 7
Acute Diarrheal Disease -49740

8
ADD Death

Communicable diseases reported in the District 2024

Chicken Pox Cases- 2984
MPox Cases-0

5
Chicken Pox Death

Rabies Cases Reported- 2
Shigella cases 7
Amoebic Meningoencephalitis - 1

2
Rabies Death

Cases Reported
Hepatitis A -339
Hepatitis B-271
Hepatitis C-77
Hepatitis E - 5

1
Hepatitis A Death

CHAPTER 3

HEALTH FACILITIES IN PALAKKAD DISTRICT

3.1. Details of Health Facilities in the District (Taluk wise details)

The district of Palakkad has a well-structured network of health institutions, comprising a total of 650 facilities (including 635 hospitals and Health & Wellness Centres, along with other public health facilities). This includes one District Hospital, six Taluk Headquarters Hospitals(One in tribal area), one taluk hospital, eleven Community Health Centres, five Community Health Centres converted to Block Family Health Centres (FHCs), three Community Health Centres converted to FHCs, twelve 24x7 Primary Health Centres converted to FHCs, 64 Primary Health Centres converted to FHCs, one District TB Centre, nine Mobile Units/Dispensaries/Health Clinics, one Women & Children's Hospital, along with other supportive institutions such as a School of Nursing, two Training Centres, a District Vector Control Unit, and one office establishment under DHS/DMOH. In addition, there are 504 Health Sub-Centres, ensuring reach to the community level. Altogether, the total number of institutions functioning under the district health system stands at 650 (Table 3.1.1).

Table 3.1.1.No. of health facilities in Palakkad District

Sl. No.	Name of District Name of Institution	PALAKKAD Total
1	General Hospital	1
2	District Hospital	1
3	Taluk Head Quarter Hospital	6
4	Taluk Hospital	1
5	Community Health Centres	11
6	Community Health Centres Converted to Block FHCs	5

7	Community Health Centres Converted to FHCs	3
8	24x7 Primary Health Centres	0
9	24x7 Primary Health Centres Converted to Block FHCs	0
10	24x7 Primary Health Centres Converted to Block FHC &FHC	0
11	24x7 Primary Health Centres Converted to FHCs	12
12	Primary Health Centres	0
13	Primary Health Centres Converted to Block FHCs	0
14	Primary Health Centres Converted to FHCs	64
15	District TB Centre	1
16	Mobile Unit/Dispensaries/Health Clinics	9
17	W & C Hospital	1
18	Mental Health Center	0
19	TB Hospital	0
20	Leprosy Hospital	0
21	Speciality Hospital	0
	TOTAL	115
Other Institutions Under DHS		
22	School of Nursing	1
23	Training Center	2
24	Government Public Lab	0
25	District Vector Control Unit	1

26	Others (DHS, DMOH, OFFSET Press)	1
27	Urban Primary Health Centres	5
28	Health and Wellness Centres	504
29	Urban Health and Wellness Centres	21
	GRAND TOTAL	**650**

**Source: District Data*

3.1.1. Healthcare Facility Distribution and Health Blocks in Palakkad District

At the primary care level, 504 SCs, 76 PHCs and 5 UPHCs are distributed all over the 14 Health blocks. At the secondary care level, Palakkad district has 19 CHCs, 5 THQH hospitals, 1 tribal specialty hospital and 1 DH with the W&C hospital functioning as a separate hospital adjacent to DH Palakkad.

Figure 3.1.1. District Health Profile

3.1.2. Distribution of health facilities in Health blocks:

The healthcare infrastructure in Palakkad district comprises a wide network of institutions across both rural and urban areas. In rural regions, there are several Community Health Centres (CHCs) and Primary Health Centres (PHCs) serving the

population. CHC Agali includes PHCs at Anakatty, Sholayur, and Pudur. CHC Alanellur is supported by PHCs at Thachanattukara, Kottopadam, Kumaramputhur, Kanjirapuzha, Thachampara, Karakurissi, and Thenkara. CHC Ambalapara oversees PHCs at Lakkidi, Perur, and Vaniyamkulam, while CHC Chalavara is linked with PHCs at Ananganady, Nellya, and Vallapuzha. CHC Chalissery manages PHCs at Nagalassery, Kumbidi, Kapoor, Thrithala, Kumaranellur, Pattithara, and Thirumittacode. CHC Katambazhipuram includes PHCs at Sreekrishnapuram, Vellinezhi, Adakkaputhur, Pookottukavu, Thrikkadeeri, Elumblassery, Cherplassery, and Kottapuram. CHC Koduvayur is associated with PHCs at Pudunagaram, Kodumba, Kollengode, Vadavannur, Elevanchery, and Muthalamada. CHC Elapully supervises PHCs at Polpully, Pallassena, and Parambikulam. CHC Kongad covers PHCs at Mannur, Keralassery, Mundur, Pudupriyaram, Akathethara, Malampuzha, Marutharode, and Kalladikode. CHC Koppam oversees PHCs at Ongallur, Pallipuram, Thiruvegapura, Vilayur, Kulukkallur, and Muthuthala. CHCs Kuzhalmannam and Coyalmannam are supported by PHCs at Mathur, Kottai, Kuthanur, Peruvemba, Peringottukurissi, Thenkurissi, Kannadi, and Pudussery. CHC Nanniyode includes PHCs at Perumatty, Ozhalapathy, Vannamada, and Nallepilly, while CHC Kozhinjampara and CHC Parli manage PHCs at Parli, Pirayiri, and Mankara. CHC Pazhambalacode oversees PHCs at Kannambra, Kunissery, Kavassery, Melarcode, and Puducode. CHC Vadakkenchery supervises PHCs at Ayilur, Vandazhy, Kizhakkenchery, and Nelliyampathy. CHC Nemmara also provides health services in the rural sector. Other key healthcare institutions in the district include the District Hospital (DH) Palakkad, Women & Children Hospital Palakkad, and Taluk Headquarters Hospitals (THQHs) located in Mannarkkad, Alathur, Chittur, Ottappalam, and Pattambi. Additionally, the Government Tribal Speciality Hospital (GTSH) in Kottathara provides specialized care for tribal populations **(Table 3.1.2)**.

Table 3.1.2 Distribution of health facilities across blocks

Health Block	Name of Institutions
CHC Agali	CHC Agali
	PHC Anakatty
	PHC Sholayur
	PHC Pudur

CHC Alanellur	CHC Alanellur
	PHC Thachanattukara
	PHC Kottopadam
	PHC Kumaramputhur
	PHC Kanjirapuzha
	PHC Thachampara
	PHC Karakurissi
	PHC Thenkara
CHC Ambalapara	CHC Ambalapara
	PHCLakkidi
	PHC Perur
	PHC Vaniyamkulam
CHC Chalavara	CHC Chalavara
	PHC Ananganady
	PHC Nellya
	PHC Vallapuzha
CHC Chalissery	CHC Chalissery
	PHC Nagalassery
	PHC Kumbidi
	PHC Kapoor
	PHC Thrithala
	PHC Kumaranellur
	PHC Pattithara
	PHC Thirumittacode
	Gh Shornur
CHC Katambazhipuram	CHC Katambazhipuram
	PHC Sreekrishnapuram
	PHC Vellinezhi
	PHC Adakkaputhur
	PHC Pookottukavu
	PHC Thrikkadeeri

	PHC Elumblassery
	PHC Cherplassery
	PHC Kottapuram
CHC Koduvayur	CHC Koduvayur
	PHC Pudunagaram
	PHC Kodumba
	PHC Kollengode
	PHC Vadavannur
	PHC Elevanchery
	PHC Muthalamada
	CHC Elapully
	PHC Polpully
	PHC Pallassena
	PHC Parambikulam
CHC Kongad	CHC Kongad
	PHC Mannur
	PHC Keralassery
	PHC Mundur
	PHC Pudupriyaram
	PHC Akathethara
	PHC Malampuzha
	PHC Marutharode
	PHC Kalladikode
CHC Koppam	CHC Koppam
	PHC Ongallur
	PHC Pallipuram
	PHC Thiruvegapura
	PHC Vilayur
	PHC Kulukkallur
	PHC Muthuthala
CHC Kuzhalmannam	CHC Coyalmannam
	PHC Mathur
	PHC Kottai

	PHC Kuthanur
	PHC Peruvemba
	PHC Peringottukurissi
	PHC Thenkurissi
	PHC Kannadi
	PHC Pudussery
CHC Nanniyode	CHC Nanniyode
	PHC Perumatty
	PHC Ozhalapathy
	PHC Vannamada
	PHC Nallepilly
	CHC Kozhinjampara
CHC Parli	Phc Parli
	Phc Pirayiri
	Phc Mankara
CHC Pazhambalacode	CHC Pazhambalacode
	PHC Kannambra
	PHC Kunissery
	PHC Kavassery
	PHC Melarcode
	PHC Puducode
CHC Vadakkenchery	CHC Vadakkenchery
	PHC Ayilur
	PHC Vandazhy
	PHC Kizhakkenchery
	PHC Nelliyampathy
	CHC Nemmara
Palakkad Municipality	PHC Melamuri
	DH Palakkad
	W&C Palakkad
	THQH Mannarkkad
	THQH Alathur
	THQH Chittur

	GTSH Kottathara
	THQH Ottappalam
	THQH Pattambi

**Source: District Data*

In urban areas, the Palakkad Municipality manages several Urban Primary Health Centres (UPHCs), including those at Diara Street, Vennakkara, Alamkode, and Kulappully. Shornur Municipality also has a UPHC at Alamkode, while Ottappalam Municipality supports its own urban health facility. The PHC Melamuri under Palakkad Municipality further strengthens the urban healthcare delivery system. **Table 3.1.3** shows the distribution of health facilities in urban areas.

Table.3.1.3 Distribution of health facilities in urban areas

UPHC Diara Street	Palakkad Municipality
UPHC Vennakkara	
UPHC Alamkode	
UPHC Kulappully	Shornur Municipality
UPHC Alamkode	Ottappalam Municipality

Source: District Data

3.2. Availability of Specialised Centres in Palakkad District

Palakkad district has a modest but well-structured network of specialised healthcare institutions under the Directorate of Health Services (DHS). Among the specialised facilities, the district houses one District TB Centre that provides diagnosis, treatment, and monitoring services for tuberculosis patients across the district. Additionally, there is one Women and Children (W & C) Hospital, which caters to maternal and child health needs, offering specialised obstetric, gynaecological, and paediatric care.

The district also has no designated Mental Health Centre, TB Hospital, Leprosy Hospital,

or Speciality Hospital, indicating limited availability of dedicated facilities for psychiatric, chronic infectious, and advanced specialty care. However, specialised services are partially integrated within the existing district and taluk-level hospitals.

3.3. Bed Strength in Different Health Facilities

Altogether, the district has 2,763 sanctioned beds of which 1,980 are functional, showing an overall utilization of nearly 72 percent. The distribution of facilities shows clear regional variations. Palakkad Assembly Constituency accounts for the largest share with 794 sanctioned beds and 785 functional beds, supported by 8 facilities, including 5 in urban areas. Mannarkkad also has a strong presence with 323 sanctioned and 312 functional beds across 14 institutions, while Alathur and Ottappalam each provide around 300 beds with predominantly rural coverage. Constituencies such as Chittur (212 sanctioned, 85 functional), Nenmara (170 sanctioned, 73 functional) and Shornur (131 sanctioned, 62 functional) reflect mid-level capacity. By contrast, Kongad, Malampuzha, Tarur and Thrithala each have fewer than 150 sanctioned beds, with functional capacity in Thrithala particularly low (22 functional out of 141 sanctioned).

Table.3.3.1. Bed strength in different level of facilities – Palakkad District (Consolidated Overview)

Name of Assembly Constituency	Sanctioned bed Final	Functional Bed	No. Health Facility in rural area including DH, W&C, THQH, TH, CHC, FHC, PHC	No. of Health facility in Urban area including DH, W&C, THQH, TH, CHC, FHC, PHC
Alathur	299	203	8	0
Chittur	212	85	7	1
Kongad	76	55	9	0
Malampuzha	72	13	10	0
Mannarkkad	323	312	13	1

Nenmara	170	73	13	0
Ottappalam	287	209	9	1
Palakkad	794	785	3	5
Pattambi	118	101	7	1
Shornur	131	62	7	2
Tarur	140	60	8	0
Thrithala	141	22	9	0
TOTAL - Palakkad District	2763	1980	103	11

Source: District Data

3.4 Health Facilities in Rural and Urban area

Table 3.4.1 presents a detailed distribution of health facilities across rural and urban areas. In the rural sector, there are 483 Sub Centres (including Health and Wellness Centres) and 75 Primary Health Centres (PHCs) that serve as the first point of contact for the community. In addition, 17 Community Health Centres (CHCs) and 3 Sub District Hospitals (SDHs) provide secondary-level healthcare services and act as referral units for the PHCs.

In the urban areas, the healthcare system is strengthened with 42 Sub-centres, including Urban Health and Wellness Centres (U-HWCs), and 6 Primary Health Centres, which include both Family Health Centres (FHCs) and Urban PHCs. The district also has 2 Community Health Centres, 4 Sub District Hospitals, 1 District Hospital (DH), and 1 Women and Children Hospital (W&C DH) that cater to the specialized and advanced healthcare needs of the urban population.

This distribution of health facilities highlights the district's commitment to ensuring accessible, affordable, and equitable healthcare services for both rural and urban population.

Table 3.4.1. Distribution of health facilities in rural and urban area in Palakkad District –Institutional Analysis

Health Facilities	Rural	Urban
Sub Centre	483	42(Including HWCs and U-HWCs)
Primary Health Centre	75	6 (Including PHC/FHC & U-PHCs)
CHC	17	2
SDH	3	4
DH		1
W&C (DH)		1
Source: District Data		

3.5. Health Facilities Converted to FHC

In Palakkad district, a total of 79 health facilities have been upgraded and converted to Family Health Centres (FHCs) as part of the ongoing health system strengthening initiatives (Table 3.5.1). This includes the conversion of 12 former 24x7 Primary Health Centres, 3 Community Health Centres, and 64 Primary Health Centres into FHCs. The transformation aims to enhance the quality and accessibility of primary healthcare services by providing comprehensive, people-centred care with extended working hours, improved infrastructure, and additional human resources.

Table 3.5.1. Total number of facilities converted to FHC

Name of the district	24x7 PHC Converted to FHC	CHC Converted to FHC	PHC Converted to FHC	Grand Total
Palakkad	12	3	64	79

Source: District data

3.6. Delivery Points in Palakkad district

Palakkad district has a total of 7 designated delivery points that provide institutional delivery services to ensure safe motherhood and newborn care. These include 1 Women and Children (W&C) Hospital and 6 Sub-District Hospitals (SDHs) equipped to handle both normal and complicated deliveries.

The concentration of delivery points at higher-level facilities such as SDHs and the W&C Hospital ensures the availability of skilled personnel, essential obstetric equipment, and round-the-clock maternal health services. This arrangement strengthens institutional delivery coverage and contributes significantly to reducing maternal and neonatal morbidity and mortality in the district.

Table 3.6.1. Number of delivery points in Palakkad district

Name of the district	CHC	DH	DH(W&C)	SDH	Grand Total
Palakkad	0	0	1	6	7

Source: District data

3.7. Other Specialised Care Centres

Palakkad district has established a range of specialised care centres to strengthen healthcare access for vulnerable populations, particularly children and tribal communities. The District Early Intervention Centre (DEIC) plays a crucial role in the early identification and management of developmental delays and disabilities in the children.

Additionally, three Nutritional Rehabilitation Centres (NRCs) situated in Agali, Anakkatti, and Sholayur provide essential care and nutritional support to children suffering from malnutrition, thereby contributing to improved child health outcomes.

The district also operates seven Mobile Medical Units (MMUs), ensuring the delivery of essential health services to remote and underserved areas. Of these, five are managed by the Health Department and HLL, while two are operated by the Department of Tribal Development, demonstrating effective interdepartmental collaboration to enhance healthcare outreach.

Table.3.7.1Number of other specialised care centres

Type of Specialised Centre	Number / Details	Remarks
District Early Intervention Centre (DEIC)	1	Functions as a referral centre for early screening, diagnosis, and intervention for developmental delays and disabilities among children.
Nutritional Rehabilitation Centres (NRCs)	3	Located at **Agali**, **Anakkatti**, and **Sholayur**; provide inpatient care, dietary counselling, and follow-up for children with severe acute malnutrition.
Mobile Medical Units (MMUs)	7	- **MMU 1 & 2:** Managed by the Directorate of Health Services (with Medical Officer & Staff Nurse). - **MMU 3, 4 & 5:** Managed by HLL (with Medical Officer, Staff Nurse, Pharmacist & Lab Technician). - **2 Additional MMUs:** Operated by the Department of Tribal Development to ensure outreach services in remote tribal areas.

Source: District Data

3.8. NQAS Accredited Facilities

As of 31st March 2025, 19 healthcare facilities in Palakkad district have achieved National Quality Assurance Standards (NQAS) accreditation, showcasing the district's strong commitment to delivering quality healthcare and ensuring patient safety. The accredited institutions represent a wide spectrum of healthcare levels — from Community Health Centres (CHCs) and Family Health Centres (FHCs) to Urban Primary Health Centres (UPHCs) and a Health & Wellness Centre (HWC) — ensuring quality coverage across both rural and urban settings. Notably, 12 FHCs form the largest group of accredited facilities, reflecting significant progress in strengthening primary care infrastructure. The inclusion of the Government Tribal Specialty Hospital (GTSH) Kottathara highlights the district's efforts to extend quality healthcare services to tribal and remote populations.

Table 3.8.1NQAS accredited facilities as on 31st March 2025

Type of Facility	Number of Accredited Facilities	Names of Accredited Institutions
CHCs	2	CHC Kadampazhipuram, CHC Koppam
FHCs	12	FHC Peruvamba, FHC Sreekrishnapuram, FHC Kalladikode, FHC Ozhallapathy, FHC Pookottukavu, FHC Adakaputhur, FHC Kizhakkenchery, FHC Puthukode, FHC Marutharoad, FHC Annakatti, FHC Sholayur, FHC Punnapadam
UPHCs	3	UPHC Kullappully, UPHC Diara Street, UPHC Vennakara
HWCs	1	HWC Punnapadam
Tribal Specialty Hospital	1	Government Tribal Specialty Hospital (GTSH) Kottathara
Total	**19**	—

Source: District Data

CHAPTER 4

HUMAN RESOURCE PROFILE

4.1. Health Human Resource – Major Indicators

The availability of health human resources and infrastructure is a crucial determinant of the quality and accessibility of healthcare services in any region. Table 4.1.1 presents the key indicators of health human resources in the district, focusing on bed–population, doctor–bed, and doctor–population ratios based on the Census 2011 population data.

The bed–population ratio in the district stands at 1:1,013, indicating that for every 1,013 individuals, there is one hospital bed available. This measure provides an insight into the capacity of healthcare facilities to accommodate patients and serves as a standard indicator for assessing the adequacy of hospital infrastructure.

The doctor–bed ratio is reported as 1:6 implying there is one doctor available for every six hospital beds. This ratio is an important indicator of the human resources available within health facilities, reflecting the potential for timely medical attention and effective patient management.

The doctor–population ratio, calculated based on the Census 2011 population, is 1:5,966, meaning that one doctor serves approximately 5,966 individuals in the district. This figure highlights the overall availability of medical practitioners and is a key metric for planning health workforce requirements, particularly in light of increasing healthcare demands.

Table 4.1.1: Bed–Population, Doctor–Bed, and Doctor–Population Ratios in the District (Based on Census 2011 Population)

Indicator	Ratio
The bed population ratio (based on Census 2011 population)	1:1013
The average Doctor bed ratio	1:6
Doctor population ratio (based on Census 2011 population)	1:5966

Source: District Data

4.2 Availability of Medical Officers

Table 4.2.1 provides a count of medical officers with specific advanced specializations within the Directorate of Health Services (DHS) in the district. The data shows the distribution across three super specialty fields. The highest number of specialists is in Cardiology with 2 doctors. Nephrology and Neurology each have 1 doctor.

