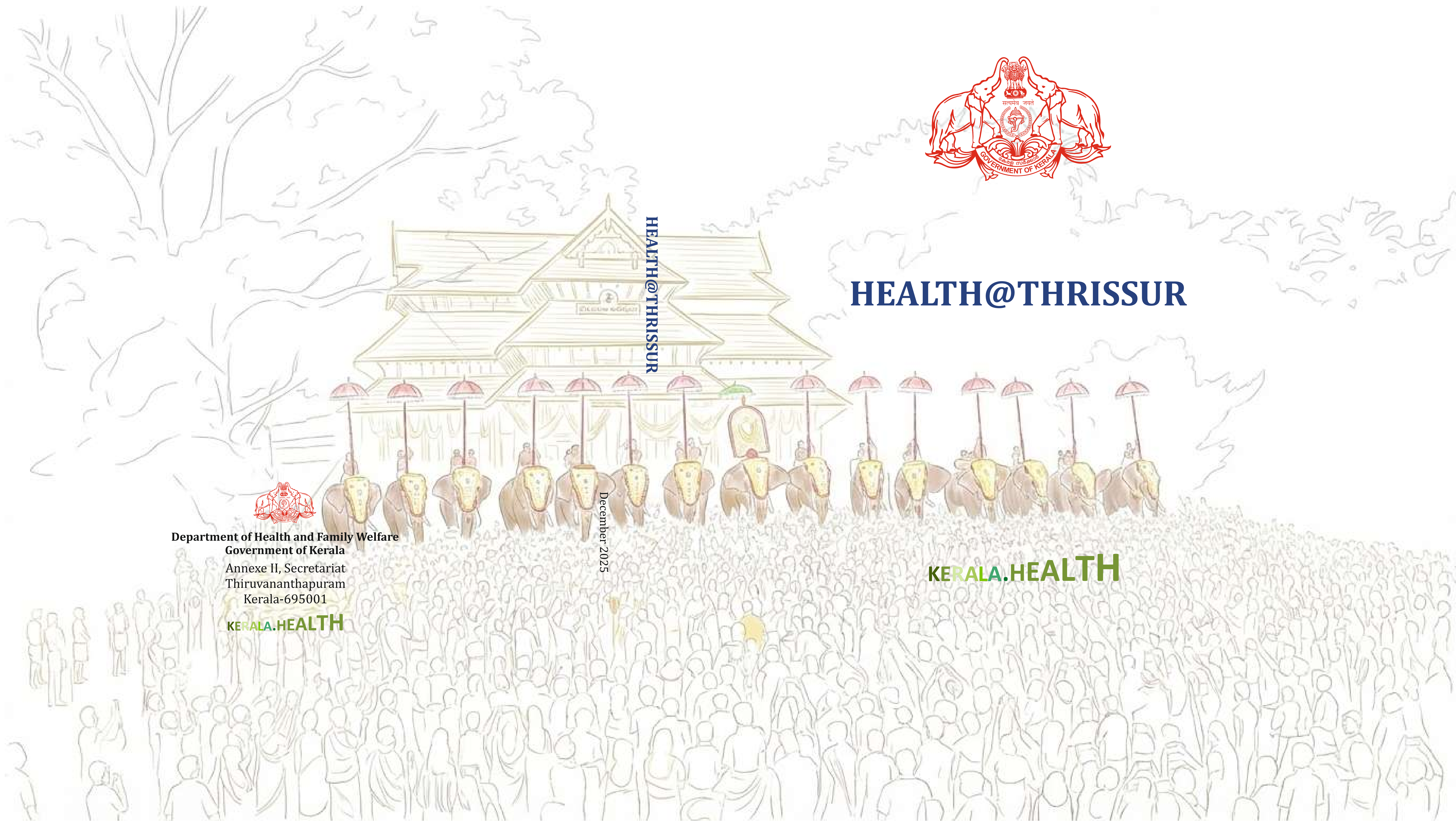

Department of Health and Family Welfare
Government of Kerala
Annexe II, Secretariat
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Kerala-695001

KERALA.HEALTH

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December 2025

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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

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Smt. Veena George

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

Message

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

I am delighted to see that the Department has brought out a comprehensive compendium to give information regarding the various health initiatives undertaken in the district of Thrissur. 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 Thrissur.

I appreciate the works done by the District Medical Officer, District Project Manager and health functionaries of Thrissur 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@Thrissur** 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@Thrissur** will be a resource book for health functionaries, researchers, students as well as to people to understand the developments in health sector in Thrissur. 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 Sreedevi T P, DMO Thrissur, Dr Sajeev Kumar, DPM Thrissur 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 Thrissur 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

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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 അഭിനന്ദനർഹമാണ്.

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

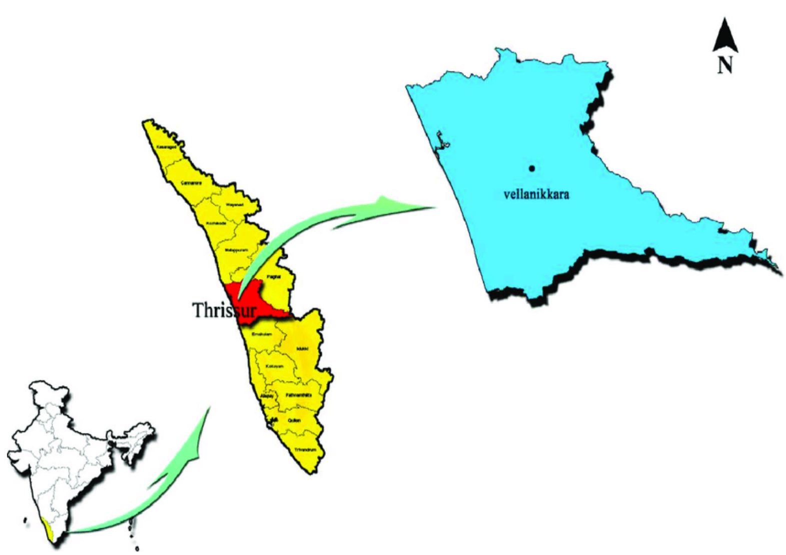
THRISSUR DISTRICT: AN OVERVIEW

1.1 Introduction

Thrissur, historically known as Trichur and Thrissivaperur, is one of the 14 districts in the southern Indian state of Kerala. It is situated in southwestern India (10.52°N 76.21°E) and is in the central part of Kerala. It is geographically bordered by Palakkad and Malappuram districts to the north, Ernakulam to the south, the Arabian Sea to the west, and the Western Ghats mountain range to the east. Spanning an area of approximately 3,032 km², the district is home to over three million people, giving it a high population density.

Thrissur holds the esteemed title of the "Cultural Capital of Kerala" due to its rich heritage and role as a centre for arts, religion, and literature. The district is renowned globally for the spectacular Thrissur Pooram, an annual temple festival, and houses major cultural institutions like the Kerala Kalamandalam, the Kerala Sahitya Akademi, and the Kerala Sangeetha Nataka Akademi. Its cosmopolitan history is significant, as places like Kodungalloor (Muziris) were ancient trade hubs that gave early shelter to diverse communities, including Christians, Jews, and Muslims, laying the foundation for a composite culture.

Figure 1.1.1 Thrissur District Map



1.1.1 Tourism

The district is a vibrant tourist destination, blending cultural landmarks with stunning natural beauty:

Figure: 1.1.2

Cultural & Religious Landmarks: The sacred Vadakkumnathan Temple, an architectural marvel and the centrepiece of the city, hosts the Thrissur Pooram. Other major religious sites include the famous Guruvayur Temple, the majestic Our Lady of Dolours Basilica (the third-tallest church in Asia), and the historic Cheraman Juma Masjid in Kodungalloor, which is believed to be the first mosque built in India.

Natural Wonders & Wildlife: The breathtaking Athirappilly and Vazhachal Waterfalls, often called "The Niagara of India," are major eco-tourism spots. The district is also home to the Peechi-Vazhani and Chimmini Wildlife Sanctuaries and scenic spots like Snehatheeram Beach and the Peechi Dam reservoir.

1.1.2 Economy Status

The economy of Thrissur is robust, diversified, and highly entrepreneurial, setting it apart as a major financial and commercial hub in Kerala.

- Gold & Jewellery: Thrissur is famously known as the "Golden City of India." It is a major manufacturing and retail centre for plain gold and diamond jewellery in South India, with numerous manufacturing units and a significant concentration of gold artisans. This industry is a massive employer in the district.

Banking and Finance: The district is a historic banking town, headquarters to prominent scheduled banks like the South Indian Bank, CSB Bank, and Dhanlaxmi Bank, as well as major Non-Banking Financial Companies (NBFCs). The finance and chit fund industries contribute significantly to its economic activity.

- Traditional Industries: Tile manufacturing (centred in areas like Ollur and Pudukad) and the Timber industry (benefitting from nearby forests) are century-old industrial pillars.
- Modern Industries: It houses major public sector undertakings and is emerging as a hub for the Ayurvedic drug manufacturing industry (e.g., Oushadhi) and the Information Technology (IT) sector, with an expansion of the Infopark.

1.1.3 Connectivity and Infrastructure

Thrissur benefits from its central position, ensuring excellent connectivity across Kerala and beyond, supported by continuous infrastructure development.

- Road Network: The district is well-connected by the National Highway 544 (NH 544), which runs through the city, providing vital links north to Palakkad/Coimbatore and south to Kochi. Major state highways further enhance intra-district connectivity.
- Rail Connectivity: Thrissur Railway Station is one of the busiest railway junctions in Kerala, situated on the main rail route connecting the north and south of the state and the rest of India.
- Air Connectivity: The nearest international airport is Cochin International Airport (CIAL) in Nedumbassery, Ernakulam district, which is approximately 50-60 km away.
- Infrastructure Development: Recent projects focus on urban mobility, including the construction of Road Overbridges (ROBs), road widening (like the Thrissur-Kuttippuram Road), and urban projects like the Thrissur Skywalk to enhance pedestrian safety and decongest traffic. Thrissur is also seeing growth in industrial infrastructure with multiple Industrial Estates and Development Plots under DIC and KINFRA.

1.1.4 Culture

Thrissur is rightly dubbed the Cultural Capital of Kerala ('Samskarika Nagari'), a status cemented by its historical significance, institutions, and world-renowned festivals.

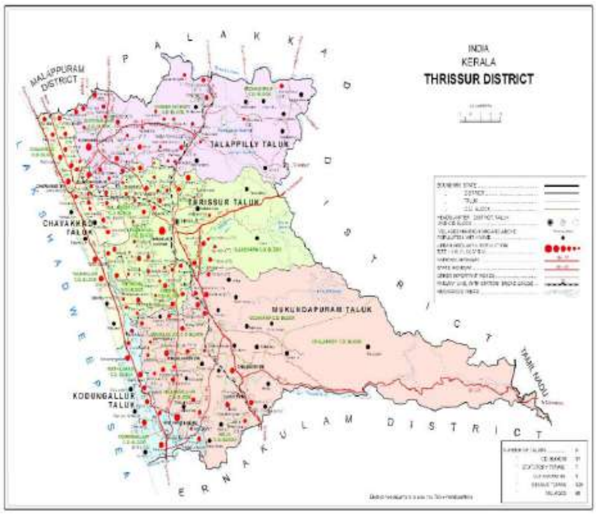
- Cultural Institutions: The city is home to the headquarters of three major state academies: the Kerala Sahitya Akademi (Literature), the Kerala Sangeetha Nataka Akademi (Music and Drama), and the Kerala Lalithakala Akademi (Fine Arts).
- Architecture and History: The city is built around the Vadakkumnathan Temple, a classic example of Kerala-style architecture. The modern layout of the city is attributed to Sakthan Thampuran, the Maharaja of Kochi, who shaped its commercial and cultural landscape.