Table 4.2.1: Number of Specialty and Super Specialty Doctors under DHS

Super Speciality	Number of doctors
Cardiology	2
Nephrology	1
Neurology	1
Total	**4**

Source: District Data

4.3 Sanctioned Strength of Health Personnel under DHS

In March 2025, the sanctioned strength of posts in Palakkad district was 3,896 posts, of which 3,496 were filled, leaving 400 vacancies (Table 4.3.1). Among these, 468 posts were filled by SC candidates, 110 by ST candidates, and 2,918 by others. The data highlights vacancies across both medical and non-medical categories. In the medical cadre, doctors in the administrative stream had 5 vacancies, while the general cadre recorded 52 vacancies, including Assistant Surgeons (36), Casualty Medical Officers (13), and Civil Surgeons (3). Specialties such as General Surgery, Anesthesia, Obstetrics & Gynecology, Ophthalmology, and TB & Chest also showed a few vacancies.

Table 4.3.1: Category-wise Sanctioned Strength of Health Personnel under DHS (Consolidated data)

Sl. No.	Category	No. of Sanctioned Posts	No. of Posts Filled	No. of Posts Vacant	Staff Position (%)
1.	**Doctors**	**466**	**407**	**59**	**87.33**
	Administrative Cadre	16	13	3	81.25
	General Cadre	323	279	44	86.38
	Specialty	127	115	12	90.55
2.	**Ministerial Staff** (AA, Jr. Supt., Typist, Clerk, etc.)	**338**	**331**	**7**	**97.93**
3.	**Paramedical Staff** (HS, HI, JHI, JPHN, Nursing Asst., etc.)	**2249**	**2043**	**206**	**90.84**
4.	**Technical Staff** (Leprosy Officer, Biologist, LT, Dental Hygienist, etc.)	**245**	**216**	**29**	**88.16**
5.	**Others** (Electrician, Driver, Housekeeper, Attendant, etc.)	**598**	**499**	**99**	**83.44**
	Total	**4362**	**3903**	**459**	**89.73**
Source: District Data					

In March 2025, the sanctioned strength of posts in Palakkad district was 3,896 posts, of which 3,466 were filled, leaving 400 vacancies (Table 4.3.2). Among these, 468 posts were filled by SC candidates, 110 by ST candidates, and 2,918 by others. The data highlights vacancies across both medical and non-medical categories. In the medical cadre, doctors in the administrative stream had 5 vacancies, while the general cadre recorded 52 vacancies, including Assistant Surgeons (36), Casualty Medical Officers (13), and Civil Surgeons (3). Specialties such as General Surgery, Anaesthesia, Obstetrics & Gynecology, Ophthalmology, and TB & Chest also showed a few vacancies. In the non-

medical and support staff category, larger gaps were observed. Overall, while most higher-level medical consultant posts were adequately staffed, shortages remain significant in support services and certain frontline medical roles, reflecting the need for targeted recruitment drives to ensure smooth functioning of health services in Palakkad district.

Table 4.3.2 Category wise sanctioned strength in Palakkad District (Disaggregated Data)

Name of post	Sanctioned	In Position				Vacancy April '25
		SC	ST	Others	All	
Doctors (Administrative Cadre)	**16**	**1**	**0**	**10**	**11**	**5**
Asst. Director (Dist. RCH Officer)	1	0	0	1	1	0
Asst. Director (Dy. DMO)	3	0	0	3	3	0
Deputy Director (DMO)	1	0	0	1	1	0
Dist. TB Officer (Assistant Director)	1	0	0	0	0	1
Dy. Superintendent (Assistant Director)	1	0	0	0	0	1
Jr. Administrative Medical Officer	1	0	0	1	1	0
Superintendent (Assistant Director)	6	1	0	2	3	3
Superintendent (Dy. DHS)	2	0	0	2	2	0
Doctors (General Cadre)	**323**	**18**	**6**	**247**	**271**	**52**
Assistant Surgeon	250	14	5	195	214	36
Assistant Surgeon (RMO)	1	1	0	0	1	0

Causality Medical officer	42	0	0	19	29	13
Civil Surgeon	18	2	0	13	15	3
Dental Asst. Surgeon	10	1	1	8	10	0
Dental Civil Surgeon	2	0	0	2	2	0
General Medicine	**16**	**3**	**0**	**12**	**15**	**1**
Chief Consultant	1	1	0	0	1	0
Consultant	3	1	0	2	3	0
Jr. Consultant	11	1	0	10	11	0
Sr. Consultant	1	0	0	0	0	1
General Surgery	**9**	**0**	**0**	**8**	**8**	**1**
Consultant	2	0	0	2	2	0
Jr. Consultant	6	0	0	5	5	1
Sr. Consultant	1	0	0	1	1	0
Anaesthesia	**11**	**0**	**0**	**9**	**9**	**2**
Consultant	1	0	0	0	0	1
Jr. Consultant	9	0	0	9	9	0
Sr. Consultant	1	0	0	0	0	1
Blood Bank/Clinical Lab/PH Lab	**1**	**0**	**0**	**1**	**1**	**0**
Consultant	1	0	0	1	1	0
Cardiology	**1**	**0**	**0**	**1**	**1**	**0**
Chief Consultant	0	0	0	0	0	0
Consultant	1	0	0	1	1	0
Dental	**1**	**0**	**0**	**1**	**1**	**0**

Jr. Consultant	1	0	0	1	1	0
Dermatology & Venerology	**4**	**1**	**0**	**3**	**4**	**0**
Consultant	1	1	0	0	1	0
Jr. Consultant	3	0	0	3	3	0
ENT	**7**	**1**	**0**	**6**	**7**	**0**
Consultant	2	1	0	1	2	0
Jr. Consultant	5	0	0	5	5	0
Forensic Medicine	**2**	**0**	**0**	**0**	**0**	**2**
Chief Consultant	1	0	0	0	0	1
Sr. Consultant	1	0	0	0	0	1
Nephrology	**1**	**0**	**0**	**1**	**1**	**0**
Consultant	1	0	0	1	1	0
Neurology	**1**	**0**	**0**	**1**	**1**	**0**
Consultant	1	0	0	1	1	0
Obstetrics & Gynaecology	**25**	**3**	**0**	**21**	**24**	**1**
Consultant	4	1	0	3	4	0
Jr. Consultant	20	2	0	17	19	1
Sr. Consultant	1	0	0	1	1	0
Ophthalmology	**9**	**0**	**0**	**7**	**7**	**2**
Consultant	2	0	0	1	1	1
Jr. Consultant	7	0	0	6	6	1
Orthopaedic Surgery	**12**	**0**	**0**	**12**	**12**	**0**
Consultant	3	0	0	3	3	0

Jr. Consultant	9	0	0	9	9	0
Paediatrics	**18**	**3**	**0**	**15**	**18**	**0**
Consultant	5	2	0	3	5	0
Jr. Consultant	13	1	0	12	13	0
Sr. Consultant	0	0	0	0	0	0
Physical Medicine & Rehabilitation	**3**	**0**	**0**	**3**	**3**	**0**
Consultant	1	0	0	1	1	0
Jr. Consultant	1	0	0	1	1	0
Sr. Consultant	1	0	0	1	1	0
Psychiatry	**4**	**0**	**0**	**4**	**4**	**0**
Consultant	1	0	0	1	1	0
Jr. Consultant	3	0	0	3	3	0
Radio Diagnosis/Radio Therapy	**2**	**0**	**0**	**2**	**2**	**0**
Consultant	1	0	0	1	1	0
Jr. Consultant	1	0	0	1	1	0
TB & Chest (Resp. Medicine)	**4**	**1**	**0**	**2**	**3**	**1**
Consultant	1	0	0	0	0	1
Jr. Consultant	3	1	0	2	3	0
Others	**3426**	**437**	**104**	**2552**	**3093**	**333**
Administrative Asst.	1	0	0	1	1	0
Asst. Leprosy Officer	0	0	0	0	0	0
Biologist	1	0	0	0	0	1

Blood Bank Technician Gr.I	1	0	0	1	1	0
Blood Bank Technician Gr.II	2	0	0	2	2	0
Camp co-ordinator	1	1	0	0	1	0
Cath Lab Technician	2	0	0	0	0	2
Chief Nursing Officer	1	0	0	1	1	0
Clerk/Typist	10	2	0	8	10	0
Clinical Psychologist	1	0	0	1	1	0
Cobler	3	1	0	0	1	2
Confidential Asst.	1	0	0	1	1	0
Cook Gr.I	1	0	0	0	0	1
Dental Hygenist Gr.I	2	0	0	2	2	0
Dental Hygenist Gr.II	6	1	0	4	5	1
Dental Mechanic Gr.I	1	0	0	1	1	0
Dental Mechanic Gr.II	4	0	0	4	4	0
Dialysis Technician	5	0	0	0	0	5
Dist. Edn. & Media Officer(DEMO)	1	1	0	0	1	0
Dist. Lab Technician	1	0	0	0	0	1
Dist. Malaria Officer	1	0	0	1	1	0
Dist. Public Health Nurse	2	0	0	0	0	2
Dist. Nursing Officer	1	0	0	0	0	1
Driver	80	6	3	60	69	11

Dy. Nursing Superintendent	9	1	0	8	9	0
Dy. District. Education and Media Officer	2	1	0	1	2	0
E.C.G.Technician Gr.I	2	0	0	2	2	0
E.C.G.Technician Gr.II	2	0	0	1	1	1
Electrician	2	0	0	2	2	0
Field Asst.	5	1	0	4	5	0
Field worker	20	1	0	8	9	11
Filaria Inspector Gr- I	1	0	0	1	1	0
Filaria Inspector Gr-II	1	0	0	1	1	0
Foreman	1	0	0	0	0	1
Foreman Mechanic	1	0	0	1	1	0
Head Clerk	10	0	0	10	10	0
Health Inspector	72	17	2	51	70	2
Health Supervisor	12	4	0	8	12	0
Helper	3	0	0	1	1	2
Helper (Limb)	1	0	0	0	0	1
Hospital Attendant Gr.I	65	10	1	39	50	15
Hospital Attendant Gr.II	304	45	9	213	267	37
Housekeeper	2	0	0	0	0	2
Insect Collector	2	0	1	1	2	0
Jr. Superintendent	6	0	0	6	6	0
Junior Health Inspector	305	40	5	253	298	7

Junior Lab Assistant	5	1	1	3	5	0
Junior P.H.Nurse Gr. I	257	47	6	161	214	42
Junior P.H.Nurse Gr. II	258	38	7	159	204	55
Junior Scientific Officer	2	0	0	0	0	2
L D/UD Clerk	171	18	6	141	165	6
L D/UD Typist	9	1	2	6	9	0
Laboratory Technician	145	13	2	122	137	8
Lady Health Inspector/PHN	80	8	0	67	75	5
Lady Health Supervisor/PHNS	12	1	0	9	10	2
Lay Secretary & Treasurer (Sr.Supdt.)	6	0	0	6	6	0
M.C.H. Officer	1	0	0	0	0	1
Mechanic helper	1	0	0	1	1	0
Medical Record Attendant	1	0	0	0	0	1
Medical Record Librarian Gr.I	1	0	0	1	1	0
Medical Record Librarian Gr.II	2	1	0	1	2	0
Mortuary Technician	1	0	0	0	0	1
Motor Mechanic	2	0	0	1	1	1
Mortuary Attendant	1	0	0	0	0	1
Non-Medical Supervisor Gr.I	0	0	0	0	0	0
Non-Medical Supervisor Gr.II	0	0	0	0	0	0

Nursing Assistant	331	56	24	242	322	9
Nursing Officer	574	44	26	484	554	20
Nursing Superintendent	3	1	0	2	3	0
Nursing Tutor	9	0	0	5	5	4
Office Attendant (Peon)	115	15	5	88	108	7
Optometrist Gr.II	20	3	0	15	18	2
P.H.N.Tutor	6	0	0	0	0	6
Part Time Sweeper	100	16	0	64	80	20
Pharmacist	172	17	4	127	148	24
Pharmasist Storekeeper	8	6	0	2	8	0
Physiotherapist	1	0	0	1	1	0
Plumber	1	1	0	0	1	0
Principal J.P.H.N Trg. School	1	0	0	0	0	1
Principal School Of Nursing	1	0	0	0	0	1
Psychiatrist Social Worker	1	0	0	0	0	1
Pump operator	1	0	0	0	0	1
Radiographer Gr.I	5	2	0	3	5	0
Radiographer Gr.II	7	1	0	6	7	0
Refrigeration Mechanic	1	0	0	1	1	0
Rehabilitation Technician (Leather)	1	0	0	0	0	1
Rehabilitation Technician (Orthetics)	2	0	0	1	1	1

Rehabilitation Technician (Prosthetics)	2	0	0	1	1	1
Senior Nursing Officer	116	8	0	107	115	1
Senior Optometrist	5	1	0	3	4	1
Senior Superintendent	2	0	0	2	2	0
Social Worker Tutor	1	0	0	0	0	1
Statistical Asst.	3	1	0	2	3	0
Statistical Asst. Gr.I	1	0	0	1	1	0
Statistical Asst. Gr.II	1	0	0	1	1	0
Store Superintendent	2	0	0	2	2	0
Stores Verification Officer	1	0	0	1	1	0
Technical Asst. Gr. I	1	1	0	0	1	0
Technical Asst. Gr. II	4	1	0	3	4	0
Treatment Organiser Gr.I	4	1	0	3	4	0
Treatment Organiser Gr.II	3	1	0	2	3	0
Vice Principal (School of Ng.)	1	0	0	1	1	0
X Ray Attender	7	1	0	6	7	0
TOTAL	**3896**	**468**	**110**	**2918**	**3496**	**400**

Source: District Data

4.4 Health Human Resource Under NHM

As shown in the above table in NHM, there are 1124 sanctioned posts, with 1022 personnel currently in position, resulting in 102 vacancies. For the NUHM component, there are 198 sanctioned posts, with 172 personnel in position, leading to 26 vacancies. Overall, the TOTAL sanctioned posts across both missions are 1322. Of these, 1194 posts are filled (In Position), leaving a total of 128 unfilled positions or vacancies.

Table 4.4.1: Number of Health Personnel Working under NHM (As on 31/12/2025)

	SANCTIONED	IN POSITION	VACANCY
NHM	1124	1022	102
NUHM	198	172	26
TOTAL	1322	1194	128
Source: District Data			

CHAPTER 5

MATERNAL AND CHILD HEALTH PROGRAMME

5.1. Pregnant Women Registration

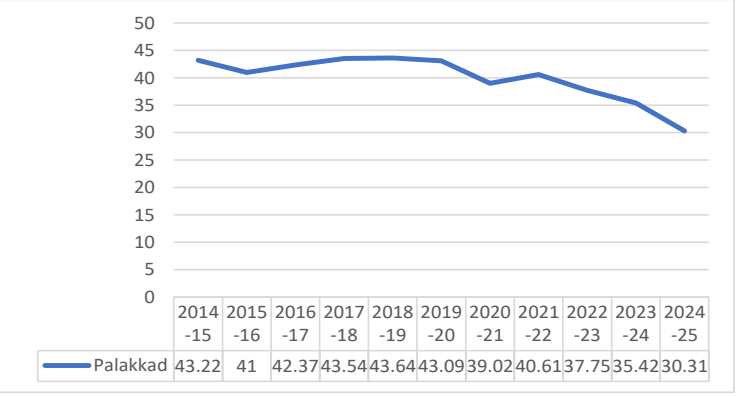
The trend in pregnant women registration in Palakkad district from 2014–15 to 2024–25 shows a fluctuating pattern with an overall declining trend in recent years. Between 2014–15 and 2018–19, the registration percentage remained relatively stable, ranging between 41% and 43.6%, indicating consistent coverage during that period. The highest registration rate of 43.64% was recorded in 2018–19.

However, from 2019–20 onwards, a gradual decline is observed. Registrations dropped from 43.09% in 2019–20 to 39.02% in 2020–21, possibly reflecting the impact of the COVID-19 pandemic on healthcare service utilization. Although there was a slight recovery in 2021–22 (40.61%), the trend continued downward thereafter.

By 2024–25, the registration percentage had significantly reduced to 30.31%, marking a steep decline of nearly 13 percentage points from the 2018–19 peak. This sharp decrease in recent years may indicate challenges in outreach, service accessibility, or reporting under the HMIS system.

Overall, the data highlights the need for renewed focus on strengthening maternal health services and improving the registration of pregnant women in Palakkad district to ensure timely antenatal care and better maternal outcomes.

Graph 5.1.1: Trend in pregnant women registration in Palakkad District (2014-15 to 2024-25)



Source-HMIS

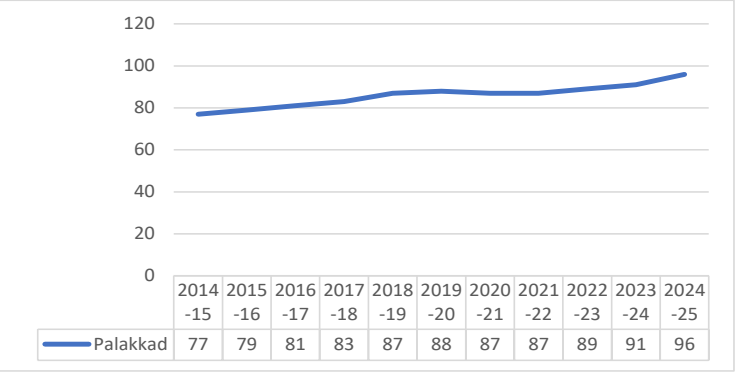
5.2. Early Initiation of Antenatal Care

The data on first trimester antenatal care (ANC) registration in Palakkad district from 2014–15 to 2024–25 shows a consistent and steady upward trend, reflecting significant improvement in early

registration of pregnancies over the years. In 2014–15, the percentage of first trimester registrations stood at 77%. This figure gradually increased each year, reaching 87% by 2018–19, indicating a positive trend in early identification and enrolment of pregnant women into ANC services. From 2019–20 to 2021–22, the percentage remained relatively stable around 87–88%, suggesting sustained progress despite the challenges posed by the COVID-19 pandemic. From 2022–23 onwards, a renewed increase is evident, with the percentage rising to 89%, then 91% in 2023–24, and finally peaking at 96% in 2024–25, the highest in the decade.

While the percentage of first trimester ANC registrations has shown a steady and impressive increase from 77% in 2014–15 to 96% in 2024–25, indicating improved awareness and timely reporting of pregnancies (Graph 5.1.2), the overall ANC registration rate has declined significantly during the same period from 43.22% in 2014–15 to 30.31% in 2024–25 (Graph 5.1.1).This suggests that although more women are registering early in their pregnancy, the total number of women being registered under ANC services has reduced. The pattern may reflect challenges in coverage or reporting under the HMIS, despite better awareness and early detection. Strengthening follow-up mechanisms and ensuring continuity of maternal care are essential to bridge this gap between early registration and total ANC coverage.

Graph 5.2.1 Trend in percentage of first trimester ANC registration in Palakkad District (2014-15 to 2024-25)



Source-HMIS

5.3. Immunization Status of Pregnant Women

In Palakkad district, a total of 30,305 pregnant women were registered for antenatal care during the reporting period. Among them, 25,700 women (approximately 85%) received the first dose of Tetanus–Diphtheria (Td1) vaccine, while 23,216 women (about 77%) completed the second dose (Td2). Additionally, 1,613 pregnant women received the Td booster dose, primarily those with a history of complete immunization in previous pregnancies.

The data reflects good overall immunization coverage among pregnant women, ensuring protection against tetanus and related complications for both mother and newborn. Continued efforts are needed to enhance Td2 and booster dose coverage to achieve universal maternal immunization and sustain safe motherhood outcomes across the district.

Table 5.3.1. Immunization status of pregnant women

District	No of PW registered for ANC	No of PW given Td1	No of PW given Td2	No of PW given Td Booster
Palakkad	30305	25700	23216	1613

Source-HMIS

5.4. Abortion

The data from 2014–15 to 2024–25 shows a significant shift in the pattern of reported abortions in Palakkad district. While the total number of pregnant women (PW) registered has fluctuated initially before sharply declining to 30,305 in 2024–25, the total number of abortions (spontaneous + induced) has shown a sharp increase, particularly in recent years.

During the initial period (2014–15 to 2018–19), the total number of abortions fluctuated moderately between 1,135 and 1,527, with spontaneous abortions being higher than induced ones. However, from 2019–20 onwards, a reversal in the trend is observed — induced abortions have gradually overtaken spontaneous cases.