1.1.5 Festivals and Traditions:

- Thrissur Pooram: This is the most famous and spectacular temple festival in Kerala, often called the "Mother of all Poorams." It is held annually in the Malayalam month of Medam (April/May) and features a grand assembly of over 50 decorated elephants, the dazzling Kudamattom (a parasol-changing ceremony), and a breathtaking fireworks display.
- Puli Kali (Tiger Dance): This is a vibrant folk art performed primarily in Thrissur during the Onam festival. Men paint their bodies like tigers and leopards and dance energetically to the beat of drums.
- Kodungallur Bharani: A significant and ancient annual festival celebrated at the Sree Kurumba Bhagavathy Temple in Kodungallur (Thrissur district), marked by the dance of Oracles (Velichappad).
- Christian Traditions: Thrissur is also a centre for the Syro-Malabar Catholic community, with the Buon Natale (Christmas) procession being a major event that once held a Guinness World Record for the maximum number of people dressed as Santa Claus.

1.2 Administrative Division

Figure 1.2.1 District Map



**Source: Census Handbook (2011)*

For healthcare governance, Thrissur is segmented into 17 health blocks, each responsible for coordinating and monitoring public health services within its jurisdiction. Administratively, the district is divided into 16 revenue blocks, facilitating effective management and local administration. Thrissur includes 1 municipal corporation, the Thrissur Municipal Corporation, which governs the urban core, and 7 municipalities that oversee smaller urban centers. In rural regions, governance is carried out through 86 Grama Panchayats, which form the base of decentralized administration and local development. Altogether, the district comprises 1,794 wards, each represented by an elected member, ensuring participatory governance at the community level. This comprehensive administrative framework reflects Thrissur’s commitment to decentralized planning, inclusive growth, and efficient public service delivery.

Figure 1.2.2 Administration Structure

Thrissur district is represented by 13 Assembly constituencies, namely Thrissur, Ollur, Guruvayoor, Chalakkudy, Kaipamangalam, Nattika, Kodungallur, Irinjalakuda, Puthukad, Manaloor, Kunnamkulam, Wadakkancheri, and Chelakkara. In addition, the major Parliamentary constituencies (Lok Sabha seats) that cover the Thrissur district are:

- Thrissur Lok Sabha constituency
- Chalakudy Lok Sabha constituency
- Alathur Lok Sabha constituency (Partially covers some areas in the district, such as the Chelakkara and Kunnamkulam assembly segments).

Table 1.2.1: Municipalities of the Thrissur District

1	Chalakudy Municipality
2	Chavakkad Municipality
3	Guruvayoor Municipality
4	Irinjalakkuda Municipality
5	Kodungalloor Municipality
6	Kunnamkulam Municipality
7	Wadakkanchery Municipality

**Source: District Report*

Table 1.2.2: Health Blocks

1.	Alappad Block
2.	Anandapuram Block
3.	Cherpu Block
4.	Elinjipra Block
5.	Erumappetti Block
6.	Mala Block
7.	Mattathur Block
8.	Mullasseri Block
9.	Ollur Block
10.	Perinjanam Block
11.	Puthenchira Block
12.	Tholur Block
13.	Vadakkekkad Block
14.	Vatanappilly Block
15.	Vellanikkara Block
16.	Pazhanji Block
17.	Pazhayannur Block

**Source: District Report*

1.3 Demographic Profile of the District

According to the 2011 Census, Thrissur has a population of 31,21,200 individuals, comprising 14,80,763 males and 16,40,437 females. The district records a sex ratio of 1107 females per 1000 males, higher than the state average, reflecting a relatively favourable gender distribution. The population density stands at 1026 persons per km^2, indicating a high concentration of people compared to many other districts. The district demonstrates remarkable achievements in human development indicators. The literacy rate is 95.32%, with male literacy at 96.98% and female literacy at 93.85%, showcasing minimal gender disparity in education. In terms of settlement distribution, 20,96,406 individuals reside in urban areas, while 10,24,794 live in rural regions, making Thrissur one of the more urbanized districts of Kerala.

1.3.1: Population Size and Density

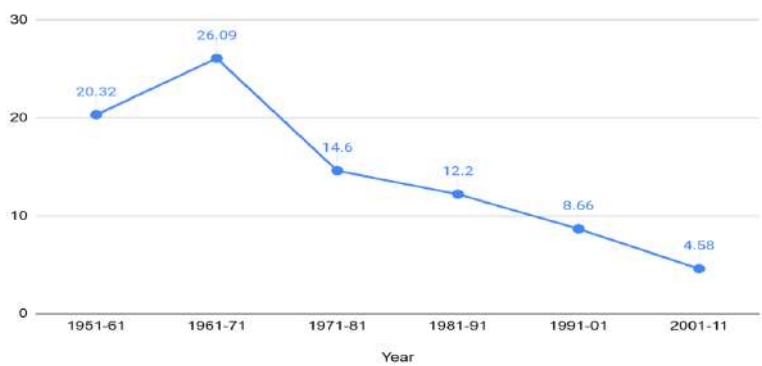
The population of Thrissur district has shown a consistent upward trend over the past century. From 683,266 persons in 1901, the total population rose steadily to 3,121,200 in 2011, marking more than a fourfold increase over 110 years. Both male and female populations have grown proportionally during this period — males increased from 341,020 in 1901 to 1,480,763 in 2011, and females from 342,246 to 1,640,437. The data reflects a progressive rise in the female population, indicating a favourable sex ratio and improvements in health and social conditions. The Compound Annual Growth Rate (CAGR) of the district's total population during 1901–2011 is estimated at 1.4 percent per annum. The male CAGR is 1.39 percent, while the female CAGR is slightly higher at 1.43 percent, signifying better female survival and demographic balance over time. This steady growth pattern demonstrates Thrissur's sustained socio-economic development, improved healthcare access, and overall demographic stability within the broader context of Kerala's demographic transition, characterized by declining fertility and enhanced life expectancy.

Table 1.3.1: Population Distribution of District (1911-2011)

Census Year	Total	Males	Females
1901	683,266	341,020	342,246
1911	769,702	383,182	386,520
1921	813,758	396,787	416,971
1931	993,913	479,089	514,824
1941	1,154,598	554,618	599,980
1951	1,403,150	666,464	736,686
1961	1,688,333	806,638	881,695
1971	2,128,877	1,022,814	1,106,063
1981	2,439,633	1,161,719	1,277,914

1991	2,737,311	1,312,683	1,424,628
2001	2,974,232	1,422,052	1,552,180
2011	3,121,200	1,480,763	1,640,437
**Source - Census of India (2011)*			

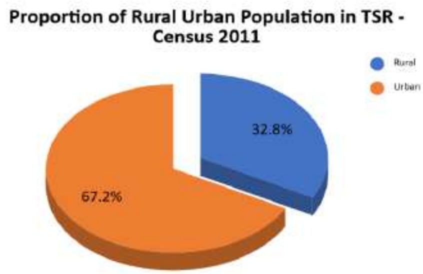
Graph 1.3.1: Decadal Population Growth of District



**Source: Census of India (2011)*

The decadal population growth rate of Thrissur district has shown a gradual declining trend over the years. During the 1951–61 decade, the district recorded a growth rate of 20.32 percent, which increased to 26.09 percent in 1961–71, marking the peak growth period. However, in the following, improved female literacy, effective family welfare measures, and enhanced access to healthcare services are achieved. The trend is consistent with the broader population stabilization observed across Kerala during the same period.

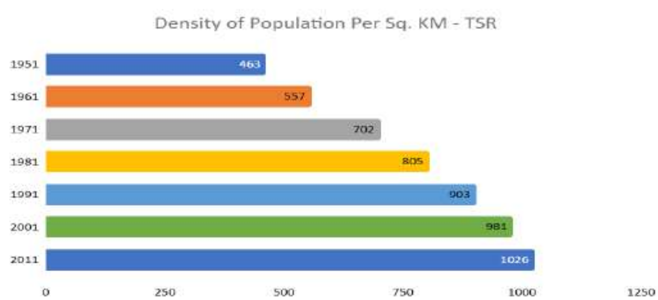
Graph 1.3.2: Density of Population per Sq. km in Thrissur (1951-2011)



**Source: Census of India (2011)*

Thrissur district's population density has followed a steady upward trend, increasing from 463 persons per sq. km in 1951 to 1,026 persons per sq. km in 2011. The most significant rise occurred between 1961 and 1971, reflecting rapid demographic growth during that decade. The overall increase over six decades highlights sustained population expansion, urbanization, and improved living conditions across the district.

Graph 1.3.3: Rural and Urban differences in Thrissur



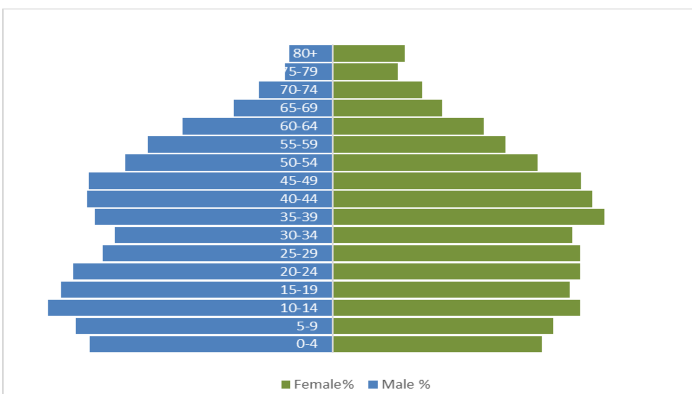
**Source: Census of India,2011*

Thrissur district exhibits a predominantly urban population, with 67.2% (2096406) of residents living in urban areas and 32.8% (1024794) residing in rural regions. This urban majority reflects the district's strong economic base, better infrastructure, and concentration of services around major towns and the Thrissur Municipal Corporation area.

1.4 Age and Sex Distribution

The age-wise distribution of Thrissur district's population reveals a relatively balanced demographic pattern, with a gradual decline in younger age groups and an increase in the older population. The 0–14 years group constitutes a smaller proportion, indicating a declining birth rate. The working-age population (15–59 years) forms the largest segment, reflecting a strong labour force base. Notably, the 60 years and above group accounts for 4,28,595 persons, highlighting a significant ageing population, with a higher proportion of females than males in older age brackets. Overall, the data suggest a demographically mature population structure with a shift toward ageing and reduced youth dependency.