The shift becomes particularly striking in the last two years. In 2023–24, out of 2,168 total abortions, 1,682 (77.5%) were induced, and in 2024–25, induced abortions rose further to 2,285 out of 2,725 total cases (83.9%), while spontaneous abortions continued to decline to 440.

This increasing proportion of induced abortions, despite a decrease in total pregnancies, suggests changing reproductive patterns, possibly reflecting better reporting, increased accessibility to safe abortion services, or higher incidence of unwanted pregnancies.

Table 5.4.1. Tends in spontaneous and induced abortion in Palakkad District

Year	PW	Total Abortions (spontaneous + Induced)	Spontaneous Abortions	Induced Abortions
2014-15	43215	1210	1079	131
2015-16	40999	1135	1020	115
2016-17	42372	1349	1160	189
2017-18	43535	1343	835	508
2018-19	43642	1527	770	757

2019-20	43093	1461	832	629
2020-21	39020	1387	762	625
2021-22	40613	1227	567	660
2022-23	37750	1219	482	737
2023-24	35416	2168	486	1682
2024-25	30305	2725	440	2285

Source-HMIS

5.5. Family Planning

Family planning services in Palakkad district continue to show a balanced mix of permanent and temporary methods, with consistent progress in sterilisation, IUCD insertions, and contraceptive distribution.

As per Table 5.5.1, both male (NSV) and female sterilisation procedures have been regularly conducted, with a notable rise in No-scalpel vasectomy (NSV) cases from 8 in 2020–21 to 32 in 2024–25, indicating growing male participation in family planning. Post- Partum Sterilisation (PPS) procedures remain the primary method for female sterilisation, followed by Laparoscopic and mini-lap procedures, reflecting sustained service delivery through public health facilities.

Table 5.5.2 shows that the insertion of Intrauterine Contraceptive Devices (IUCDs), including post-partum (PPIUCD) and postabortal (PAIUCD) insertions, has increased steadily. The total number of IUCD insertions rose from 1978 in 2020–21 to 3,155 in 2024–25, demonstrating improved acceptance of spacing methods among women of reproductive age.

According to Table 5.5.3, there has been a consistent rise in the distribution of temporary contraceptive commodities, especially condoms, which increased more than sixfold from 30,478 in 2020–21 to 197,075 in 2024–25. Similarly, the distribution of Centchroman (weekly pill) and Emergency Contraceptive Pills (ECPs) has also improved, reflecting enhanced availability and awareness of modern contraceptive options.

Table 5.5.1. Male and female sterilisation reported in Palakkad District

Period	NSV	Laparoscopic sterilizations	Mini-lap sterilizations	PPS	PAS
2020-21	8	459	179	4549	8
2021-22	15	680	292	4087	10
2022-23	13	1340	403	4249	24
2023-24	11	1384	498	2821	55
2024-25	32	1336	260	3053	105

Source-HMIS

Table 5.5.2. IUCD insertion reported in Palakkad District

Period	FP elements	Total Number
2020-21	IUCD	1863
	PPIUCD	109
	PAIUCD	6
2021-22	IUCD	1830
	PPIUCD	138
	PAIUCD	12
2022-23	IUCD	2509
	PPIUCD	101
	PAIUCD	4
2023-24	IUCD	2530

	PPIUCD	119
	PAIUCD	120
2024-25	IUCD	2976
	PPIUCD	120
	PAIUCD	59

Source-HMIS

Table 5.5.3. Distribution of family planning commodities

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	7297	30478	563	730
2021-22	7902	75229	615	927
2022-23	6384	157448	142	236
2023-24	6415	168125	637	717
2024-25	9681	197075	1019	833

Source-HMIS

5.6. Delivery

The trend in total deliveries in Palakkad District (Table 5.6.1) over the past five years shows an overall decline, though the figures fluctuated initially. In 2020–21, a total of 31,984 deliveries were reported, which increased slightly to 32,845 in 2021–22. However, subsequent years have shown a consistent decrease, with 30,910 deliveries in 2022–23, 28,591 in 2023–24, and 23,600 in 2024–25 (up to the reporting period).

This downward trend may be attributed to declining fertility rates, increased use of

family planning methods, and better awareness of reproductive health services among the population.

Table 5.6.1. Trend in total deliveries

Period	All	%
2020-21	31984	0.10943
2021-22	32845	0.14919
2022-23	30910	0.09382
2023-24	28591	0.10143
2024-25	23600	0.0678

Source-HMIS

Institutional deliveries continue to remain exceptionally high in Palakkad District, reflecting the success of maternal health programmes and strengthened healthcare infrastructure. In 2020–21, out of 31,984 total deliveries, 23,181 (72.5%) occurred in private institutions and 8,768 (27.4%) in public health facilities, while only 35(0.1%) deliveries were reported at home. In 2021–22, the number of institutional deliveries remained almost the same, with 23,991 (73.0%) in private hospitals and 8,805 (26.8%) in public facilities. A slight decline in the total number of deliveries was observed from 2022–23 onwards, with 23,666 deliveries in the private sector and 7,215 in public facilities. The declining pattern continued in 2023–24, where 22,406 deliveries occurred in private institutions and 6,156 in public ones (Table 5.6.2)

Table 5.6.2. Trend in home and institutional deliveries in Palakkad district

Period	Palakkad			
	Public	Private	Home Delivery	All
2020-21	8768	23181	35	31984

2021-22	8805	23991	49	32845
2022-23	7215	23666	29	30910
2023-24	6156	22406	29	28591
2024-25	5566	18018	16	23600

Source-HMIS

5.7. Caesarean Section Deliveries

Caesarean section (C-section) delivery rates (Table 5.7.1) are an important indicator of maternal health services and obstetric care practices. Table 5.7.1 presents the C-section rates in public and private hospitals in Palakkad district from 2020-21 to 2024-25, based on HMIS data.

In public hospitals, the C-section rate shows a slight declining trend, decreasing from 42.10% in 2020-21 to 39.69% in 2024-25. This indicates a gradual reduction in surgical deliveries in government facilities over the five-year period.

Conversely, private hospitals show a fluctuating trend, initially declining before sharply rising, with rates increasing overall from 35.10% in 2020-21 to 39.77% in 2024-25. Notably, by 2024-25, the C-section rate in private hospitals slightly exceeds that in public hospitals, reflecting changing delivery patterns and possibly differences in case management or patient preference.

Table 5.7.1: C-Section Rate in Public and Private Hospitals (2020-21 to 2024-25) in Palakkad

Period	C-Section Rate in Public and Private Hospitals		
	Public	Private	All
2020-21	42.10	35.10	37.02
2021-22	41.02	33.95	35.85
2022-23	42.05	38.89	39.63

2023-24	40.50	38.69	39.08
2024-25	39.69	39.77	39.75

Source-HMIS

5.8. Maternal Deaths

Table 5.8.1 presents the year-wise distribution of reported maternal deaths in Palakkad district from 2014–15 to 2024–25. The data show that the number of maternal deaths remained constant at 18 during the first three years, followed by an increase to 23 in 2017–18—the highest during the decade. After the peak, the trend was **highly fluctuating**, dropping sharply to 12 in 2019–20, but then rising significantly to **22 in 2021–22**. A steep decline in subsequent years led to the lowest reported number of **9 in 2023–24**. In 2024–25, a slight increase to 11 was reported. Overall, the trend indicates wide fluctuations in maternal deaths across the years, highlighting the need for continuous monitoring and strengthening of maternal health interventions in the district.

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

Year	Total deaths
2014–15	18
2015–16	18
2016–17	18
2017–18	23
2018–19	20
2019–20	12
2020–21	14
2021–22	22
2022–23	12

2023–24	9
2024–25	11

Source-HMIS

5.9. Infant Mortality

Table 5.9.1 shows the year-wise number of neonatal deaths reported in Palakkad district from 2014–15 to 2024–25. The data indicate a fluctuating but overall declining trend over the years. Neonatal deaths were highest in 2014–15 with 188 cases, followed by a gradual reduction in subsequent years. A fluctuation was observed in 2017–18 (149 deaths) 2020–21 (138 deaths), which included a peak of 160 deaths in 2018–19. However, from 2021–22 onwards, a consistent downward trend is seen, with the number of neonatal deaths reducing to 79 by 2024–25—the lowest in the decade.

Table 5.9.1: Number of Neonatal Deaths (2014-15 to 2024-25)

Year	Number of Neonatal Deaths
2014–15	188
2015–16	179
2016–17	134
2017–18	149
2018–19	160
2019–20	110
2020–21	138
2021–22	99
2022–23	109
2023–24	100

2024–25	79

Source-HMIS

Table 5.9.2 presents the number of infant deaths reported in Palakkad district over an eleven-year period, from 2014–15 to 2024–25. The data reveal a declining trend overall, indicating gradual improvement in child survival outcomes. The number of infant deaths was highest in 2014–15 (268 deaths) and showed a steady decrease, thereafter, dropping to 191 in 2020–21 and further to 132 in 2024–25. Although minor fluctuations were noted—particularly in 2018–19 and 2022–23—the general downward pattern suggests strengthened maternal and child health initiatives, better neonatal care, and improved community-level health interventions under NHM and related programmes. Continued focus on early neonatal care, timely referral, and management of high-risk pregnancies could help sustain and further reduce infant mortality in the district.

Table 5.9.2: Number of Infant Deaths Reported (2014-15 to 2024-25)

Year	Number of Infant Deaths
2014–15	268
2015–16	262
2016–17	204
2017–18	213
2018–19	236
2019–20	203
2020–21	191
2021–22	154
2022–23	168
2023–24	162
2024–25	132

Source-HMIS

Table 5.9.3 presents the number of child deaths (under 5 years) reported in Palakkad district from 2021–22 to 2024–25. The data indicate that the number of under-five deaths increased from 169 in 2021–22 to a peak of 206 in 2022–23, followed by a gradual decline to 191 in 2023–24 and 169 in 2024–25. Although the trend shows short-term fluctuations, the overall pattern suggests a return to the initial level observed in 2021–22, reflecting possible improvements in child health outcomes. The temporary rise in 2022–23 could be attributed to factors such as post-pandemic service disruptions or reporting variations. Continued efforts in strengthening neonatal and child health services, improving early identification of high-risk cases, and ensuring quality facility-based and community-based care are essential to sustain and further reduce under-five mortality in Palakkad district.

Table 5.9.3: Number of Child Deaths (Under 5) Reported (2021-22 to 2024-25)

Year	Number of Child Deaths (Under 5)
2021–22	169
2022–23	206
2023–24	191
2024–25	169

Source-HMIS

Table 5.9.4 depicts the Infant Mortality Rate (IMR) and Neonatal Mortality Rate (NMR) in Palakkad district from 2019–20 to 2024–25. Over this six-year period, both IMR and NMR have remained relatively stable with only minor fluctuations. The IMR ranged between 5 and 6 per 1,000 live births, while the NMR fluctuated between 3 and 4 per 1,000 live births.

This stability indicates consistent progress in neonatal and infant care services across the district. The marginal variations could reflect periodic differences in case reporting or health service access. Overall, Palakkad's mortality rates remain close to the state average, highlighting sustained efforts in maternal and child health interventions, institutional deliveries, and newborn care under the National Health Mission. Continued

focus on early neonatal survival, quality postnatal care, and surveillance of high-risk infants will be crucial for achieving further reductions.

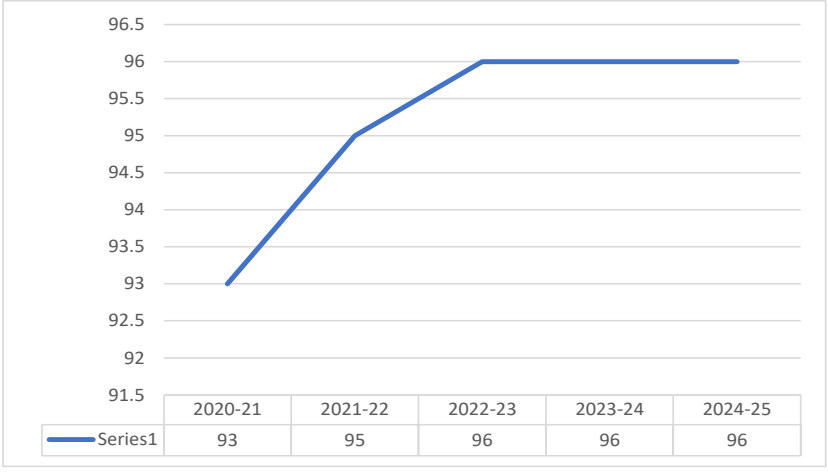
Table 5.9.4: Infant and Neonatal Mortality Rates in Kerala (2019-20 to 2024-25)

Year	Infant Mortality Rate (IMR)	Neonatal Mortality Rate (NMR)
2019–20	6	3
2020–21	6	4
2021–22	5	3
2022–23	5	4
2023–24	6	3
2024–25	6	3

Source-HMIS

5.10. Child Immunisation

Graph 5.10.1: Trend in Percentage of Children Fully Immunized



Source: HMIS *Data*

Immunization coverage is a key indicator of the effectiveness of a district's child health programmes. Table 5.10.1 presents antigen-wise immunization coverage in Palakkad

district as per the RCH portal data. The coverage rates indicate that the district has achieved consistently excellent immunization performance, with nearly all antigens reporting coverage levels between 95% and 100%.

BCG coverage has reached 100%, reflecting complete reach to all newborns. Primary doses of major vaccines - including OPV, Penta, and Rota vaccines - all maintain high coverage between 97% and 98%. Similarly, the Hepatitis B birth dose and IPV 1 also stand at 98%. The coverage for the MR2 and PCV booster doses is slightly lower (96% and 95%, respectively), suggesting minor drop-offs during later immunization stages.

Full immunization coverage for the district, representing children who have received all recommended vaccines, is 96%, which is close to the national target for universal immunization.

The coverage for later and booster doses is slightly lower, suggesting minor drop-offs in the follow-up schedule. Specifically, the PCV Booster (PCBB) is the lowest at 95%, and MR 2 coverage is 96%.

Overall, Palakkad demonstrates excellent immunization coverage, reflecting effective implementation of the Universal Immunization Programme (UIP), strong community outreach, and timely tracking through the RCH portal. Continued efforts to maintain high rates and to close the small gap in booster dose coverage will ensure sustained herd immunity and protection against vaccine-preventable diseases.

Table 5.10.1: Antigen-wise Immunization Coverage in Palakkad district

Antigen	Coverage (%)
BCG	100
OPV 0	99
Hepatitis B (Birth Dose)	98
OPV 1	98
OPV 2	97
OPV 3	97

MR 1	97
Full Immunization	96
PENTA 1	98
PENTA 2	97
PENTA 3	97
Rota 1	98
Rota 2	97
Rota 3	97
IPV 1	98
IPV 2	97
PCV 1	98
PCV 2	96
PCV Booster (PCBB)	95
MR 2	96

Source: RCH Data

CHAPTER 6
COMMUNICABLE AND NON-COMMUNICABLE DISEASES

6.1. Disease burden overview: common communicable diseases

Communicable diseases continue to pose a significant public health challenge in the district, affecting populations across all age groups. Monitoring the incidence of these diseases is essential for planning targeted interventions, improving outbreak preparedness, and strengthening the overall health system. The trends in reported cases over the last five years provide insights into disease patterns, emerging threats, and areas requiring focused preventive and control measures.

6.1.1 Communicable diseases-Cases reported

Table 6.1.1 presents the number of reported cases of various communicable diseases in the district from 2020 to 2024. The data highlights a rising trend in several vector-borne, viral infections and enteric infections.

Dengue fever has shown a substantial increase from 47 cases in 2020 to 1,303 cases in 2024, indicating escalating transmission and the need for strengthened vector control measures. Malaria cases, while lower in absolute numbers, have shown a gradual increase over the same period, from 15 cases in 2020 to 54 cases in 2024. Chikungunya, though relatively rare, was reported in 2023 and 2024.

Acute Encephalitis Syndrome (AES) cases have increased steadily, reaching 39 cases in 2024. Japanese Encephalitis (JE) was reported sporadically, with 3 cases in 2023. Leptospirosis, a waterborne disease, showed notable fluctuation, with a peak of 235 confirmed cases in 2024 compared to 36 in 2020.

Viral hepatitis continues to contribute to the disease burden, with Hepatitis A showing a sharp rise to 339 cases in 2024. Hepatitis B and Hepatitis C also demonstrate increasing trends, with 271 and 77 cases reported in 2024, respectively. Hepatitis E cases remained minimal but were reported in 2024.

Enteric infections such as Acute Diarrheal Disease (ADD) remain the most frequently reported communicable disease, with nearly 49,740 cases in 2024, reflecting ongoing challenges in water, sanitation, and hygiene. Other bacterial infections such as typhoid and Shigella were reported in small numbers.

Emerging and re-emerging infections are also a focus of concern. Influenza cases, including H1N1, H3N2, Influenza A, and B, rose significantly to 300 cases in 2024, highlighting seasonal outbreaks and the importance of vaccination programmes. **Scrub typhus** cases demonstrated an increasing trend overall, rising from 5 cases in 2020 to **26 in 2024**. Other infections like **rabies** and **West Nile virus** showed only sporadic occurrences. However, **Chickenpox**, a common viral infection, reported a notable increase to **2,984 cases in 2024**. Rare diseases such as Kala Azar, Nipah, Zika, and Kysanur Forest Disease were either absent or reported in negligible numbers across the entire period.

Table 6.1.1 Number of reported cases of communicable disease in the district (2020-24)

Sl. No	Name of Diseases	2024	2023	2022	2021	2020
1	Dengue Fever: Confirmed	1303	1063	152	99	47
3	Malaria	54	37	26	22	15
4	Chikungunya	1	1	0	0	0
5	Acute Encephalitis Syndrome	39	24	9	5	6
6	Japanese Encephalitis (JE)	0	3	0	0	0
7	Leptospirosis : Confirmed	235	86	123	78	36
9	Hepatitis - A : Confirmed	339	48	19	9	16
11	Hepatitis - B	271	164	174	92	78
12	Hepatitis - C	77	68	34	10	23
13	Hepatitis - E	5	0	0	0	0
14	Cholera	5	0	0	0	0
16	Typhoid	7	4	5	5	6

17	Acute Diarrheal Disease	49740	46458	38439	19889	23174
19	Shigella	7	1	5	1	0
20	Scrub Typhus	26	26	9	8	5
21	Kala Azar	0	0	0	1	0
22	Kysanur Forest Disease	0	0	0	0	0
23	Influenza (H1N1, H3N2, Infl A, Infl B)	300	122	18	0	0
24	Rabies : Confirmed	2	0	3	0	0
26	Zika	0	0	0	0	0
27	West Nile	1	1	0	0	0
30	Nipah	0	0	0	0	0
33	Chicken Pox	2984	1662	514	27	466

Source: DHS *data*

6.1.2. Trend in Fever Outpatient and Inpatient Cases

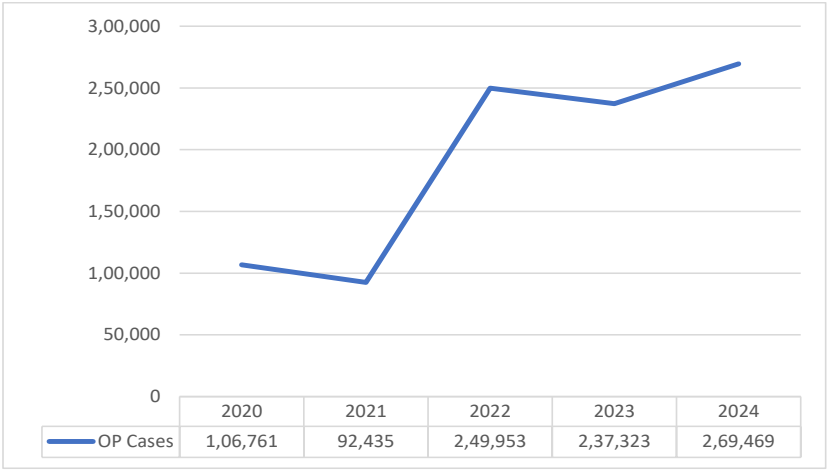
The trend of fever cases in Palakkad district from 2020 to 2024 demonstrates fluctuations in both outpatient (OP) and inpatient (IP) reporting. This pattern reflects seasonal variations, outbreak occurrences, and changes in healthcare-seeking behaviour in the district.

In 2020, Palakkad reported 106,761 Outpatient cases and 2,076 Inpatient cases. This decreased slightly in 2021 to 92,435 OP cases and 1,776 IP cases. This initial decline could be attributed to reduced healthcare utilization or disruptions in health service delivery during the COVID-19 pandemic period.

From 2022 onwards, there was a sharp increase in reported fever cases, with 249,953 OP cases and 3,334 IP cases. The trend continued into 2023 with 237,323 OP cases and a significant rise in IP cases to 5,817, possibly indicating outbreaks or higher disease severity requiring hospitalization. In 2024, Outpatient cases further increased to 269,469, while Inpatient cases declined to 1,593, suggesting that although more

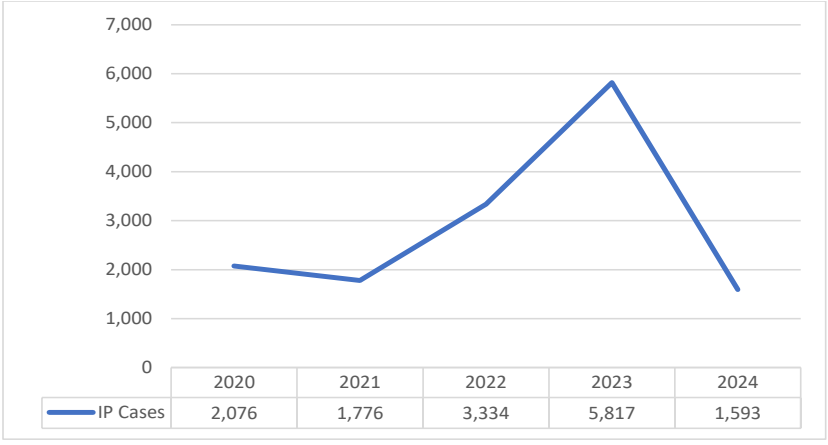
people sought care for fever at health facilities, fewer required hospitalization compared to the previous year.

Graph 6.1.2.1 Trend in Fever Outpatient Cases (2020-2024)



Source: DHS *data*

Graph 6.1.2.2 Trend in Fever Inpatient Cases (2020-2024)



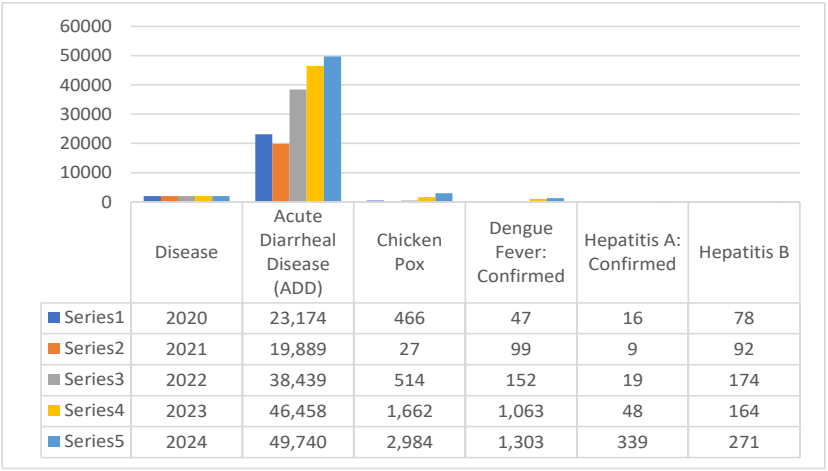
Source: DHS *data*

6.1.3. Trend in Top Five Reported Communicable Diseases in Palakkad District

The trend from 2020 to 2024 shows a substantial increase in the burden of communicable diseases in the district.

- Acute Diarrheal Disease (ADD) has consistently been the most reported disease, increasing from 23,174 cases in 2020 to 49,740 cases in 2024, indicating ongoing challenges in sanitation and safe drinking water access.
- Chickenpox has shown a remarkable rise, from 466 cases in 2020 to 2,984 cases in 2024, possibly reflecting outbreak events or improved reporting and diagnosis.
- Dengue fever cases have increased sharply, from 47 cases in 2020 to 1,303 cases in 2024, highlighting the growing vector-borne disease burden.
- Hepatitis A shows a sudden surge in 2024 to 339 cases, up from single-digit reports in previous years, which may indicate localized outbreaks or enhanced surveillance.
- Hepatitis B has gradually increased from 78 cases in 2020 to 271 cases in 2024, reflecting the ongoing public health challenge of viral hepatitis.

Graph 6.1.3.1 Trend in top five reported communicable disease



Disease	Acute Diarrheal Disease (ADD)	Chicken Pox	Dengue Fever: Confirmed	Hepatitis A: Confirmed	Hepatitis B
Series1 2020	23,174	466	47	16	78
Series2 2021	19,889	27	99	9	92
Series3 2022	38,439	514	152	19	174
Series4 2023	46,458	1,662	1,063	48	164
Series5 2024	49,740	2,984	1,303	339	271

Source: DHS *data*

6.1.4. Major Communicable Diseases-Deaths Reported

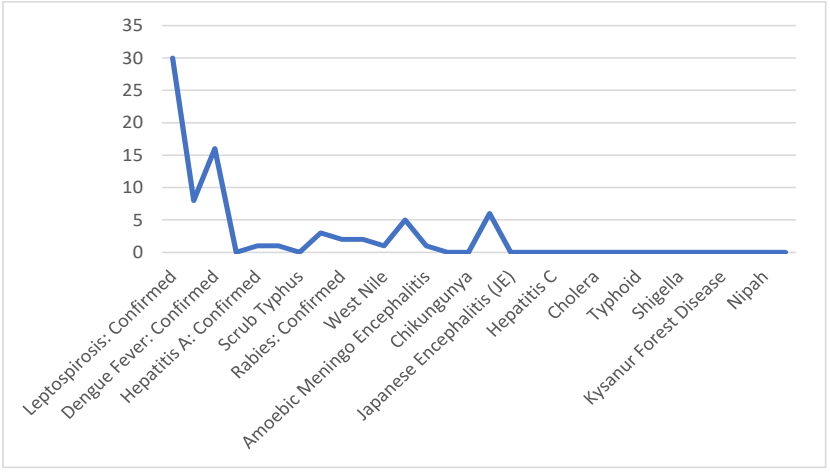
In Palakkad district, Leptospirosis accounted for the highest number of deaths (30) among communicable diseases in 2024, highlighting the ongoing risk of water-borne and zoonotic infections in the region.

Dengue fever also contributed significantly, with 16 confirmed deaths, reflecting the severity of vector-borne outbreaks. Acute Diarrheal Disease (ADD) caused 8 deaths, indicating that despite high case numbers, the fatality rate is lower compared to vector-borne and zoonotic diseases.

Chickenpox led to 5 deaths, showing that even typically mild diseases can result in mortality under vulnerable conditions, such as in immunocompromised individuals or delayed access to care. Acute Encephalitis Syndrome (AES) accounted for 6 deaths, emphasizing the need for early detection and supportive care.

Other notable deaths include Influenza (3 deaths), Rabies (4 deaths combined from confirmed and probable), West Nile (1 death), and Amoebic Meningo Encephalitis (1 death).

Graph 6.1.4.1 Disease - wise Distribution of Deaths due to Communicable Diseases



Source: DHS *data*

6.2. Major Non-Communicable Diseases in the District

Non-communicable diseases (NCDs) constitute a significant public health burden in the district. The data from 2022 to early 2025 (January–March) as shown in **Table 6.2.1**, highlights the growing impact of conditions such as cancers, cardiovascular diseases, diabetes, neurological disorders, renal failure, and accidental injuries on morbidity and mortality.

- **Accidental Injuries and Road Traffic Accidents-**Accidental injuries remain

one of the most frequently reported conditions, increasing sharply from 17,729 cases in 2022 to 63,239 cases in 2024 before reducing to 14,392 in the first quarter of 2025 (Table **6.2.1**). Mortality, though relatively low, was reported across the years. Road traffic accidents also showed a rising trend, with 8,412 cases in 2024, and associated deaths varying annually. Snakebites were consistently reported but with minimal mortality.

- **Cancers-**Cancers are an important contributor to both morbidity and mortality in the district. Breast cancer cases rose steadily from 1,211 in 2022 to 2,520 in 2024, with a corresponding increase in deaths (from 5 in 2022 to 28 in 2024). Lung cancer also showed a rising trend, peaking at 789 cases and 39 deaths in 2024. Cervical cancer cases remained relatively stable, while oral cancer showed fluctuating trends, with a spike in 2024 (1,006 cases with 17 deaths).
- **Cardiovascular Diseases-**Cardiovascular conditions represent a major health burden. Hypertension showed a steep rise, from 40,001 cases in 2022 to 231,792 cases in 2024, though associated mortality remained relatively low. Ischemic heart disease recorded high mortality, with 296 deaths in 2023 and 225 in 2024, making it a leading cause of death among NCDs. Congenital heart disease, though less frequent, also showed an increasing trend until 2024.
- **Diabetes-**Diabetes has emerged as a significant challenge in the district. Type 2 diabetes increased from 33,933 cases in 2022 to 146,551 cases in 2024, accompanied by notable mortality. Type 1 diabetes cases remained much lower but steady across the years.
- **Neurological Disorders-**Cerebrovascular disorders represent another critical NCD, with cases peaking at 6,883 in 2024 and associated deaths ranging between 67 (2022) and 141 (2023). Chronic neurological disorders were less frequent but consistently reported.
- **Renal Failure-**Both acute and chronic renal failure were reported, with chronic renal failure showing a marked increase from 1,180 cases in 2022 to 5,957 cases in 2024. Mortality associated with renal conditions was consistently high, particularly in 2023 and 2024.
- **Other Conditions-**Psychiatric disorders were also notable, with common mental disorders and severe mental disorders showing rising trends, peaking

in 2024. Obesity cases also increased significantly, from 70 cases in 2022 to 4,387 in 2024.

Table 6.2.1 Major Non-Communicable Diseases in the District

Disease	2022		2023		2024		2025 (Jan-March)	
	Case	Death	Case	Death	Case	Death	Case	Death
Accidental injuries	17729	3	38480	10	63239	5	14392	0
Cancers								
• Cancer Cervix	220	6	236	6	242	3	342	0
• Breast Cancer	1211	5	1899	17	2520	28	1027	6
• Lung Cancer	396	9	568	34	789	39	238	5
• Oral Cancer	441	2	69	1	1006	17	41	1
Cardiovascular disease								
• Rheumatic fever	0	0	211	0	1530	0	16	0
• Hypertension	40001	2	149768	14	231792	12	34320	4
• Ischemic Heart disease	840	114	7279	296	10681	225	1797	11
• Congenital Heart disease	46	3	456	10	918	6	182	0
Others	2939	46	10325	80	17772	158	2779	64
Diabetes								
• Type 1	277	0	3579	0	3728	0	3496	0
• Type 2	33933	10	86694	65	146551	58	20762	10
Neurological disorders								
• Cerebrovascular disorders	1040	67	5098	141	6883	133	1507	23
• Chronic neurologic	16	0	392	2	284	3	567	0

al disorders								
Others	172	2	2062	1	380	1	185	0
• Obesity	70	0	3573	0	4387	0	576	0
Psychiatric disorders								
• Common Mental disorders	4927	0	12348	0	14201	2	2095	0
• Severe mental disorders	2681	0	3367	0	7859	1	1152	0
Renal Failure								
• Acute	287	20	684	38	728	30	77	9
• Chronic	1180	37	4690	137	5957	90	1360	18
Road Traffic Accident	3752	4	6530	14	8412	13	1592	5
Snake bite	319	5	801	0	1121	2	222	0

6.3 Disease Specific Outbreaks and Health concerns

During 2024, Palakkad district experienced multiple outbreaks of communicable diseases, posing significant public health challenges. Major reported outbreaks included mumps (23 outbreaks), acute diarrhoeal disease and food poisoning (15 outbreaks), hepatitis A (15 outbreaks), chickenpox (5 outbreaks), dengue (4 outbreaks), and influenza (4 outbreaks).

Mumps recorded the highest case burden with over 10,000 reported infections across multiple localities, making it the most widespread outbreak in the district. Dengue remained a critical concern with 4,000+ cases and 16 deaths (12 confirmed, 4 probable), primarily concentrated in Kuthannur, Kumaranellur, Agali, and Pirayiri. Hotspots such as Palakkad Municipality, Pudur, and Ongallur reported high transmission due to issues like water stagnation, poor waste management, and overcrowded migrant settlements.

Leptospirosis caused 36 deaths (26 confirmed, 10 probable), accounting for about 40% of the total communicable disease deaths in the district. Most deaths occurred among males aged 40–59, many with comorbidities such as diabetes and hypertension. Although no major leptospirosis outbreaks were reported, the disease remained endemic with

seasonal surges from May to October.

Hepatitis A reported 15 localized outbreaks with 1 associated death, mainly linked to contaminated water sources and unsafe sanitation practices. Chickenpox outbreaks were observed in five localities, resulting in five deaths, mostly among individuals with underlying health conditions.

Emerging health issues in the district included increasing influenza-like illnesses (ILI) and sporadic cases of acute encephalitis syndrome (AES), which together caused seven deaths, mostly among children and elderly individuals.

Overall, Palakkad district's key disease concerns in 2024 were dominated by dengue, leptospirosis, mumps, and hepatitis A, exacerbated by environmental and behavioural factors such as poor sanitation, low awareness, and unsafe water sources.

CHAPTER 7

CRITICAL OBSERVATION IN NFHS-5

7.1. Comparison of Observations of NFHS 4 & 5 data in Palakkad district.

Table 7.1.1: Critical observations of Palakkad district, NFHS 4 & 5

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 (%)	89.6	92.2
2. Population below age 15 years (%)	19.3	20.1
3. Sex ratio of the total population (females per 1,000 males)	1,148	972
4. Sex ratio at birth for children born in the last five years (females per 1,000 males)	1,012	1,075
5. Children under age 5 years whose birth was registered with the civil authority (%)	99.5	100.0
6. Deaths in the last 3 years registered with the civil authority (%)	95.4	NA
7. Population living in households with electricity (%)	98.9	99.2
8. Population living in households with an improved drinking-water source[1] (%)	94.7	94.2
9. Population living in households that use an improved sanitation facility[2] (%)	99.0	97.0
10. Households using clean fuel for cooking[3] (%)	67.5	50.7
11. Households using iodized salt (%)	99.7	97.2
12. Households with any usual member covered under a health insurance/financing scheme (%)	53.8	48.0
13. Children age 5 years who attended pre-primary school during the school year 2019-20 (%)	32.8	NA
Characteristics of Women (age 15-49 years)		
14. Women who are literate[4] (%)	94.4	NA

15. Women with 10 or more years of schooling (%)	63.2	63.4
Marriage and Fertility		
16. Women age 20-24 years married before age 18 years (%)	14.1	12.5
17. Births in the 5 years preceding the survey that are third or higher order (%)	0.0	0.4
18. Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	4.4	5.8
19. Women age 15-24 years who use hygienic methods of protection during their menstrual period[5] (%)	87.5	87.5
Current Use of Family Planning Methods (currently married women age 15–49 years)		
20. Any method[6] (%)	58.9	62.2
21. Any modern method[6] (%)	51.9	57.6
22. Female sterilization (%)	48.1	53.5
23. Male sterilization (%)	0.0	0.0
24. IUD/PPIUD (%)	1.7	2.3
25. Pill (%)	0.2	0.4
26. Condom (%)	1.9	1.5
27. Injectables (%)	0.0	0.0
Unmet Need for Family Planning (currently married women age 15–49 years)		
28. Total unmet need[7] (%)	10.8	12.1
29. Unmet need for spacing[7] (%)	6.7	7.3
Quality of Family Planning Services		
30. Health worker ever talked to female non-users about family planning (%)	14.6	14.0
31. Current users ever talked about side effects of current method[8] (%)	56.6	61.0

Note: Major indicators are highlighted in grey.

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 (%)	97.7	93.4
33. Mothers who had at least 4 antenatal care visits (%)	68.4	90.4
34. Mothers whose last birth was protected against neonatal tetanus[9] (%)	87.9	97.7
35. Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	71.7	79.3
36. Mothers who consumed iron folic acid for 180 days or more when they were pregnant (%)	58.8	62.7
37. Registered pregnancies for which the mother received a Mother and Child Protection (MCP) card (%)	87.3	84.9
38. Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	97.5	89.0
39. Average out-of-pocket expenditure per delivery in a public health facility (Rs.)	6211	4337
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 within 2 days of delivery (%)	93.2	NA
Delivery Care (for births in the 5 years before the survey)		
42. Institutional births (%)	100.0	100.0
43. Institutional births in public facility (%)	29.6	33.0
44. Home births that were conducted by skilled health personnel[10] (%)	0.0	0.0
45. Births attended by skilled health personnel[10] (%)	100.0	100.0
46. Births delivered by caesarean section (%)	31.2	34.4

47. Births in a private health facility that were delivered by caesarean section (%)	29.7	38.3
48. Births in a public health facility that were delivered by caesarean section (%)	34.7	26.6
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] (%)	51.8	88.1
50. Children age 12-23 months fully vaccinated based on information from vaccination card only[12] (%)	73.2	97.7
51. Children age 12-23 months who have received BCG (%)	90.2	97.4
52. Children age 12-23 months who have received 3 doses of polio vaccine[13] (%)	57.0	93.8
53. Children age 12-23 months who have received 3 doses of penta or DPT vaccine (%)	71.0	89.9
54. Children age 12-23 months who have received the first dose of measles-containing vaccine (MCV) (%)	77.0	90.1
55. Children age 24-35 months who have received a second dose of measles-containing vaccine (MCV) (%)	11.5	NA
56. Children age 12-23 months who have received 3 doses of rotavirus vaccine[14] (%)	11.0	NA
57. Children age 12-23 months who have received 3 doses of penta or hepatitis B vaccine (%)	62.4	79.3
58. Children age 9-35 months who received a vitamin A dose in the last 6 months (%)	77.6	71.3
59. Children age 12-23 months who received most of their vaccinations in a public health facility (%)	94.1	88.6
60. Children age 12-23 months who received most of their vaccinations in a private health facility (%)	5.9	11.4
Treatment of Childhood Diseases (children under age 5 years)		
61. Prevalence of diarrhoea in the 2 weeks preceding the	2.7	6.8

survey (%)		
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 (%)	1.9	0.5
66. Children with fever or symptoms of ARI in the 2 weeks preceding the survey taken to a health facility or health provider (%)	82.5	*

Note: Major indicators are highlighted in grey.