Graph 1.4.1 Age and sex distribution of the Population



Source: Census of India,2011

The population pyramid of Thrissur district illustrates a narrow base and a wider upper segment, indicating a declining proportion of children and a growing elderly population. The working-age group (15–59 years) dominates the structure, reflecting a strong labour force. The female proportion exceeds males in older age groups, suggesting higher female longevity. Overall, the pyramid reflects a demographically ageing population, typical of regions with low fertility and improved life expectancy.

Table 1.4.1 Sex Ratio at Birth

Year	**Sex Ratio at Birth**
2020-21	955
2021-22	953
2022-23	951
2023-24	949
2024-25	998

**Source: HMIS*

The sex ratio at birth in Thrissur district has shown a fluctuating trend over the past five years. It declined gradually from 955 in 2020–21 to 949 in 2023–24, indicating a slight gender imbalance at birth. However, a notable improvement was recorded in 2024–25, with the ratio rising sharply to 998, suggesting progress toward achieving a more balanced sex ratio and improved awareness of gender equity in the district.

Table 1.4.2 Sex Ratio

Year	Sex Ratio
1991	1085
2001	1092
2011	1108

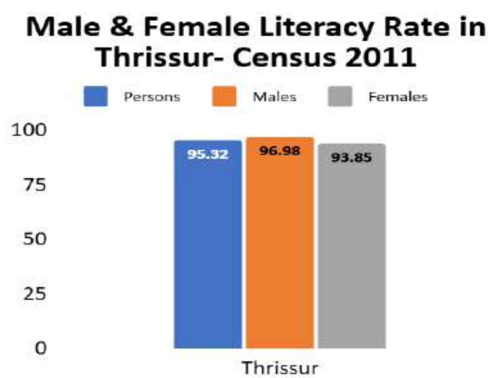
**Source: Census of India (2011)*

The sex ratio in Thrissur district has shown a consistent improvement over the past decades, rising from 1,085 females per 1,000 males in 1991 to 1,108 in 2011. This upward trend reflects the district's favourable demographic balance and progress in female survival, health, and social status, aligning with Kerala's overall pattern of gender equity.

1.5 Literacy rate

Thrissur district records a high literacy rate of 95.32%, with male literacy at 96.98% and female literacy at 93.85%. The narrow gender gap highlights the district's strong educational infrastructure and continued emphasis on universal education and gender equality in literacy.

Graph 1.5.1 Literacy Rate of Thrissur



**Source: Census 2011*

This bar chart illustrates the male and female literacy rates in Thrissur district as per the 2011 Census. The overall literacy rate stands at 95.32%, with male literacy at 96.98% and female literacy at 93.85%. The minimal gender gap in literacy reflects Thrissur's strong educational achievements and the district's emphasis on inclusive education and gender equality in learning opportunities.

1.6 Vulnerable Population Groups

In Thrissur district, the Scheduled Caste (SC) population comprises 3,24,350 persons, including 1,56,480 males and 1,67,870 females. The Scheduled Tribe (ST) population is comparatively small, totalling 9,430 persons, with 4,362 males and 5,068 females. Both groups show a higher proportion of females, consistent with the district's overall positive sex ratio.

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

	SC	ST	Total
Total	324,350	9430	333,780
Male	156,480	4362	160,842
Female	167,870	5068	172,938

**Source: Census 2011*

As per Census 2011, the Scheduled Caste (SC) population in Thrissur district is 3,24,350, while the Scheduled Tribe (ST) population is 9,430, together accounting for a total of 3,33,780 persons. Among them, 1,60,842 are males and 1,72,938 are females, indicating a higher female representation within these social groups, consistent with the district's favourable overall sex ratio.

CHAPTER 2

DISTRICT HEALTH DASHBOARD

District AT A GLANCE

Administrative Divisions

Thaluks –7

Villages –

Municipalities –

Corporations-1

Block-17

Panchayath-86

Grama Panchayath -

Population

Population As per Census 2011– 3121200

Male – 1480763

Female–1640437

Area

Total Area (Sq. K) – 3027

Population Density (No per Sq K) - 1026

Decadal Population Growth Rate - 4.58

Healthcare Infrastructure under DHS

District Level Hospitals

DH – 1

GH – 2

W&C – 0

3

Sub District Level Hospitals

THQH – 3

TH – 3

6

Community Health Centres

Total CHC – 24

Converted to FHC - 2

24

Primary Health Centres

Total PHC – 86

Converted to FHC –86

86

Janakeeya Arogya Kendram

Janakeeya Arogya Kendram

495

Other Institutions

School of Nursing –1

Training Center – 0

PH Lab – 0

DVC Units – 1

Offset Press - 0

Blood Bank –16

Public –2

Private -14

Blood Storage Unit –16

Reproductive, Maternal, and Child Health Services 2024-25

Pregnant Women Registration: 2024-25

25953

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

Pregnant Women- Anaemia 2024-25

30%

30% pregnant women were identified as anaemic through VIVA testing.