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] (%)	55.2	70.0
68. Children under age 6 months exclusively breastfed[16] (%)	*	*
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] (%)	26.8	16.1
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] (%)	23.7	16.9
73. Children under 5 years who are stunted (height-for-age)[18] (%)	29.7	20.2
74. Children under 5 years who are wasted (weight-for-	21.7	10.3

height)[18] (%)		
75. Children under 5 years who are severely wasted (weight-for-height)[19] (%)	9.0	4.1
76. Children under 5 years who are underweight (weight-for-age)[18] (%)	27.7	19.1
77. Children under 5 years who are overweight (weight-for-height)[20] (%)	1.1	0.8
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] (%)	12.9	13.5
79. Women who are overweight or obese (BMI ≥25.0 kg/m^2)[21] (%)	32.9	32.1
80. Women who have high risk waist-to-hip ratio (≥0.85) (%)	66.2	na
Anaemia among Children and Women		
81. Children age 6-59 months who are anaemic (<11.0 g/dl)[22] (%)	51.9	41.1
82. Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl)[22] (%)	50.0	42.8
83. Pregnant women age 15-49 years who are anaemic (<11.0 g/dl)[22] (%)	40.5	*
84. All women age 15-49 years who are anaemic[22] (%)	49.6	42.3
85. All women age 15-19 years who are anaemic[22] (%)	43.3	47.4
Blood Sugar Level among Adults (age 15 years and above)		
Women		
86. Blood sugar level - high (141-160 mg/dl)[23] (%)	9.0	NA
87. Blood sugar level - very high (>160 mg/dl)[23] (%)	12.8	NA
88. Blood sugar level - high or very high (>140 mg/dl) or taking medicine to control blood sugar level[23] (%)	24.6	NA
Men		
89. Blood sugar level - high (141-160 mg/dl)[23] (%)	10.5	NA
90. Blood sugar level - very high (>160 mg/dl)[23] (%)	13.0	NA

91. Blood sugar level - high or very high (>140 mg/dl) or taking medicine to control blood sugar level[23] (%)	26.3	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) (%)	17.9	NA
93. Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100mm of Hg) (%)	7.8	NA
94. Elevated blood pressure (Systolic ≥140 mm of Hg and/or Diastolic ≥90 mm of Hg) or taking medicine to control blood pressure (%)	32.4	NA
Men		
95. Mildly elevated blood pressure (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	22.4	NA
96. Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100mm of Hg) (%)	8.5	NA
97. Elevated blood pressure (Systolic ≥140 mm of Hg and/or Diastolic ≥90 mm of Hg) or taking medicine to control blood pressure (%)	35.3	NA
Screening for Cancer among Women (age 30-49 years)		
98. Ever undergone a screening test for cervical cancer (%)	3.7	NA
99. Ever undergone a breast examination for breast cancer (%)	1.1	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 (%)	5.1	NA
102. Men age 15 years and above who use any kind of tobacco (%)	22.5	NA
103. Women age 15 years and above who consume alcohol (%)	0.4	NA

104. Men age 15 years and above who consume alcohol (%)	23.1	NA

Note: Major indicators are highlighted in grey.

Key Observations and Changes:

Table 7.1.1 describes the demographic and health indicators related to women aged 15–49 years.

- **Female education:** The proportion of females aged 6 years and above who ever attended school declined slightly from **92.2% (NFHS-4)** to **89.6% (NFHS-5)**, suggesting a marginal setback in female educational attainment and possible school discontinuation among older girls.
- **Sex ratio:** The overall sex ratio improved significantly from **972 to 1,148 females per 1,000 males**, reflecting better female survival and gender balance in the total population.
- **Access to clean energy:** The percentage of households using clean fuel for cooking increased from **50.7% to 67.5%**, a substantial gain showing the positive impact of LPG penetration and energy transition initiatives.
- **Health insurance coverage:** Households with at least one member covered under a health insurance or financing scheme increased from **48.0% to 53.8%**, showing moderate progress but highlighting that nearly half the population still remains uninsured.
- **Early marriage:** The proportion of women aged 20–24 years who were married before age 18 rose slightly from **12.5% to 14.1%**. The increase suggests that **social norms, economic vulnerability, and lack of awareness** still influence marriage decisions in certain communities, despite legal restrictions and educational improvements.
- **Antenatal care:** The proportion of mothers receiving **four or more antenatal visits** fell drastically from **90.4% to 68.4%**, indicating a serious service coverage gap.
- **Iron and folic acid supplementation:** Mothers who consumed IFA tablets for at least 100 days during pregnancy reduced from **79.3% to 71.7%**, showing a decline in antenatal nutrition compliance.

- **Institutional delivery:** Institutional births remained at **100%**, maintaining universal facility-based deliveries across the district.
- **Full immunization:** The proportion of children aged 12–23 months who were fully vaccinated dropped sharply from **88.1% to 51.8%**, signalling a major setback in child immunization performance. Coverage for individual vaccines like DPT, polio, and measles has dropped, suggesting service delivery and tracking gaps under RI (Routine Immunization).
- **Child nutrition:** Indicators of undernutrition worsened-
  - Stunting (height-for-age) increased from **20.2% to 29.7%**.
  - Wasting (weight-for-height) more than doubled from **10.3% to 21.7%**.
  - Underweight prevalence rose from **19.1% to 27.7%**. These trends indicate deterioration in both chronic and acute malnutrition among children.
- **Anaemia prevalence:**
  - Among children aged 6–59 months, anaemia increased from **41.1% to 51.9%**.
  - Among women (15–49 years), anaemia rose from **42.3% to 49.6%**, suggesting persistent nutritional deficiencies.
- **Contraceptive Use and Family Planning Trends**
  - Overall Contraceptive use: The proportion of currently married women (15–49 years) using *any method* of family planning decreased from 62.2% (NFHS-4) to 58.9% (NFHS-5). Similarly, the use of *any modern method* declined from 57.6% to 51.9%. This downward trend suggests a slowing momentum in family planning uptake despite established service availability.
  - Female sterilization: continues to dominate as the most common method, though it declined from 53.5% to 48.1%. This reflects a heavy dependence on permanent methods and indicates that most family planning decisions occur after achieving the desired family size, rather than as part of spacing strategies.

- IUD/PPIUCD: marginally reduced from 2.3% to 1.7%, pointing to limited acceptance of long-acting reversible contraceptives.
- Pill use: decreased slightly from 0.4% to 0.2%, showing reduced uptake of short-term oral methods.
- Condom use: rose modestly from 1.5% to 1.9%, suggesting small gains in male-led temporary methods but remaining very low overall.
- Injectables: continued to be negligible (0.0%), indicating that newer reversible options are underutilized.
- Unmet need for family planning: The total unmet need reduced slightly from 12.1% to 10.8%, showing marginal improvement, but the proportion of unmet need for spacing (6.7%) still reflects the need for better counselling and access to temporary methods.
- Male Sterilisation: The NFHS data reveal that male sterilization remained at 0.0% in both NFHS-4 and NFHS-5. This highlights the persistent gender imbalance in contraceptive responsibility. Despite decades of national advocacy, social stigma, cultural barriers, and lack of male-focused family planning counselling continue to prevent uptake.

- **Non-communicable diseases:**
  - About **24.6% of women** and **26.3% of men** had elevated blood sugar or were on medication, pointing to a growing burden of diabetes.
  - **32.4% of women** and **35.3% of men** had hypertension or were on treatment, confirming the rising trend of lifestyle-related diseases.
  - **Overweight and obesity:** The proportion of overweight or obese women remained high and stable (**32.1% to 32.9%**), indicating persistent risk factors for non-communicable diseases.

Conclusion:

- Palakkad district demonstrates **commendable performance in institutional delivery and sanitation**, but faces **critical setbacks in child immunization, maternal care, and nutrition**.

- The **rising trend in undernutrition and anaemia** among children and women demands urgent nutrition-sensitive interventions.
- **Declining contraceptive use and persistent absence of male participation** indicate the need for renewed community-based family planning awareness and gender-inclusive approaches.
- The emergence of **high NCD prevalence** underscores the importance of integrating preventive, promotive, and lifestyle modification programmes at primary care level.

CHAPTER 8

DISTRICT MENTAL HEALTH PROGRAMME

8.1 District Mental Health Programme

DMHP Palakkad conducts 19 regular clinics in primary health centres (PHCs), community health centres (CHCs) and taluk hospitals, ensuring that mental health care is accessible at the grassroot level. The report regarding the activities conducted by DMHP Palakkad during the year 2024 to 2025, is presented in Table 8.1.1.

Table 8.1.1 Activities conducted by DMHP

DMHP clinics	228
New Cases	882
Follow Up	14010
Psycho education	548
Counselling	345
No: of IECs	19
No: of trainings	58
Source: District data	

8.2 Post Flood Mental health activities & Training programs

The DMHP team visited flood relief camps in the district and provided mental health support to those affected by the disaster. Group counselling sessions were conducted to help individuals cope with trauma and emotional distress. Additionally, psycho education was given to raise awareness about stress management and promote psychosocial well-being among the camp residents.

Table 8.2.1. Post Flood Mental health activities

Flood Camp Visit	Numbers
Total No: of camps visited	12
Total No: of participants in group counselling	218
Total No: of Psycho social intervention given	7
Source: District data	

8.3 DMHP Targeted Interventions

1. During the year 2024-2025, DMHP organized SMA Review camps at two FHCs (Kizhakkenchery FHC and Kalladikode FHC), enabling systematic follow up and continuity of care for previously screened beneficiaries.

2. The DMHP team visited various FHCs to ensure that SMA Camp and ASWAS Clinics are being conducted regularly. These visits also focused on verifying the proper maintenance of Mental Health records. The monitoring aimed to strengthen the quality and consistency of mental health services at primary level.

List of FHCs Visited:-

- Kanjirampuzha
- Elumpulasserry
- Kuthanur
- Puthukode
- Malampuzha

8.3.1 Sampoorna Manasika Aarogyam (SMA): -

During the year 2024- 2025, Sampoorna Manasika Aarogyam (SMA) was implemented in 10 FHCs. A total of 30 mental health screening camps were conducted and 239 new cases were registered and given appropriate mental health care.

Table 8.3.1. Sampoorna Manasika Arogyam Activities

No: of FHCs	10
No: of camps	30
New Cases	239
Source: District data	

8.3.2 Amma Manas: -

Amma Manas training sessions were given to 787 health staff across 13 health blocks, aiming to enhance the capacity of healthcare providers in identifying and managing maternal mental health issues.

Table 8.3.2 Amma Manas activities

Name of the Institution	Participants
Kuzhalmannam Block	139
Parali Block	27
Nanniyod Block	49
Kongad Block	50
Koppam Block	48
Pazhampalakode Block	45
Alanallur Block	43
Chalissery Block	33
Vadakkenchery Block	77
Chalavara Block	67
Agali Block	52
Koduvayur Block	57
Kadampazhipuram Block	100
Source:District Data	

CHAPTER 9
TRIBAL HEALTH PROGRAM

9.1. Communicable disease

On reviewing the data on Communicable diseases for the last few years it is observed that the number of cases is comparatively less here in this area. At the same time its need to be considered seriously as the tribes are more susceptible to death. Moreover, the health seeking behaviour is observed to be less among tribal population; such as managing an acute diarrhoeal episode within home or just before reaching a health facility is poor.

Table 9.1.1 Communicable Disease Deaths Among Tribes of Attappady

Sl.no	Disease	2022	2023	2024	2025
1	Tuberculosis	1	3	3	4
2	Leptospirosis. (probable)	1	0	1	1
3	Leptosprosis (confirmed)	0	0	1	0
4	Hepatitis (confirmed)	0	0	0	0
5	ADD	0	0	0	1
6	Dengue .C	0	1	0	0

9.2 Malnutrition

Table 9.2.1 tracks the trend of low birth weight (< 2.5kg) children in Attappady over three financial years, 2022-2023,2023-2024 and 2024-2025. The data reveals a positive trend where, despite a slight rise in total live births, the number of underweight children has declined from 244to 188.

Table 9.2.1Data regarding underweight children in Attappady

Year	No of live birth	No. of children having weight <2.5kg (Agali, anakkatty, Pudur, sholayur)
2022-2023	704	244 (SC-14, ST-230)
2023-2024	710	230 (SC-15, ST-215)
2024-2025	756	188 (SC-7, ST-181)

Source: District data

9.3 Maternal Health

Visits are conducted all 5 days of a week to see antenatal mothers and assess any danger signs by JPHN, ASHA, Anganwadi worker, Tribal promoter and social animator each on one day. If any danger signs are detected, she will be shifted to the hospital.

Fig.9.3.1 Agali PMSMA programme

Fig.9.3.2 Anakatty PMSMA programme

Fig.9.3.3 Sholayur PMSMA programme

Fig.9.3.4 Nelliyampathy PMSMA programme

9.4 Delivery Services

All antenatal are admitted before EDC and institutional delivery is conducted.

9.5 Child Health

- All children are provided vaccinations from birth.
- Malnourished children are admitted to the NRC and diet provided.
- SNCU service available in ATTSH Kottathara and W & C Hospital.

9.6 Nutrition Rehabilitation Centre (NRC)

The Nutrition Rehabilitation Centre (NRC) plays a vital role in the management of malnutrition among children aged 0–5 years in Agali Panchayath. Several activities are being carried out to identify, manage, and prevent malnutrition at the community level.

Key Activities

1. Screening of 0–5-year-old children at Anganwadi Centres (AWCs) for malnutrition.
2. Identification of SAM (Severe Acute Malnutrition) and MAM (Moderate Acute Malnutrition) children, followed by AWC-level nutrition counseling and referral/admission to NRC where necessary.
3. Nutritional awareness programs conducted regularly for parents and caregivers.
4. Joint malnutrition interventions in collaboration with ICDS and other departments.
5. Monthly sub-centre level screening for SAM and MAM confirmation.
6. Follow-up of discharged children to ensure sustained improvement in nutritional status.

Difficulties Faced in Admissions

Despite continuous efforts, challenges persist in securing admissions to the NRC, primarily due to the **non-willingness of families**. The major concerns expressed include:

- Responsibility of caring for siblings

- Caring for domestic animals
- Household routines and daily works
- Work commitments such as coolie work, farming, and MGNREGS employment

Field Level Interventions

In order to address these challenges and improve NRC admissions, several interventions have been implemented at the field level:

1. **Regular Screening:** Conducting screenings in 12 sub-centres each month to cover

all underweight, SAM, MAM, and medically complicated children.

2. **Community Strengthening:** Enhancing community-level interventions to motivate families and maximize NRC admissions.
3. **Nutrition Support:** Preparing diet charts and distributing IEC materials in tribal hamlets.
4. **Special Clinics:** Organizing SAM & MAM clinics at the field level.
5. **Hb Screening:** Conducting special hemoglobin screenings for SAM/MAM children and pregnant women.
6. **Coordination Meetings:** Holding joint meetings with ITDP, ICDS, Anganwadi Workers, and ASHAs for better management and referral of malnourished children.
7. **Counseling Services:** Providing individualized diet counseling to outpatients.

NRC Admissions Over the Years

The details of NRC admissions from 2013 to 2025 are presented in Table 9.6.1. A total of 713 admissions were recorded during this period. Admissions were highest in 2013–14 (121 cases), while a declining trend was observed in subsequent years, with slight improvements during 2022–23 and 2023–24 (75 cases each). In the most recent year (2024–25), admissions stood at 55 cases.

Table 9.6.1. NRC admission over the years

Sl no.	Financial year	Total admission
1	June 2013 – March 2014	121
2	April 2014 – March 2015	76
3	April 2015 – March 2016	32
4	April 2016 – March 2017	58
5	April 2017 – March 2018	31
6	April 2018 – March 2019	59
7	April 2019 – March 2020	48
8	April 2020 – March 2021	26
9	April 2021 – March 2022	57
10	April 2022– March 2023	75
11	April 2023– March 2024	75
12	April 2024– March 2025	55
Total admission		**713**

Source: District data

9.7. Mobile Intervention Unit (MIU)

Mobile intervention unit is a group of therapists working for the development of differently abled children under 18 years. There are 2 MIU under Palakkad district (MIU 1 and 2). This group consists of physiotherapist, psychologist, speech therapist, and special educator. The MIU was started on 31.03.2018 and the working time is from 9am to 4 pm.

Cases reported:

2022-2023: 2678; 2023-2024: 2447; 2024-2025: 3010

EIDMU-KOTTATHARA

The Early Intervention and Disability Management Unit (EIDMU) is established under Kerala social security Mission (ANUYATHRA) and National Health Mission (NHM) for the children from the age of 0-18 years, who are identified with developmental delays, deficiencies, defect at birth and diseases (4 D'S). This unit is working at Government Tribal specialty hospital every Monday to Saturday from 9am to 4pm. The team also visits FHC, CHC, sub centres and conducts camps at schools, Anganwadis and hamlets of Attappady to identify children who come under 4D'S. EIDMU includes professionals such as Paediatrician, Developmental Therapist, Medical Social Worker, Special Educator, Physiotherapist, Audiologist cum Speech Therapist, Dental Hygienist, Dietician and Optometrist to provide intervention and management for the disabled children. Average children registered during the period 2022-2025 are 8135. The EIDMU vehicle is parked at GTSH Kottathara.

CHAPTER 10
FINANCIAL ALLOCATION & UTILIZATION

10.1. Financial allocation and utilization for the last four years (in lakhs)

Table 10.1.1 shows the financial allocation and utilisation for the last four years (2022-2025). The NHM received the largest total allocation (Rs 25,768 lakhs) but also exhibits the largest gap between allocation and utilization compared to the other two sources. The Tribal fund demonstrates the highest efficiency in utilization, with its utilization figures being very close to its allocated funds across the four years.

Table 10.1.1 Financial allocation and utilization for the last four years (in lakhs)

Source	2022		2023		2024		2025		Total	
	Allocation	Utilisation	Allocation	Utilisation	Allocation	Utilisation	Allocation	Utilisation	Allocation	Utilisation
DHS-Plan	9572.37	8970.78	2184.55	1781.15	2272.71	2083.31	2880.83	2718.60	16910.46	15553.84
NHM	4610.55	4043.62	6221.09	4352.89	6831.57	3797.29	8105.43	5324.99	25768	17519
Tribal fund	1956.10	1948.15	1777.00	1650.08	3065.00	3058.90	1800.00	1799.53	8598.10	8456.66

CHAPTER 11

NHM PROGRAMMES

11.1 NHM Activities in the District

Even though the state of Kerala has advanced critical health indicators as compared to the other states of India, the state is facing challenges that are unique and specific. State is facing the problem of high morbidity both from re-emergence of communicable diseases, aging population and non-communicable diseases. Moreover, the challenge of sustaining the privileged health indicators remains. Further, improving the quality of health care where the health seeking behaviour is very high is of utmost importance. The resources of National Rural Health Mission came in an appropriate time when the state was finding it difficult to find resources matching the demand. During the last three years the State has been able to initiate many programmes suiting to its specific requirements and health issues that need immediate intervention. These initiatives correspond to the Key Performance areas outlined by NRHM like a) Institutional Strengthening b) Improving access to better health care and quality services and c) Accessibility of health care to the under privileged and marginalised.

The Goal of the Mission is to improve the availability of and access to quality health care for the people, especially those residing in the rural areas, the poor, women and children. The goals and objectives are:Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)

- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy lifestyles

Programmes under NHM

1. RBSK/RKSK
2. DEIC
3. Biomedical Engineering programme
4. NUHM
5. Palliative care programme
6. NCD
7. Quality Assurance Programme
8. ASHA programme
9. IEC/BCC
10. Monitoring and Evaluation
11. HMIS
12. HWC

11.1.1 Rashtriya Bal Swasthya Karyakram (RBSK) & Arogya Kiranam (AK):

The Rashtriya Bal Swasthya Karyakram (RBSK) is a flagship initiative under the National Health Mission aimed at early identification and intervention for children from birth to 18 years to cover the "4 Ds" – Defects at birth, Diseases, Deficiencies, and Developmental delays including disability. The program covers children enrolled in Anganwadis and schools.

Activities & Achievements under R B S K

Shalabham - Mobile Health Unit
Hridyam
Anuyatra-Mobile Intervention Unit (MIU)
District Early Intervention Centres (DEIC)

Arogya Kiranam (AK) is a unique scheme launched by the Government of Kerala to provide free treatment to children under 18 years of age for conditions identified under RBSK, irrespective of family income. It ensures universal health coverage for children with any of the 30 identified health conditions.

Table 11.1.1 tracks the treatment expenditure of RBSK-AK across four financial years,

from 2021to 2024.

Table 11.1.1Treatment expenditure of RBSK-AK

Year	RBSK	AK	Beneficiaries	Total
2021-22	3045610	3654780	13658	6700390
2022-23	2065431	4768312	16543	6833743
2023-24	2976010	17667850	13754	20643860
2024-25	2479531	13003412	18432	15482943
Source: District data				

11.1.2 New-born Screening (Visible Birth Defect-VBD Screening)

New-born screening is an essential component of RBSK to identify visible birth defects at the point of delivery. It enables early detection of critical conditions and ensures timely referral and intervention. The new born screening programme in the district shows consistent coverage of deliveries (Table 11.1.2.1). In 2022–2023, a total of 7,278 deliveries were reported, with 7,365 new-borns screened, leading to the identification of 278 conditions. In 2023–2024, the total deliveries slightly declined to 6,166, and all new-borns were screened, with 255 cases identified. By 2024–2025, the total number of deliveries further decreased to 5,555, and 5,564 new-borns were screened, detecting 268 conditions. The Rashtriya Bal Swasthya Karyakram (RBSK) screening data (Table 11.1.2.2) highlights significant progress in outreach and coverage across age groups. In 2020–2021, a total of 1,43,671 children were screened, which gradually increased over the years. The highest surge was seen in 2023–2024 with 5,12,452 screenings, showing a steep rise in both 0–6 years (1,84,872) and 6–18 years (3,27,580) age groups. In 2024–2025, though the total number screened declined slightly to 4,56,298, the programme maintained high coverage compared to the initial years.