Rising C-Section Rates in the District 2024-25

46.15%

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

Maternal Deaths 2024-25

11

Total Maternal Deaths Reported in the District - 11

Preterm Births 2024-25

7.21%

The proportion of preterm births in the district -

Underweight Newborns 2024-25

11.8%

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

Delivery 2024-25

Institutional Delivery in the district – 26775

Public – 7719
Private – 19056

Home Delivery 2024-25

Home Delivery Reported in the district – 17

No. of Migrant Home Delivery -4

Live Birth 2024-25

Total Live Birth Reported– 27143
Male – 13827
Female – 13316
Sex Ratio at Birth - 998

CHILD IMMUNIZATION 2024-25

% Birth Dose

Hep B0 – 99

OPV 0 – 99

BCG-100

6 Weeks Vaccines Coverage (%)

OPV1 - 99

Pentavalent 1 - 99

Rotavirus 1 - 99

PCV1 -99

10 Weeks Vaccines Coverage (%)

OPV2 - 98

Pentavalent 2 - 98

Rotavirus 2 - 98

IPV 1 - 99

% 14 Week Vaccines

OPV3 -98

Pentavalent 3 98

Rotavirus 3 -9

IPV 2 -98

PCV2-97

% Children Fully Immunized

MR1 -98

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

MR 2 Coverage (%)

MR2 -96

Communicable diseases reported in the District 2024

Cases Reported

Dengue- 2162
Malaria- 114
Chikungunya- 0
West Nile-1
Zika- 0
JE- 0

17

Dengue Death

Cases Reported

Kala Azar-0
Scrub Typhus - 3
Leptospirosis- 413

41

Leptospirosis Death

Cases Reported

Cholera - 1
Typhoid- 8
Acute Diarrheal Disease -51989

0

ADD Death

Communicable diseases reported in the District 2024

Chicken Pox Cases- 2619

MPox Cases-1

2

Chicken Pox Death

Rabies Cases Reported- 1

Shigella cases- 6

Amoebic Meningo Encephalitis - 1

1

Rabies Death

Cases Reported

Hepatitis A -337

Hepatitis B-29

Hepatitis C-16

Hepatitis E - 1

5

Hepatitis A Death

CHAPTER 3

HEALTH INFRASTRUCTURE PROFILE OF THE DISTRICT

3.1 Details of Health Facilities in Thrissur

Thrissur district has a well-structured network of health facilities across various levels of care. Primary and community health services are provided through 11 24x7 PHCs converted to Family Health Centres (FHCs), 68 PHCs converted to FHCs, 7 Urban PHCs (UPHCs), 22 Community Health Centres (CHCs), and 2 CHCs converted to FHCs. Secondary and tertiary care are offered by 3 Taluk Hospitals (THs), 3 Taluk Headquarters Hospitals (THQHs), 1 District Hospital (DH), and 2 General Hospitals (GHs). Specialized services include 1 District TB Centre (DTBC), 1 Leprosy Hospital, 1 Mental Health Centre (MHC), 3 General Dispensaries (GDs), and 4 Mobile Health Units. Additionally, the district has 471 Janakeeya Arogya Kendras (JAKs) and 24 Urban Health & Wellness Centres (UHWCs), which extend outreach services to underserved areas.

Table 3.1.1 Number of Health Facilities in Thrissur

Type of Facility	No: of Institutions
24x7 PHC Converted to FHC	11
PHC Converted to FHC	68
UPHC	7
CHC	22
CHC Converted to FHC	2
TH	3
THQH	3
DH	1
GH	2
DTBC	1
General Dispensary	3
Leprosy	1
MHC	1
Mobile Unit	4
Grand Total	129
JAK	471
UHWC	24

**Source: District Report*

3.2 Availability of Specialized Centres

Thrissur district has one District Leprosy Hospital, one District Mental Health Centre, one Tuberculosis (TB) Centre, one Nursing School, and one District Vector Control Unit, ensuring the provision of specialized public health services and training facilities within the district.

3.3 Bed Strength in Different Health Facilities

The state has a total of 3,477 sanctioned beds across various healthcare facilities, of which only 2,235 beds are currently functional, indicating a significant shortfall in operational capacity. Community Health Centres (CHCs) have 820 sanctioned beds, but only 486 are functional, leaving 41% of beds non-operational, reflecting gaps in infrastructure, staffing, or resources. District Hospitals (DHs) report 642 functional beds against 573 sanctioned, suggesting slight over-utilization or temporary expansions. Primary Health Centres (PHCs) face a severe shortfall, with only 25 functional beds out of 372 sanctioned, highlighting major under-utilization and urgent need for improvements in inpatient services. Sub-District Hospitals (SDHs) have 732 functional beds compared to 691 sanctioned, indicating a relatively efficient use of capacity. Other health facilities have 350 functional beds out of 1,021 sanctioned, leaving 66% non-functional, suggesting substantial under-utilization. Overall, the state faces a gap of 1,242 (about 36% of sanctioned capacity) with the most critical deficits in PHCs and other facilities, emphasizing the need for targeted interventions to strengthen healthcare access and optimize existing resources.

Table 3.3.1 Bed Strength in Different Levels of Facilities

Type of Facility	Sum of Sanctioned bed	Sum of Functional Bed
CHC	820	486
DH	573	642
PHC	372	25
SDH	691	732
Others	1021	350
Grand Total	**3477**	**2235**

**Source: District Report*

3.4 Health Facilities in Rural and Urban Areas

The distribution of health facilities across rural and urban areas plays a crucial role in ensuring equitable access to healthcare services. Strategic placement of these facilities is vital for improving health outcomes, reducing travel and treatment delays, and strengthening the overall healthcare system by providing a continuum of care from primary to tertiary levels, particularly in underserved rural areas.

Table 3.4.1 Distribution of Health Facilities in Rural and Urban Areas

Type of Facility	Rural	Urban	Grand Total
CHC	23	1	24
DH		3	3
PHC	68	11	79
SDH	2	4	6
Others	3	3	6
Grand Total	96	22	118
SC	416	55	471

**Source: District Report*

Table 3.4.1 presents the distribution of health facilities across rural and urban areas in the district. Out of a total of 118 health facilities, the majority are located in rural areas (96 facilities) compared to 22 in urban areas. Community Health Centres (CHCs) are predominantly rural, with 23 out of 24 facilities situated in rural locations. District Hospitals (DHs) are entirely urban, with all three facilities located in urban centres. Primary Health Centres (PHCs) show a strong rural presence, with 68 out of 79 facilities in rural areas, while Sub-District Hospitals (SDHs) and other facilities are evenly distributed between rural and urban settings. Overall, this distribution highlights a greater concentration of health facilities in rural areas, reflecting the district's focus on ensuring accessibility of healthcare services to the rural population.

3.5 Ardram Status (2024-2025)

Under the Ardram Mission 2024–25, Thrissur district has made significant strides in upgrading its healthcare infrastructure. The conversion of primary-level institutions, particularly SCs to HWCs and PHCs to FHCs, has seen substantial completion, reflecting strong progress in strengthening primary healthcare services. While most of the first-phase conversions have been completed, several second- and third-phase projects are still underway. At higher-level institutions, including CHCs, taluk hospitals, district/general hospitals, and medical colleges, progress has been partial, with many projects in early phases or pending commencement.

Table 3.5.1provides details about the district's Ardram status:

Table 3.5.1 Ardram Status (2024-2025)

Type of Hospitals	Phases	Total Institutions	Work Completed	Work Progressing	Works to be started
SC to HWC	First phase	62	52	4	6
	Second phase	38	5	9	24
	Third phase	123	0	0	0
PHCs into FHCs	First phase	18	18	0	0
	Second phase	48	47	1	0
	Third phase	15	5	7	3
CHC to Block FHCs	First phase	7	5	1	1
	Second phase	9	1	4	4
OPs of District / General Hospitals	First phase	3	3	0	0

OPs of Taluk Hospitals	First phase	3	2	1	0
Medical Colleges	First phase	1	1	0	0

**Source: District Ardram Report (2024-25)*

In the SC to HWC conversion, most of the first-phase institutions (52 out of 62) have been completed, while 5 institutions from the second phase completed. But 123 of the third phase are yet to start. The PHC to FHC transformation shows remarkable achievement, with all 18 institutions in the first phase completed and 47 of 48 in the second phase upgraded, leaving only a few works pending in the third phase. In the CHC to Block FHC category, 5 of the 7 institutions in the first phase and 1 of 9 in the second phase have been completed, with several projects still in progress.

For higher-level institutions, OP conversions in district/general hospitals completed in all the 3 hospitals in the first phase, while the second phase is yet to commence. In taluk hospital OPs, 1 out of 3 in the first phase has been completed, and the rest are under progress, while the second phase has not yet started. In the case of medical colleges, one project completed under the first phase. Overall, the Ardram Mission 2024–25 reflects notable completion in primary health care transformation, especially at the PHC and SC levels, while progress in higher-level hospitals and later phases remains slower, requiring renewed focus for timely completion.

3.6 Delivery points

Delivery points in both public and private facilities play a key role in reducing maternal and neonatal morbidity and mortality, improving access to skilled care, and supporting the overall health infrastructure. Assessing the number and distribution of delivery points provides insights into the capacity of the district to provide comprehensive maternal care.

Table 3.6.1 Number of Delivery points in the District

Type of Facility	Public	Private
CHC	0	58
SDH	4	
DH/GH	3	
MCH	1	
Total	8	58

**Source: HMIS*

Table 3.6.1 shows the distribution of delivery points across public and private health facilities in the district. Community Health Centres (CHCs) are not delivery points. Private hospitals account for 58 delivery points, indicating a significant role of private sector in maternal services. 4 Sub-District Hospitals (SDHs), 3 District or General Hospitals (DH/GHs) and 1 Maternity and Child Health (MCH) centres are delivery points. Women and Child (W&C) facilities has not reported any delivery in the in the portal. This distribution with more private facilities for maternal care services, underscores the need to strengthen the government delivery services to ensure equitable access across the district.

3.7 Other Specialized Care Centers

Specialized health centres play a vital role in strengthening the healthcare system by providing advanced, targeted, and life-saving services that go beyond routine primary and secondary care. Facilities such as District Early Intervention Centres (DEICs), Neonatal Care Units, physiotherapy units, dialysis units, and specialized cardiac and stroke units ensure that patients receive timely and appropriate care for complex conditions. These centres are essential for reducing morbidity and mortality, improving quality of life, and supporting vulnerable populations such as newborns, patients with chronic diseases, and individuals requiring rehabilitation. The strategic development and accessibility of such centres contribute significantly to comprehensive healthcare coverage and enhance the overall resilience of the district health system.

Table 3.7.1 Number of other Specialised care Centers

Type of Health Facility	**No. of Facility** (31st march 2025)
DEIC	1
SNCU	2
NBSU	4
Physiotherapy Units	24
Dialysis Unit	11
Cath lab	1
Stroke unit	1

**Source: District Report*

As of 31st March 2025, the district has a range of specialized health facilities aimed at providing targeted and advanced medical care. There is one District Early Intervention Centre (DEIC) to support early detection and intervention for children with developmental delays and disabilities. Neonatal care is strengthened by 2 Special Newborn Care Units (SNCUs) and 4 Newborn Stabilization Units (NBSUs), ensuring specialized care for critically ill and premature infants. Rehabilitation services are supported by 24 physiotherapy units, while renal care is provided through 11 dialysis units. The district also has a single catheterization (Cath) lab and one stroke unit, highlighting the availability of specialized cardiac and neurological services. These facilities reflect the district's efforts to expand tertiary and specialized care alongside primary and secondary health services, improving access to advanced treatment for the population.