Table 11.1.2.1 New born screening

Year	Total no of deliveries	Total no of Newborns Screened	No of Conditions identified
2022-2023	7278	7365	278
2023-2024	6166	6166	255
2024-2025	5555	5564	268
Source: District data			

Table 11.1.2.2 Screening under RBSK

Indicators	2020-21	2021-22	2022-23	2023-24	2024-25
0-6 years	18796	45537	40530	184872	180183
6-18 years	124875	147850	106901	327580	276115
Total	143671	193387	147431	512452	456298
Percentage	22.3%	32.05%	24.8%	89.1%	86%

11.1.2.1 Special Child Health Programme of Palakkad District

(Kadambazhippuram health Block)

To strengthen preventive and promotive healthcare among school children, a comprehensive District Health Programme has been implemented under the guidance of the Kadambazhippuram Block Panchayat authorities. The programme integrates multiple child health initiatives focusing on dental care, eye health, dermatological conditions, and nutrition. These sub-programs aim to ensure early detection, timely treatment, and sustained health awareness among children across the district.

1. **Susmitham Programme (Dental Treatment and Referral System):** The Susmitham Programme is a Block Panchayat initiative launched in July 2018 to provide comprehensive dental care for school children. Between 2018 and 2020, a total of 1,092 children received various types of dental treatments, which included Tooth extraction, scaling and filling

   Activities were temporarily suspended during the COVID-19 pandemic, but the program resumed in September 2023. Since the restart, 573 children have received treatment. The RBSK Nurse conducted dental screenings in schools, and children requiring treatment were referred to the hospital every Wednesday, accompanied by school teachers. To date, a total of 1,665 children have benefited from this program. The initiative continues to run successfully (Fig.11.1.1). The expenses of above services were met from the block panchayat fund. The Susmitham Project is still ongoing and continues to provide essential dental care services to children across the block.

2. **Sunetram Programme (Eye Examination for Children aged 3–18 years):** The Sunetram Programme was initiated in 2019 to ensure early detection and management of visual impairments among children aged 3 to 18 years (Fig.11.1.2). The expenses of above services were met by the block panchayat fund. During the 2019–2020 period,5,145 children were screened and 261 children were referred for specialist care. Referred children received treatment from District Hospital, Palakkad by Dr. Geetha, Ophthalmologist. The program resumed in September 2023, and since then 20,012 children were screened by RBSK Nurses through preliminary vision tests, 405 children were identified with refractive errors, and 223 children received free spectacles through the District Blindness Control Programme (DBCP).

3. **Sparsham Programme (Skin-Related Treatment and Referral System):** The Sparsham Programme began on 10th July 2018, focusing on identifying and treating skin conditions among school children. Between 2018 and 2020, 541 children received treatment for various dermatological conditions. Similar to other programs, activities were paused during the COVID-19 period and resumed in September 2023. During this resumed phase, 64 children were treated. Screening and identification were carried out by the RBSK Nurse in schools, and the children were referred to the hospital for treatment every Wednesday. Overall, 1,665 children have availed services under this program so far. In 2023, one child was referred for SLIT Skin Smear testing, which returned negative results (Fig.11.1.3). The expenses for the above services were met from the block panchayat fund.

4. **Nutritional Programme:** A comprehensive nutritional program is being implemented across all schools and Anganwadis within the Kadampazhipuram Block. This initiative emphasizes nutrition education and the promotion of healthy eating habits among children (Figure 11.1.4). Activities include:

   - Conducting health education classes on nutrition and hygiene.

- Encouragement of locally prepared nutritious dishes, particularly those made from leafy vegetables and jaggery.

  The program continues to run effectively, contributing to improved nutritional awareness and child health outcomes.

In addition to the above discussed projects, various capacity-building and health education training sessions were conducted during November-December 2024 across the district. The Adolescent Health and Wellness Programme included block-wise training sessions focused on adolescent clinic counselling and addressing adolescent health issues (Fig. 11.1.5). Under the SAANS initiative, training sessions were organized for ASHA, medical officers, and staff nurses to enhance awareness and management of childhood pneumonia (Fig. 11.1.6). Furthermore, RBSK refresher training was conducted for new officers and RBSK nurses (Fig. 11.1.7).

Fig.11.1.1. Susmitham Programme

Fig.11.1.2. Sunethram Programme

Fig.11.1.3. Sparsham Programme

Fig.11.1.4. Nutritional Programme

Fig.11.1.5. Adolescent Health and Wellness Programme

Fig.11.1.6. SAANS Training for Medical Officers, Paediatricians

Fig.11.1.7 RBSK Refresher Training

11.1.3 District Early Intervention Centre (DEIC):

The Ministry of Health and Family Welfare in February 2013 launched the Rashtriya Bal Swasthya Karyakram (RBSK) for 'Child Health Screening and Early Intervention

Services under National Health Mission. It is a systematic approach to early identification of 4Ds, Defects at birth, Diseases, Deficiencies and Developmental delays to prevent or limit Disabilities in children 0 to 18. Rashtriya Bal Swasthya Karyakram is an innovative scheme to provide expert screening, early treatment and care for 30 common health problems in children below 18 years of age. Comprehensive Child Health screening and management as a public health approach assures a package of health services for all children from birth to 18 years of age under this initiative.

Table 11.1.3.1 DEIC data

INDICATORS	2022-23	2023-24	2024-25	Total
DEIC client Load	10040	8127	5525	23692
Death case reported	6	3	5	14
Follow up	6664	6471	4030	17165
ROP	361	362	375	1098
CVI	587	549	489	1625
Hearing Aid	29	26	12	67
Cleft Lip/Palate	19	16	11	46
Source: District data				

11.1.4 Hridyam:

A unique initiative by the Government of Kerala to support children with Congenital Heart Disease (CHD). This web-based registry for CHD cases across Kerala, aims to monitor the progress of the management of children with CHD, identify the bottlenecks for implementing the protocols, to track the case status and response time of the system and the outcome.

11.1.5 Mobile Intervention Unit (MIU)

Mobile intervention unit is a group of therapists working for the development of differently abled children under 18 years. There are 2 MIU under Palakkad district (MIU 1 and 2). This group consists of physiotherapist, psychologist, speech therapist, and special educator. The MIU was started on 31.03.2018 and the working time is from 9am to 4 pm.

Cases reported:

2022-2023: 2678; 2023-2024: 2447; 2024-2025: 3010

EIDMU-KOTTATHARA

The Early Intervention and Disability Management Unit (EIDMU) is established under Kerala social security Mission (ANUYATHRA) and National Health Mission (NHM) for the children from the age of 0-18 years, who are identified with developmental delays, deficiencies, defect at birth and diseases (4 D'S). This unit is working at Government Tribal specialty hospital every Monday to Saturday from 9am to 4pm. The team also visits FHC, CHC, sub centres and conducts camps at schools, Anganwadis and hamlets of Attappady to identify children who come under 4D'S. EIDMU includes professionals such as Paediatrician, Developmental Therapist, Medical Social Worker, Special Educator, Physiotherapist, Audiologist cum Speech Therapist, Dental Hygienist, Dietician and Optometrist to provide intervention and management for the disabled children. Average children registered during the period 2022-2025 are 8135. The EIDMU vehicle is parked at GTSH Kottathara.

11.1.6 Mobile Health Team (MHT):

The **Mobile Health Team (MHT)** is responsible for systematic health screening in Anganwadis and schools. In Palakkad district we have 2 MHT s approved in ROP. MHT-1 Covers 7 Health Blocks and MHT-2 Covers 6 Health Blocks.

MHT-I

1.Parali

2.Kongad

3.Koduvayur

4.Kuzhalmannam

5.Nanniyode

6. Pazhampalacode

7.Vadakkencherry

MHT-2

1.Alanallur

2.Ambalappara

3.Chalavara

4.Chalissery

5.Kadampazhipuram

6.Koppam

11.1.7 Nutrition Rehabilitation Centre (NRC)to address Severe Acute Malnutrition:

A Nutritional Rehabilitation Centre is a unit in a health facility where children with Severe Acute Malnutrition (SAM) are admitted and managed. Children are admitted as per the defined admission criteria and provided with medical and nutritional therapeutic care. Once discharged from the NRC the child continues to be in the nutrition rehabilitation program till she/he attains the defined discharge criteria from the programme. In addition to curative care, special focus is given on timely, adequate and appropriate feeding for children; and on improving the skills of mothers and caregivers on complete age-appropriate caring and feeding practices. Efforts are also made to build the capacity of mothers through counselling and support to identify the nutrition and health problems in their child.

Now 3 NRCs are functioning in Palakkad District:

1. NRC Agali

2. NRC Pudur
3. NRC Sholayur

NRC Staff: 23 (3 Medical officers; 3 Dieticians; 3 Social workers; 8 Staff nurses and 6 Cook/ Attender)

11.1.8 Rashtriya Kishor Swasthya Karyakram (RKSK):

Adolescents are individuals aged between 10 and 19 years. Adolescence is an important phase in the life of an individual, with long term influence on his / her overall health. In order to promote Adolescent Health in a holistic manner, a multi-component intervention targeting both determinants of health problems and their consequences is imperative. The Ministry of Health and Family Welfare -National Health Mission, along with Government of Kerala has put in place a comprehensive health programme for adolescents, i.e., Rashtriya Kishor Swasthya Karyakram (RKSK)/Adolescent Health Programme.

Table 11.1.8.1 RKSK data

Case Profile	Sexual and reproductive health	Substance abuse	Nutrition	Mental health
Total Cases (2024-25)	2061	262	8810	2880
Follow Up cases	2045	262	5789	1459
Source: District data				

11.1.9 Peer Educators Programme -SDC (Student Doctor Cadet)

A peer educator program involves training and deploying adolescents within a community to educate their peers on various topics, often related to health and well-being. These peer educators, typically chosen for their leadership and communication skills, help disseminate information and foster positive behaviour changes among their peers.

The Major Objectives of SDC:

- Nurture the scientific understanding of health

- Increase the awareness of various health issues
- Improving the mental health of children

Table 11.1.9.1 shows the number of total peer educators selected and trained from 2022- 2025.

Table 11.1.9.1 Peer Educators training

Year	Total Peer Educators selected	Trained
2022-2023	800	740
2023-2024	800	640
2024-2025	1000	200
Source: District data		

11.1.10 Weekly Iron Folic Supplementation Program (WIFS)

Table 11.1.10.1 provides data related to the implementation and performance of the Weekly Iron Folic

Supplementation Program (WIFS) over a five-year period.

Table 11.1.10.1. Weekly Iron and Folic acid

Year	Target population	Total covered	% Achievement	No. of school program initiated
2020-21	525720	46900	8.9%	3
2021-22	602516	187470	31.11%	2
2022-23	364194	216148	60%	3
2023-24	371025	15960	4.3%	2
2024-25	325095	24793	7.6%	2
Source: District data				

11.1.11 Sickle Cell Disease Project (If applicable)

Introduction

Attappady, located in the Palakkad district of Kerala, is a predominantly tribal area with a population of approximately 65,000, nearly half of whom belong to Scheduled Tribes. It consists of about 190 tribal hamlets. The region faces serious health challenges, particularly Sickle Cell Anaemia, a hereditary blood disorder that severely impacts individuals and the community at large. At present, testing is mostly done only for symptomatic patients attending health centres. There is no comprehensive database due to limited community-level screening.

The need of the hour is wide-scale community screening to:

- Identify patients (Sickle cell trait and disease)
- Provide Sickle Cell ID cards
- Ensure treatment initiation and regular follow-up

Currently, 5 Mobile Medical Units (MMUs) support healthcare delivery in Attappady. MMU 1 & 2, managed by Directorate of Health Services (with Medical Officer & Staff Nurse) and MMU 3, 4 & 5 are managed by HLL (with Medical Officer, Staff Nurse, Pharmacist & Lab Technician). Two additional MMUs are operated by the Department of Tribal Development.

Vision

To integrate sickle cell screening, diagnosis, treatment, and follow-up into the existing healthcare system and ensure regular, structured activities for management of the disease.

Objectives

- Comprehensive sickle cell screening of the tribal population
- Screen using Point-of-Care (PoC) test kits
- Conduct confirmatory HPLC tests for PoC positives
- Create a line-list of patients for follow-up and treatment

- Prepare hamlet-wise registry of affected individuals (trait and disease)
- Distribute Sickle Cell ID Cards (as per National Sickle Cell Elimination Mission)
- Provide appropriate follow-up care
- Achieve zero preventable mortality and reduced morbidity

Draft Plan of Action

1. Preparation Phase

Planning and Logistics

- Map all tribal hamlets under sub-centres. Assign staff (JHI, JPHN, MLSP, etc.).
- Prepare hamlet-wise line-list of residents.
- Schedule screening camps:
  - Large hamlets: one per day
  - Small hamlets: two per day
- Select suitable camp sites & timings in consultation with community leaders.

IEC (Information, Education, Communication)

- Conduct IEC campaigns to promote awareness.
- Involve *ooru mooppan* (hamlet heads), tribal promoters, NGOs, ICDS, and schools.
- Organize IEC workshops for effective message delivery.

Human Resources

Role	**Responsibility**
Medical Officer (FHC)	Overall supervision
Medical Officers (MMU)	Examine participants/patients
Health Supervisor/Inspector	Coordination, supervision

JHI	Preparation & coordination
JPHN	Screening for T2DM
MLSP	Screening for BP
Staff Nurse (MMU)	Hb & PoC testing
ASHA	Recording height & weight
Tribal Promoter	Registration & slips
Tribal ASHA	Mobilization & tracking
Lab Technician (MMU)	Sample collection & storage
Data Entry Operator	Data entry of results

2. Execution Phase

Inauguration

- Campaign to be launched by elected representatives, district/block administration, and heads of health and tribal departments.

Camp Scheduling

- Duration: 6 months
- Frequency: 3 days/week (to avoid disruption of routine services)
- Screening to include:
    - Sickle cell disease
    - Nutritional status
    - Anaemia
    - NCD risk factors

Screening Process

- PoC test for all consenting individuals.

- Database entry of results.
- Confirmatory HPLC testing for positives (CHC Agali).
- Provide counselling & guidance for positives.
- Ensure biomedical waste management.

Confirmatory Testing (HPLC)

- Contract Lab Technician at CHC Agali
- Duties: SOP preparation, sample testing, documentation, reporting, BMW management

Data Management

- Maintain hamlet-wise registry at Sub-centre.
- Compile sub-centre data at PHC & CHC level.
- Ensure line-listing of all positives for follow-up.

3. Follow-Up Phase

- Medical consultations at CHC/FHC for all positive cases
- Referral to higher centres if required
- Link patients with health institutions/MMUs for continuity of care
- Conduct community feedback sessions and distribute IEC materials

Monitoring & Evaluation

District Monitoring Committee-A district-level monitoring committee will be formed under the Chairmanship of the District Collector. This committee will include the Sub-Collector (Ottapalam, also serving as Nodal Officer for Attapady), the District Medical Officer (Health), District Program Manager (NHM), Deputy DMO (Attapady Block), Ardram Nodal Officer, District Lab Technician, and District Tribal Officer.

The committee will ensure:

- Preparation of a comprehensive action plan

- Supervision of implementation and periodic review
- Modification of strategies when needed
- Collection and maintenance of a comprehensive line-list of sickle cell patients in Attapady

The committee will also facilitate coordination with other departments such as ICDS, Police, Excise, Agriculture, and Education.

Block Monitoring Committee

At the block level, a Block Monitoring Committee will be formed under the Block Development Officer (BDO), Attapady. Members will include the Medical Officer of CHC Agali, Medical Officers of FHCs (Sholayur, Anakkatty, Pudur), the Health Supervisor (Agali), and the Assistant Project Officer from the Tribal Department.

This committee will oversee:

- Effective implementation of the screening camps
- Coordination among health facilities and field staff
- Timely reporting of progress to the district committee
- Addressing local-level challenges during execution

Inter-Departmental Coordination

Department	Role
Revenue Dept.	Ensure inter-departmental coordination
Tribal Dept.	Involve tribal leaders, provide hamlet-wise line-list
LSGD	Awareness campaigns, mobilization, financial support
Education Dept.	IEC through schools, mobilization via children
Police Dept.	Legal support, mobilization, active participation

Excise Dept.	Mobilization, camp participation
ICDS	IEC support, mobilization
NGOs & Kudumbasree	IEC, mobilization, voluntary support

Collaboration with Institutions

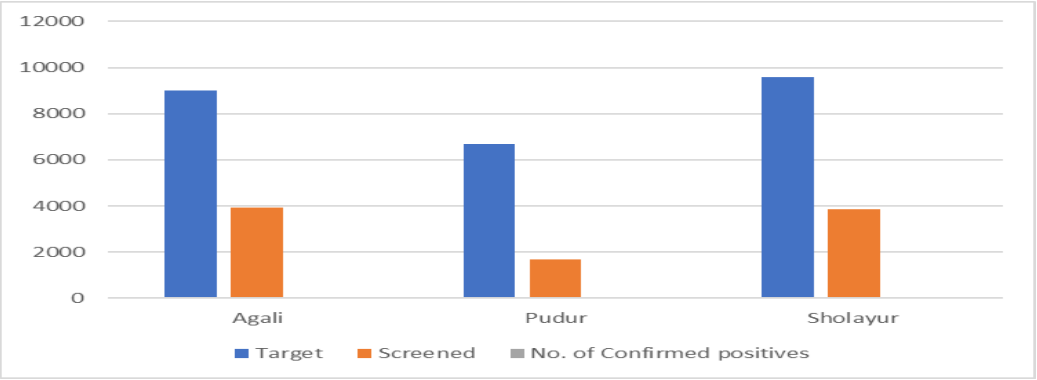
- Govt. Medical College, Kozhikode: Technical support, research, training (experience from Wayanad).
- Govt. Medical College, Palakkad: Proposed collaboration.
- Sickle Cell Anaemia Management Unit, Wayanad: Training in PoC testing and program implementation.

Screening for sickle cell disease and trait was carried out across 12 hamlets **(Table 11.1.11.1)**. A total of 123 individuals were screened. Out of these, 116 cases (94.3%) were identified as trait carriers, while 7 cases (5.7%) tested positive. Most hamlets reported only trait cases, while Kollamkadavu, Kookkampalayam, Chindakki 2nd Site, Kakkuppadi, and a few others recorded positive cases. This highlights the need for continued monitoring, genetic counseling, and preventive interventions in affected communities.

Table 11.1.11.1. Sickle Cell Anaemia screening data

Name of Panchayat	Target	Screened	% screened	No. of Confirmed positives
Agali	9017	3931	44	32
Pudur	6674	1686	26	21
Sholayur	9577	3847	40	34
Source: District data				

Graph.11.1.1. Sickle cell anaemia screening



11.1.12 Biomedical Equipment Maintenance Program (BEMP)

- Implemented through KMSCL via Third Party (CYRIX Healthcare PVT Ltd) as a PPP model.
- All medical equipment, other than cold chain equipment exclusively for immunization, of all Govt. hospitals under DHS (warranty equipment will be added after the completion of existing contract).
- 24X7 IVRS call centre (toll free registration), Web enabled equipment management system with KMSCL & Third Party
- Preventive Maintenance & Calibration
- District level Monthly review meeting with third party agencies and quarterly review with DPM /KMSCL and Third-Party Agency.
- State Level Quarterly Review with District BMEs, KMSCL and Third Party.

BEMP Overview:

- Total institutions under BEMP scheme -110
- Total Assets –10811
- Total no of Assets Mapped & added in dashboard-10770

- Total number of calls registered through IVRS (from Dec 2021 to 20th January 2024)- 13789
- Total calls rectified -13401
- Total pending -33, Long pending (More than 7 days)-3
- Total calls registered through email/drive/OfflineTicket-1539(1441E mail calls +99 (offline calls)
- Total calls rectified -1526
- Total RBER- 297
- Number of Long terms pending -1

Table 11.1.12.1 Biomedical Equipment Maintenance Program (BEMP)

Description	Total Call Registered	Total Call rectified	Pending calls	Percentage of rectified calls
DH &W&C	4950	4828	28	97.53
THQHS	4613	4503	20	97.61
CHCS	2110	2038	8	96.58
PHCS and UPHCS	3581	3432	19	95.83
Source: District data				

11.1.12.1 Compliance to the norms of AERB for equipment under Radiology department

Total facility - 13
eLORA registered facility - 12

11.1.12.2 Procurement of Equipment at State level through KMSCL – NHM

Table 11.1.12.2 Year wise details are as follows:

Year	Details	Sanctioned Amount (Rs)	Status
22-23	Maternal Health & Child health	4092186	Supply completed

23-24	Additional equipment to THQH Chittur (Supplementary ROP)	6497145	Supply completed
24-25	Maternal health &Other equipment	6742807	Equipment supply ongoing
Source:District Data			

11.1.13. ASHA Programme

In Palakkad District, there are 2302 ASHAs working. All health programmes are coordinated by ASHAs. EcMan software is used for monitoring, for timely disbursement of ASHA incentives & honorarium, conducting training activities, district level review and grievance redressal.

Total No. of ASHAs is 2302 (Rural -2138; Urban – 122; Hamlet ASHA- 42)

Table 11.1.13.1 Block wise numbers of ASHA

Agali	113
Alanallur	235
Ambalappara	106
Chalavara	123
Chalissery	162
Katampazhipuram	154
Koduvayur	215
Kongad	198
Koppam	198
Kuzhalmannam	191
Nanniode	129
Parali	74

Pazhambalacode	150
Vadakkanchery	159
THQH Alathur	3
THQH Chittur	28
THQH Mannarkkad	8
THQH Otappalam	4
Palakkad Municipality	52
TOTAL	**2302**
Source: District data	

Table 11.1.13.2 shows the status of incentive released along with the number of beneficiaries (2019- 2024).

Table 11.1.13.2 ASHA Incentive Released Status 2019 - 2024

Sl.No	No. of Beneficiaries	Amount (In Crores)
2024 - 2025 (Till Oct 2024)	2258	5.22
2023 - 2024	2280	9.16
2022 - 2023	2298	9.22
2021 - 2022	2331	8.46
2020 - 2021	2334	8.11
2019 - 2020	2277	7.12

Table 11.1.13.3 shows the honorarium released status along with the number of beneficiaries and amount from 2019- October 2024.

Table 11.1.13.3 ASHA Honorarium released Status

Sl.No	No.of Beneficiaries	Amount (In Crores)
2024 - 2025 (Till Nov 2024)	2250	12.43
2023 - 2024	2278	17.08
2022 - 2023	2295	16.22
2021 - 2022	2340	16.59
2020 - 2021	2334	13.68
2019 - 2020	2275	11.54
Source: District data		

- ASHA Training – Completed till 9th Module
- Hamlet ASHA Training – Completed till 3rd Module
- Distributed HBNC & HBYC KIT, ASHA Drug Kit
- Shaili App Survey Completion - 1st Phase – 88% & 2nd Phase - 64%
- Completed 2 batches of Computer training for ASHAs through Akshaya Centres
- Ward health facilitation Centre (2021) - At FHC Sreekrishnapuram (Total 14 wards)
- ANM Course Completed ASHAs - 4
- Literacy Course Offering to ASHAs - 10th Equivalency - 2 batches & Plus One - 133
- Honorarium - Distributed up to November 2024
- Incentive - Distributed up to October 2024

Fig.11.1.8. ASHA training

11.1.14. Health and Wellness Centres (HWCs)

The total number of health and wellness centres in the district is shown in Table 11.1.14.1

Table 11.1.14.1 No. of HWCs

Number of Health Blocks in the District	14
Number of institutions (PHC/CHC) in the District	95
Total no. of Janakeeya Arogya Kendrams in the District	504
Branding (AAM) GoI Approved	326
Sanctioned Post	504
In Position	400
Vacancy	104
Source: District data	

HWC Activities:

- **Jan Arogya Samiti** constituted 493 HWCs and monthly JAS meetings were conducted.
- No. of JAKs conducted at least 10 JAS meetings in the last financial year 2023-2024 = 153.
- Average OP footfall = 8-10/ JAK/ day.
- **Jan Arogya Club and patient support groups** are being initiated in various sub centres.
- **NCD, Well-women and Wellness services** are being provided through HWCs (JHI/JPHN/MLSP).
- Patients with serious health related suffering/ chronic illness and homebound patients are included in **priority visits** of MLSPs and home-based care is being given.

Fig.11.1.9. HWCs

11.1.15. Palliative care

Table 11.1.15.1 provides a snapshot of the number of various types of palliative care units and services

Available in the district.

Table 11.1.15.1 Palliative Care Units and Services

Total no of primary units	104
Total no of secondary units	26
Total no of physiotherapy units	19
Total no of institutions having morphine licence	12
Source: District data	

Activities:

- Conducted district level monthly review meetings for Community nurses, secondary staff nurses, physiotherapists.
- Conducted PQAS training for Community nurses, secondary nurses, & physiotherapists.
- District Palliative care monitoring committee held on 19.12.2024.
- Conducted 3 days district level training for community nurses.
- Completed second batch 10 days foundation course for doctors.
- Completed second batch 10 days foundation course for Nursing officers.
- Completed 1st batch BCCPM course for doctors.
- Completed BCCPN course for staff nurses.

Fig.11.1.10. Palliative activities

CHAPTER 12

NATIONAL URBAN HEALTH MISSION

12.1 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.

- No of Urban local bodies in the district - 7
- No of ULBs where UPHC/UHWC implemented -3
- No of UPHCs -5
- No of UPHCs in rented building -0
- No of UHWCs (XV FC) sanctioned -23
- No of UHWCs (XV FC) operationalized-18
- No of UHWCs (XV FC) unctional in rented building-15

NUHM Best Practices:

- Kayakalp 2nd Price got UPHC Kulappully
- UPHC Panamanna shifted to New building
- Urban Shaili Survey started
- UPHC Venakkara & Diarastreet State assessment completed on 25th & 26th November

Table 12.1.1 shows the number of approved and in position activities of NUHM.

Table 12.1.1. NUHM activities

Community process	Approved
No. of Mahila Arogya Samithi (MAS) constituted	70
No. of MAS Accounts opened	70
No. of MAS trainings/	70

orientations held	
No. of ASHAs	62
No. of UHNDs held in 2024-25 with frequency (Weekly, Monthly, Quarterly)	57
No. of special outreach medical camps	0
a. 2023-24	20
b. 2024-25	0
Population and households assigned per ASHA	141998
Population and households assigned per JPHN	26987
NGO Support in Community process if any	NA

12.1.1 Institutional Level Activities

During 2024–25, institutional level activities recorded significant service delivery. A total of 1,18,601 outpatients were attended, of which 39,137 cases were related to non-communicable diseases (NCDs), reflecting the growing demand for chronic disease management. Laboratory services were also extensively utilized, with 1,01,478 tests conducted during the year (Table 12.1.1.1). However, it is noteworthy that no outreach labour camps were organized in this period, which indicates a gap in extending services beyond the facility setting

Table 12.1.1.1 Institutional level activities

ITEMS	2024-25
Total OP	118601
Total NCD	39137
Total Lab	101478

Total Outreach labour camps	0
Source: District data	

Under the National Urban Health Mission (NUHM), several capacity-building initiatives were undertaken to strengthen the skills of health personnel. Key training included infection control (29.04.2024), HMIS and AB-HWC training (09.04.2024), and induction training for UHWC staff (09.05.2024). Specialized thematic training such as NHP (06.06.2024), disaster management (22.06.2024), and ICTC (22.08.2024) were also conducted. Further, technical capacity was enhanced through finance management (18.10.2024), BLS (06.07.2024), Kayakalp (18.07.2024), and IUCD training for selected JPHNs (16–18.12.2024). Quality improvement measures were supported with NQAS orientation (07.11.2024), HIC training (12.11.2024), and DDMS & FPLMIS training for pharmacists (30.12.2024). Additionally, digital health services were promoted through eSanjeevani training (27.06.2024) for UHWC staff (Table12.1.1.2).

Overall, while institutional care and staff training remained strong, the absence of outreach labour camps points to the need for strengthening community-based service delivery.

Table12.1.1.2. NUHM Capacity Building

Infection control training	29-04-2024
HMIS & ABHWC training to uhwc staffs	09-04-2024
Induction training for uhwc staffs second level	09-05-2024
NHP training	06-06-2024
Disaster management training	22-06-2024
ICTC Training	22-08-2024
Finance management	18-10-2024
BLS training	06-07-2024

Kayakalp training	18-07-2024
IUCD training for selected JPHNs 2 nd batch	16,17,18-12-2024
NQAS orientation training	07-11-2024
HIC training	12-11-2024
DDMS & FPLMIS training to pharmacist	30-12-2024
Esanjeevani training to UHWC staff	27/6/2024

Fig.12.1.1NUHM

CHAPTER 13

NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME (NTEP)

13.1 National Tuberculosis Elimination Programme (NTEP)

In Palakkad district, tuberculosis (TB) control and diagnostic infrastructure is well established. There is a District TB office and there are 7 Tuberculosis Units (TUs) operating across the district. They are:

1. Palakkad
2. Ottappalam
3. Attappady
4. Mannarkad
5. Chittur
6. Pattambi
7. Alathur

The district is supported by 121 Peripheral Health Institutions (PHIs) and 45 Designated Microscopy Centres (DMCs) that facilitate sputum testing and TB diagnosis. For molecular diagnostics, Palakkad has 3 CBNAAT machines, which include an additional mobile CBNAAT unit transferred from Kozhikode District TB Centre (DTC) on 27/01/2025, enhancing diagnostic outreach in remote areas. In addition, there are 12 TrueNat machines and 13 X-ray testing facilities, providing strong support for early and accurate diagnosis of TB.

The district also actively engages the private sector through 10 STEPS centres (System for TB Elimination in Private Sector), ensuring comprehensive coverage and involvement of all healthcare providers. Notably, the district offers upfront NAAT testing for all vulnerable populations and sends an additional sample to IRL Trivandrum for Line Probe Assay (LPA). Furthermore, all TB-suspected outpatient (OP) cases are provided NAAT testing. The District TB Centre is well-equipped, housing both TrueNat and CBNAAT machines, along with an X-ray unit, ensuring a one-stop facility for effective diagnosis and management of tuberculosis. The programme also involves:

- Providing timely treatment facilities and medicines to patients

- Providing nutritional and other facilities using CSR fund
- Providing awareness among the public
- Conducted intensive campaigns and screening among especially tribal people *AKSHAYA JYOTHI 1.0 and 2.0* was implemented under the auspices of District Medical Office (Health), Arogya Keralam and District TB Centre Palakkad. This project was implemented in Agali, Pudur, Sholayur, Kizhankkanchery, Vandazhi and Muthalamada panchayats.
- *MUKTHI* Program conducted in Mathur Panchayat.
- TB Mukt Bharat Abhiyaan --- 100 Days Campaign by central government.

13.2. Details of New Health Initiatives related in Palakkad District:

I. TB

1.AKSHAYA JYOTI-2 PROJECT:

The Scheduled Caste areas are special reserved regions where the government has been prioritizing the welfare of Scheduled Tribes. Children from these communities face significant health challenges, particularly due to malnutrition and lack of health education. They are often more susceptible to diseases, and are generally hesitant to rely on health systems. Tuberculosis, a deadly disease, can easily infect immunocompromised individuals, and there have been cases of tribal children dying from it. However, tuberculosis is a disease that can be detected early and treated effectively. To address this, the Akshaya Jyoti project, initiated by the Palakkad District Health Department, aims to free tribal children under the age of 15 in the Pattika Varga region from Tuberculosis.

Akshaya Jyoti-1 was a program jointly launched by the Palakkad District Medical Office and the District TB Centre in December 2023. It achieved success in six panchayats: Agali, Sholayur, Pudur, Kizhakancheri, Vandazhi, and Mudalamada, which have a significant Scheduled Caste population in Palakkad district. A total of 830 samples were collected from 7,804 TB screenings during Phase 1 of the Akshaya Jyoti program. Following the detection of four positive cases in adults, the second phase of Akshaya Jyoti will be rolled out in August 2024, covering 38 panchayats with Scheduled Tribe populations in the district. This innovative

initiative is being implemented under the direct supervision of the District Medical Officer (Health), with operational leadership provided by the District TB Officer. The MOTC program is coordinated at the unit level, while trained health workers, including MLSPs, ASHAs workers, Hamlet ASHAs, and Anganwadi workers, visit tribal households, Anganwadis, and schools in the selected panchayats to collect sputum samples and refer suspected cases to medical officers. Field-level operations are overseen by Health Inspectors and Health Supervisors..

Operational Guidelines:

- As a first step, in the six Gram Panchayats of Agali, Sholayur, Puthur, Kizhakkancherry, Vandazhi and Mudalamada, which have a large scheduled caste population in Palakkad district, Janu from 23rd December.
- As a second phase, the remaining 38 scheduled caste panchayats of Palakkad district will also be implemented. List of Panchayats is enclosed herewith.
- Trained health workers MLSP, ASHA, Hamlet ASHAs and Anganwadi workers visit homes of children below 15 years of age, Anganwadis and schools to collect samples and deliver them to the public health centres. Suspicious children are referred to the Medical Officer. Supervised by the Health Inspector and Health Supervisor.
- Family Health Centres prepare home visit micro plans focusing on various villages. The Medical Officer, Health Supervisor and MOTC are keeping an eye on it.
- The District TB Officer prepares a practical system for sputum testing. Complete and free treatment is provided to those who need it.

Benefits

- Making tribal children Tuberculosis free.
- This improves the health status of children.
- Proper health services are reaching the tribal areas.
- In the next phase, the program is being extended to other areas as well.

- This is a project to free tribal children from tuberculosis in the state of Kerala itself.

Table 13.2.1. Snap shot of the Programme-Akshaya Jyoti

Akshaya Jyothi 1.0 (Screening of Tribal Children 0 to 15 years) Akshaya Jyothi 1.0 covered 6 Panchayaths.	• Tribal children population: 8064 Nos.
	• Tribal children population screened: 7804 Nos.
	• Sample collected from Tribal Children: 655 Nos.
	• Sample collected from others: 175 Nos.
	• Total Samples collected/tested: 830 Nos.
	• Total Positive: 4 Nos.
	• Children: 0
	*Adult: 4 Nos
Akshaya Jyothi 2.0 (Screening of Tribal Children 0 to 15 years)	• Tribal children population: 3250 Nos.
	• Tribal children population screened: 3128 Nos.
	• Sample collected from Tribal Children: 288 Nos.
	• Sample collected from others: 213 Nos.
	• Total Samples collected/tested: 501 Nos.
	• Total Positive: 8 Nos.
	• Children: 2
	• Adult: 6 Nos
(Source: District data)	

Fig.13.1.1. Akshaya Jyothi programme inauguration

Fig.13.1.2. Field activities

2.MUKTHI Programme:

The primary objective of the program Mukti 2024 is active tuberculosis (TB) case finding among the whole population of Mathur Grama Panchayath irrespective of age. This initiative in Mathur Grama Panchayath of Palakkad district is conducted by Family Health Centre (FHC), Mathur along with Mathur Grama Panchayath. The program commenced on 21.08.2024 and concluded on 02.10.2024. Initially a meticulous action plan was devised by FHC Mathur. The program utilized the available human resources of FHC Mathur including Junior Health Inspectors (JHIs), Junior Public Health Nurses (JPHNs), Mid-Level Service Providers (MLSPs), Accredited Social Health Activists (ASHAs) and volunteers of the institution without disturbing their routine field activities. They were given their respective field areas for the efficient coverage of the population. A

meticulous training was conducted by the medical officers prior to the program and trained the field staff, ASHAs and volunteers. A questionnaire was prepared consisting of personal details, presumptive symptoms and associated illnesses. The data was entered in an excel sheet and a daily report was sent to the

District TB officer (DTO). Health workers conducted house to house surveys. The screening

process involved assessing symptoms such as cough > 2 weeks, evening rise of temperature, prolonged fever, significant weight loss and unexplained malaise in all age Groups. Special emphasis was given to the screening of vulnerable population, undernourished individuals, contacts of all pulmonary TB cases and old TB patients for the symptoms of presumptive TB.

Fig.13.1.3. Submission of action plan of Mukhti 2024

Fig.13.1.5. Inter sectoral meeting

Fig.13.1.4. Training program for field staff

Table 13.2.2. Snapshot Of Mukthi Programme

Mukthi programme conducted in Mathur Panchayat	•Total Houses: 7251
	•Total Houses screened: 7251
	•Total population: 27962
	•Population screened: 26092
	•Sample tested: 574
	*Positive: 7 Nos
(Source: District data)	

Table 13.2.3 provides a status report on the staffing for the National Tuberculosis Elimination Programme (NTEP), listing the sanctioned posts and the number of personnel currently in position across various roles.

Table 13.2.3. NTEP Human Resource

Name of Post	Sanctioned	In position
District TB Officer (DTO)	1	1 (In charge)
Consultant	1	Vacant
Jr. Consultant	1	1
Medical Officer Tuberculosis Elimination (MOTE)	7	7
STLS	7	7
STS	7	7 + 1 (NHM STS)1(PPM Co-ordinator -i/c)
TB Health Visitor	6	6
Pharmacist	1	1+1 (NHM)
Statistical Assistant	1	1

DR-TB & TB-HIV Co-Ordinator	1	1
Data Entry Operator	1	1
Accountant	1	1
(Source: District data)		

13.3. Progress in the Tuberculosis Eradication in the District

The district has been actively engaged in presumptive TB case testing through Microscopy, TrueNAT, and CBNAAT methods. The consolidated data for the years 2023, 2024, and 2025 is as follows:

- **Microscopy:**

  In 2023, a total of 20,381 presumptive TB cases were tested by microscopy, with 438 positives detected. In 2024, testing increased to 22,010 cases, though the yield reduced to 265 positives. By 2025, testing declined to 5,189 cases, with 49 positives identified. This indicates both a reduction in microscopy use and a lower contribution to overall case detection compared to molecular methods.

- **TrueNAT:**

  Use of TrueNAT showed a remarkable increase in 2024, with 22,694 cases tested and 709 MTB detections, compared to 4,695 tested and 313 detections in 2023. In 2025, the number of tests stood at 8,586, detecting 147 MTB cases. TrueNAT has become an important diagnostic tool, providing higher sensitivity than microscopy.

- **CBNAAT:**

  In 2023, 5,921 presumptive cases were tested using CBNAAT, detecting 564 MTB cases. The number tested in 2024 was slightly lower (5,604), with 365 positives. In 2025, 2,443 tests were conducted with 151 MTB detected. Despite fewer tests in 2025, CBNAAT maintained a significant contribution to MTB detection.

Table 13.3.1 shows the progress in the Tuberculosis eradication in the district from 2023-March 2025.

Table 13.3.1. Progress in the Tuberculosis eradication in the district

		2023	2024	2025	Jan 2025	Feb 2025	March 2025
Total number of Presumptive TB Tested by MICROSCOPY	Tested	20381	22010	5189	2164	1596	1429
	Positive	438	265	49	22	16	11
Total number of Presumptive TB Tested by TRUENAT	Tested	4695	22694	8586	3877	2592	2117
	MTB Detected	313	709	147	53	53	41
Total number of Presumptive TB Tested by CBNAAT	Tested	5921	5604	2443	892	901	650
	MTB Detected	564	365	151	46	57	48
Total	Tested	30997	50308	16218	6933	5089	4196
	Positive /MTB Detected	1315	1339	347	121	126	100

Table 13.3.2 show the number of CB-NAAT Testing conducted and the number of positive cases from 2020-2025.

Table 13.3.2 CB-NAAT Testing

Year	No. of tests conducted	Positive cases	Percentage
2020-21	4797	1037	22

2021-22	12012	1238	10
2022-23	15654	1338	9
2023-24	10616	1315	12
2024-25	28298	1339	5
(Source: District data)			

13.4. Challenges in NTEP

- Non-cooperation to treatment by the patients
- Staff shortage in the programme
- Lack of vehicle in the programme
- Migration of patients to other place/states leading to lost follow up
- Didn't pick up transfer out cases from our TU to other state TU
- Due to less transportation facility and lack of mobile /new telecommunication facilities in remote areas like Attappady and Parambikulam it is difficult to follow up patients.

13.5. Fund allocation for NTEP

The National Tuberculosis Elimination Program (NTEP) in Palakkad has seen a progressive increase in fund allocation over the past five years, reflecting the Government's continued commitment to strengthening tuberculosis control efforts. In the financial year 2020-21, the allocated amount was Rs. 74 lakh, which increased significantly to Rs. 108.85 lakh in 2021-22. This upward trend continued in 2022-23, with Rs. 128 lakh sanctioned for program activities. The highest allocation during this period was recorded in 2023-24, amounting to Rs. 137.50 lakh, indicating an intensified focus on eliminating tuberculosis. However, in 2024-25, there was a slight decrease in allocation to Rs. 126.71 lakh, which still represents a substantial investment in NTEP initiatives.

Table.13.5.1. Fund Allocation

Sl. No	Year	Amount (in lakhs)
1	2020-21	74
2	2021-22	108.85
3	2022-23	128
4	2023-24	137.50
5	2024-25	126.71
(Source: District data)		

CHAPTER 14

NATIONAL AIDS CONTROL PROGRAMME (NACP) IMPLEMENTATION

14.1. National AIDS Control Program (NACP) implementation

India's response to the HIV/AIDS epidemic was initiated in the form of sero-surveillance in 1985. While initial responses (1985-1991) focused on search for HIV in different population groups and locations, screening of blood before transfusion, and targeted awareness generation; the launch of National AIDS and STD Control Programme (NACP) in 1992 institutionalized the beginning of a comprehensive response to the HIV/AIDS epidemic in India. Thirty-five years since then, NACP has evolved as one of the world's largest programmes through five distinct phases. The first phase of NACP (1992-1999) focussed on awareness generation and blood safety. The second phase witnessed launch of direct interventions across the prevention-detection-treatment continuum with capacity building of States on programme management. The third phase (2007-2012) was story of scale-up with programme management decentralised up to the district level. The fourth phase (2012-2017) was a period of consolidation and enhanced Government funding. The NACP Phase-IV (Extension) was first approved for the period of 2017-2020 and then further extended for one more year i.e., 2020-21. The formulation of NACP Phase-V was necessitated by the need for continuous action and the vigil in the context of the country's commitment on ending the AIDS epidemic as a public health threat by 2030.

Overview of NACP Phase-V (2021-26)

NACP Phase-V is a Central Sector Scheme, fully funded by the Government of India, with an outlay of Rs 15471.94 crore. The NACP Phase-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010. The NACP Phase-V also aims to attain dual elimination of vertical transmission, elimination of HIV/AIDS- related stigma while promoting universal access to quality STI/RTI services to at-risk and vulnerable populations.

Goal 1: Reduce annual new HIV infections by 80%

Goal 2: Reduce AIDS-related mortalities by 80%

Goal 3: Eliminate vertical transmission of HIV and Syphilis.

Goal 4: Promote universal access to quality STI/RTI services to at-risk and vulnerable

populations

Goal 5: Eliminate HIV/AIDS-related stigma and discrimination.

14.2. Targeted Intervention projects in Palakkad

Table 14.2.1 Targeted Intervention

Indicator	FSW	MSM	TG	Truckers	Migrant
Total No. of TI Projects	1	1	1	1	1
Total registration till March 2025	1349	1576	106	9961	10494
New registration 2024-25	251	203	13	9961	6516
New registration for the 1st quarter	86	63	2	2500	1639
Total HIV screening during 2024-25	1803	2026	172	4774	3023
HIV Positive found	0	6	0	4	7
Total no. of alive HRG currently registered at ART Centres	0	6	0	3	7
Total HRG Positive currently on ART	6	16	1	3	7
Total STI screening during 2024-25.	3323	4290	224	6031	7179
STI cases diagnosed and treated	42	37	4	65	39
Total Syphilis screening during 2024-25	1752	1783	150	0	80
Syphilis positive cases	0	24	1	0	0
Source: KSACS data					

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

From April to March 2025, a total of 84,226 general clients were tested across ICTC, FICTC, CBS, and PPP, of which 97 were found positive, accounting for 0.11% (Table 14.3.1).

Table 14.3.1. General clients April-March 2025

ICTC	FICTC	CBS	PPP	TOTAL	General clients positive	% positive
48044	36182			84226	97	**0.12%**

In Palakkad district, 21,481 ANC clients were tested under ICTC, FICTC, and PPP, with 1 ANC positive case reported (Table 14.3.2).

Table 14.3.2. Prevention of Parent-to-Child Transmission of HIV

District	ICTC	FICTC	PPP	Total	ANC positive
Palakkad	7270	14211		21481	1

Under PALS, 102 cases (77 male and 25 female) were reported in 2023-24, and 97 cases (75 male and 22 female) in 2024-25 (Table 14.3.3).

Table 14.3.3 PALS Data

Year	Male	Female	Total
2023 -24	77	25	102
2024 -25	75	22	97

The implementation of the National AIDS Control Programme (NACP) in Palakkad district reflects steady progress in both prevention and care. Targeted Intervention (TI) projects have been effectively implemented across diverse high-risk groups, ensuring regular HIV/STI screening and treatment, though new case detection remains relatively low, indicating improved awareness and early prevention. Testing services for general clients have achieved wide coverage, with over 84,000 individuals screened during 2024–25, and the positivity rate remained low at 0.11%, suggesting successful containment of the epidemic. Efforts under Prevention of Parent to Child Transmission (PPTCT) also yielded positive results, with only one ANC case detected among more than 21,000 tested women, reinforcing progress towards the goal of eliminating vertical transmission. PALS data further indicates a decline in reported cases compared to the previous year, while blood safety continues to be ensured through adequate collection of 24,807 units in 2024–25**(Table 14.3.4)**. Overall, Palakkad district demonstrates a comprehensive and sustained response under NACP Phase-V, contributing to the national commitment of reducing new infections and AIDS-related deaths, while moving closer to the 2030 goal of ending AIDS as a public health threat.

Table 14.3.4. Blood Collection

Year	No of Blood Units Collected
2024-2025	24807

Annexures

ANNEXURES

Health Initiatives of Palakkad

1.PARIRAKSHA

The *Pariraksha* Cancer Screening Programme was inaugurated at Parali Community Health Centre (CHC) in Palakkad on January 22, 2024, and ran until March 31, 2024. This innovative district-level initiative aimed to educate the public on the symptoms of cancer, facilitate early diagnosis, and ensure timely treatment. Field health workers, including JHI, JPHN, MLSP, and ASHA, were trained to visit households and educate the public using pamphlets detailing cancer symptoms. Individuals showing any signs were encouraged to visit the nearest health centre. The campaign focused on individuals identified through the Shaili app for screening, who were then examined by Medical Officers (MOs). Those requiring further evaluation were referred to specialists at the sub-district level for sample collection and confirmation. During the campaign, a total of 8,308 persons were surveyed, 116 were screened by MOs, and 32 were referred to specialists. The programme demonstrated the importance of early diagnosis in improving treatment outcomes, reducing severity, and lowering healthcare costs. As a way forward, authorities proposed extending the campaign, revising the action plan, and improving the reporting mechanism to enhance efficiency and coverage in the future.

District level inauguration of Pariraksha Cancer Screening Programme

PHOTOGRAPHS

District map

Government Medical College Palakkad

District Hospital Palakkad

Government Tribal Speciality Hospital Kottathara

Government Taluq Headquarters Hospital Ottappalam

Government Taluq Headquarters Hospital Chittur

Government Taluq Headquarters Hospital Pattambi

Government Taluq Headquarters Hospital Mannarkkad

Government Taluq Headquarters Hospital Alathur

CHC Alanallur

CHC Koduvayur

CHC Chalissery

CHC Kadambazhippuram

CHC Koppam

CHC Kongad

CHC Kuzhalmannam

CHC Koduvayur

CHC Vadakkanchery

CHC Agali

FHC Mathur

FHC Kannambra

FHC Kuthannur

FHC Kottayi

FHC Kizhakkanchery

FHC Ozhalapathy

FHC Nalleppilly

FHC Vannamada

FHC Nelliyambathy

FHC Pallassana

FHC Ayilur

FHC Perumatty

FHC Elavanchery

FHC Pudunagaram

FHC Vandazhy

FHC Thenkara

FHC Kalladikkode

FHC Pudur

FHC Thachampara

FHC Kottoppadam

FHC Sholayur

FHC Kanjirappuzha

FHC Anakkatty

FHC Thachanattukara

FHC Karakkurissi

FHC Sreekrishnapuram

FHC Vallappuzha

FHC Nagalassery

FHC Nellaya

FHC Kumaranellur

FHC Thrikkadeeri

FHC Lakkidi

FHC Kappur

FHC Thirumittacode

FHC Kumbidi

FHC Adakkaputhur

FHC Vaniyamkulam

FHC Pokkottukavu

FHC Pattithara

FHC Vellinezhi

FHC Perur

FHC Melamuri

FHC Akathethara

FHC Marutharode

FHC Thenkurissi

FHC Peringottukurissi

FHC Muthalamada

FHC Pudusserry

FHC Pirayiri

FHC Polpully

FHC Kodumba

FHC Vadavannur

FHC Parambikkulam

FHC Peruvemba

FHC Mankara

FHC Malampuzha

FHC Kollengode

FHC Kannadi

UPHC Diara Street

UPHC Alankode

UPHC South Panamara

UPHC Koluppully

UPHC Vennakkara

BCC ACTIVITIES

IEC/BCC activities have been conducted every month for various health related programmes. Here the activities conducted in month of march 2025 has been listed below:

1.IEC-BCC WEEKLY REPORT MARCH 3rd – 7th 2025 PALAKKAD DISTRICT

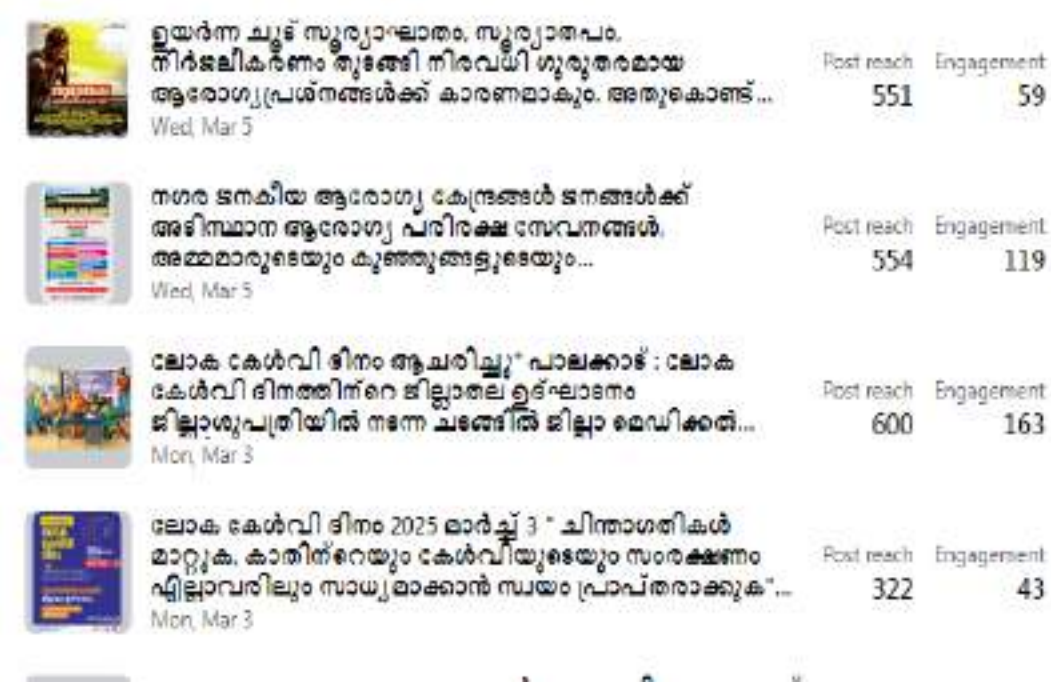
The first week of March 2025 witnessed the conclusion of the massive Cancer Campaign- 'Arogyam Anandham' that aims to detect cancer risk among the general public to ensure early treatment. And also the world Hearing Day Observance done along with a weeklong awareness campaign and many other ground level sensitization activities were also carried out.

Cancer screening camps conducted at various institutions

District Level inauguration of World Hearing Day 2025 held at District Hospital, Palakkad by DMO Dr. Vidhya K.R which was presided over by DH Superintendent Dr. P.K Jayasree

Orientation classes conducted by Audiologists for Nodal school teachers, Anganwadi workers and health staff, general public emphasizing the importance of care and treatment regarding hearing issues

Moreover, activities are being conducted district wide regarding the control and prevention of various communicable diseases. NCD Screening camps and one to one sensitization via field staff are also ongoing effectively. Social media intervention has also been doing well. WhatsApp communities and FB platforms use to be updated in regular intervals ensuring adequate reach of health awareness messages.



2.IEC-BCC WEEKLY REPORT MARCH 10th – 15th 2025 PALAKKAD DISTRICT

The first phase of the massive Cancer Campaign- 'Arogyam Anandham' which aims to detect cancer risk early to ensure timely treatment is concluded on 8th march with a remarkable mega cancer screening camp. Moreover the world Hearing Day was observed along with a weeklong awareness campaign progressing effectively and many other ground level sensitization activities were also carried out in the second week of March.

District Level Mega cancer screening camp inaugurated by Mr. Sethumadhavan, President, Palakkad Block Panchayath, Other LSGD representatives, officials, health staff and volunteers participated in the Programme

Breast and cervical cancer examination service provided to around 600 women and people with evident symptoms were referred to higher health facilities. Cultural programmes of staff and ASHA also held in connection with the programme.

Orientation classes conducted by Audiologists for Nodal school teachers, Anganwadi workers and health staff, general public emphasizing the importance of care and treatment regarding hearing issues

World Glaucoma Day observance District Level Programme conducted at THQH Alathur. Screening and awareness session carried out as part of the programme

Moreover, activities are being conducted district wide regarding the control and prevention of various communicable diseases. NCD Screening camps and one to one sensitization via field staff also ongoing effectively.NCD clinics conducted under various health institutions and awareness sessions about various life style diseases, TB Nikshay shivir mass campaign, Leprosy, Dengue fever, Cancer etc.

Social media intervention has also been doing well. WhatsApp communities and FB platform updated in regular intervals ensuring adequate reach of health awareness messages.

3.IEC-BCC WEEKLY REPORT MARCH 17th – 21st 2025 PALAKKAD DISTRICT

The district-level inauguration of the 'Arogya Tarangam' was performed by Palakkad District Panchayat President Binumol K. The health alert calendar was released and the epidemic awareness materials implemented in the district were released.

പകർച്ചവ്യാധി പ്രതിരോധം: മുൻപേ ഇറങ്ങി ആരോഗ്യവകുപ്പ്

പകർച്ചാവ്യാധി പ്രതിരോധ നിയന്ത്രണ ജില്ലാതല കർമപദ്ധതിക്ക് തുടക്കം

പകർച്ചവ്യാധി പ്രതിരോധ, നിയന്ത്രണ കർമപദ്ധതിക്ക് തുടക്കം മാധ്യമം 21-03-2025

The district-level inauguration of World Oral Health Day was held at District hospital by Deputy District Medical Officer Dr. Ahmed Afzal K. P. District Hospital Superintendent Dr. P. K. Jayashree presided over the function. An awareness session was conducted by Dr. Biniraj

സന്തുഷ്ട വദനം, സന്തുഷ്ട മനസ്സ്: ജില്ലാതല ഉദ്ഘാടനം നടന്നു

Social media intervention has also been doing well. WhatsApp communities and FB platforms use to be updated in regular intervals ensuring adequate reach of health awareness messages.

4.IEC-BCC WEEKLY REPORT MARCH 24th – 29th 2025 PALAKKAD DISTRICT

The District Level inauguration of World TB Day done by District Panchayath Health Standing Committee Chairperson A. Shabira at Koppam community hall. The function was presided over by Koppam Block Panchayat President Geetha Manikandan and welcomed by Deputy District Medical Officer Dr. Ahmed Afzal KP. Appreciation awards were distributed to the units that detected the highest number of TB cases at district level.

World TB day observance activities also held at periphery institutions. Inagural functions, rallies, street plays, oath taking and competitons for students are being carried out.

District specific massive campaign to battle communicable diseases 'Arogya Tarangam' progressing effectively. Panchayath Level inauguration and intersectoral meetings are ongoing dsitrictwide.

Control, prevention and awareness activities pertaining to various communicable diseases carried out district wide effectively

Social media intervention has also been doing well. WhatsApp communities and FB platform use to be updated in regular intervals ensuring adequate reach of health awareness messages.

എത്ര പനിയും എലിപ്പനിയാകാം ... ഡോക്സിസൈക്ലിൻ കഴിക്കാം എലിപ്പനിയെ പ്രതിരോധിക്കാം... പ്രതിരോധമാണ് പ്രധാനം ..... സ്വയം ചികിത്സ ആപത്ത്...
Sat, Mar 29

Post reach
181

ലോക ക്ഷയരോഗ ദിനത്തിന്റെ ജില്ലാതല ഉദ്ഘാടനം 2025 മാർച്ച് 24 തിങ്കളാഴ്ച രാവിലെ 10 മണിക്ക് കൊപ്പം വാസ് ഓഡിറ്റോറിയത്തിൽ വെച്ച് പാലക്കാട് ജില്ലാ പഞ്ചായ...
Mon, Mar 24

Post reach
465

ലോക വദനാരോഗ്യ ദിനത്തിന്റെ ജില്ലാതല ഉദ്ഘാടനം ജില്ലാ ആശുപത്രിയിൽ നടന്നു പരിപാടിയിൽ ഡെപ്യൂട്ടി ജില്ലാ മെഡിക്കൽ ഓഫീസർ ഡോ. അഹമ്മദ് അഫ്സൽ...
Thu, Mar 20

Post reach
455

മാർച്ച് 20 - ലോക വദനാരോഗ്യ ദിനം ' സന്തുഷ്ട വദനം സന്തുഷ്ട മനസ്സ് ' ജില്ലാതല ഉദ്ഘാടനം രാവിലെ പത്തിന് ജില്ലാ ആശുപത്രി, പാലക്കാട് #oralhealthawareness

Post reach
340

List of Contributors - District Health Intiative

Name of Officer/ Staff	Designation	Office (DMO/NHM)	Role in Preparation	Mobile Number	Email ID
Dr. Rosh T V	DMO and DPM (I/C)	DMO &NHM	Review & Monitoring	9946105488	dmo palakkad @gmail.com
Dr. Kavya Karunakaran	Dy. DMO, DSO	DMO	Review & Monitoring	9961488206	palakkadidsp @gmail.com
Dr. Anitha A.K	RCH Officer	DMO	Review	9946972837	rchpkd @gmail.com
Dr Sruthi V	JC-M&E (I/C), Block Epidemi-ologist	NHM	Data Compilation, Analysis , Drafting , editing, Documentation review and coordination	9496962930	sruthinhm 2024@ gmail.com
Mr Abhilash E M	Statistical Assistant	DMO	Data Drafting , Analysis , drafting , documentation and compilation	9895552492	abhi. edamana @gmail.com
Preetha N	JR CONSULTANT DOCUMEN TATION	NHM	Report writing, documentation and editing	9754640020	jcnrhmpkd 2015 @gmail.com
Dr. Geetha	DTO/ DACO	DTC	Review	9446228363	dtokeplk @rntcp.org
Dr. Rajalakshmi Aiyyappan	DLO	DMO	Review	8289880085	nleppalakkad @gmail.com

Name of Officer/ Staff	Designation	Office (DMO/NHM)	Role in Preparation	Mobile Number	Email ID
Dr. Anoob Razak	Ardaram Nodal Officer	DMO	Review	9264440490	aardram palakkad @gmail.com
Dr. Ahammed Afsal KP	Dy. DMO, NCD officer	DMO	Review	9446238577	ncdpalakkad @gmail.com
Mr SunilKumar	Cluster Programme Manager, DISHA	DTC	Review	9003458999	disha pkdksacs @gmail.com