3.8 NQAS Accredited Facilities

The district has made significant progress in implementing the National Quality Assurance Standards (NQAS) to ensure high-quality healthcare services across its health facilities. Currently, 21 institutions have achieved NQAS accreditation, reflecting adherence to national benchmarks for service quality, patient safety, and facility management. In addition, one Primary Health Centre (PHC) has its assessment results awaiting final approval, and another PHC is scheduled for national assessment, indicating ongoing efforts to expand accreditation coverage. The implementation of NQAS standards strengthens the overall health system, promotes continuous quality improvement, and enhances patient trust and satisfaction.

Table 3.8.1 NQAS Accredited facilities (31st march 2025)

Type of Health Institution/Facility	Total number of Institution/Facility	State Certified	Nationally certified
DH	3	1	0
TH	6	0	1
CHC	22	0	1
PHC	69	15	12
UPHC	7	0	7
AAM-SC	471	0	0

**Source: District Report*

Thrissur district's health institutions exhibit varying levels of quality certification across different facility types. Among higher-level hospitals, 1 out of 3 district hospitals (DH) is state-certified, while none have national certification. Of the 6 taluk hospitals (TH), 1 has achieved national certification. For community health centres (CHCs), 1 facility holds national certification, with none certified at the state level. Primary health centres (PHCs) show stronger state-level recognition, with 15 certified, alongside 12 nationally certified. Urban primary health centres (UPHCs) have full national certification for all 7 facilities, whereas the 471 Ayushman Arogya Mandir-Sub Centres (AAM-SCs) remain uncertified. This distribution highlights focused quality recognition at PHC and UPHC levels, while many secondary and primary sub-centres await formal certification.

CHAPTER 4

HEALTH HUMAN RESOURCE PROFILE OF THE DISTRICT

4.1 Human Resource: Major Indicators

This section presents a comprehensive summary of the public health facility infrastructure and key health ratios for the district.

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

Indicator	Ratio
The bed population ratio (based on Census 2011 population)	1:898
The average Doctor bed ratio	1:67
Doctor population ratio (based on Census 2011 population)	1:6084

**Source: Census of India, 2011*

The ratios highlight the distribution of healthcare infrastructure and manpower. While the bed and doctor availability are improving indicators, the doctor-to-population ratio suggests that there is still scope for strengthening medical human resources to ensure adequate healthcare coverage.

4.2 Availability of Medical Officers

Medical officers are crucial to the healthcare system for several key reasons including, direct patient care, clinical supervision and Management, Public Health implementation, Administrative and policy roles, emergency responses etc. Essentially, they bridge the gap between clinical practice and administrative oversight, making them fundamental to both individual patient well-being and the overall health of a population.

Table 4.2.1 Availability of Doctors

HR Type	TSR
Doctors (Administrative Cadre)	19
Additional Director	1
Assistant Director	13
Deputy Director	3
JAMO	2

Doctors (General Cadre)	345
Assistant Surgeon	301
Civil Surgeon	33
Dental Assistant Surgeon	10
Dental Civil Surgeon	1
Doctors (Speciality)	149
Anaesthesia	12
Blood Bank	1
Dental	3
Dermatology & Venerology	6
ENT	9
Forensic Medicine	1
General Medicine	15
General Surgery	11
Obstetrics & Gynaecology	28
Ophthalmology	9
Orthopaedic Surgery	13
Paediatrics	18
Physical Medicine & Rehabilitation	2
Psychiatry	12
Radio Diagnosis/Radio Therapy	3
TB & Chest (Resp. Medicine)	6

** Source: District Report*

In Thrissur district, the General Cadre serves as the backbone of healthcare delivery, ensuring the continuity of essential services across facilities. The Specialist Cadre provides critical domain expertise in major medical disciplines, supporting both clinical decision-making and the provision of quality care. Administrative personnel contribute to effective leadership, monitoring, and supervision, enabling smooth functioning of the health system. However, Super Specialty positions remain limited, indicating a need to strengthen advanced care services to meet growing healthcare demands.

4.3 Sanctioned Strength of Health Personnel under DHS

The sanctioned strength (official, approved number of posts) of health personnel in a hospital is directly linked to ensuring safe, effective, and quality patient care based on its physical capacity and the complexity of services it offers.

This strength is not arbitrary; it is the mandated minimum required to match the hospital's infrastructure (like bed capacity) and the scope of its services (like specialties offered).

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

Category/Division	Number
Doctors (Administrative Cadre)	19
Doctors (General Cadre)	345
Doctors(Speciality)	149
NURSING SERVICE	714
JPHN to MCH Officer	604
JPHN/NURSING SCHOOL	9
DENTAL	12
LAB (GENERAL)	130
PHARMACY & MEDICAL SUPPLY	206
LEPROSY	2
PUBLIC HEALTH	485
TB	7
OPHTHALMOLOGY	27
TRANSPORT	1
OTHERS	1409
Grand Total	4119

**Source: District HR Report*

4.4 Health Human Resource under NHM

Under the National Health Mission (NHM), a total of 1,357 human resource positions are sanctioned, of which 1,284 (94.6%) are in place across different categories. The district shows strong HR positioning in several critical areas, with full staffing of ANMs, Pharmacists, AYUSH MOs, Dental Surgeons, Programme Managers, and DEIC staff, ensuring effective coverage of primary and community-level services.

Despite this, there are persistent shortages in specialist cadres, notably Obstetricians & Gynaecologists, Surgeons, Radiologists, Anaesthetists, and Paediatricians at urban health centres, which limits the scope of secondary-level care and increases dependency on higher facilities. Other significant gaps are seen in RBSK ANMs (82.3%), Staff Nurses (87%), Mid-Level Providers at Health & Wellness Centres (94.1%), and Urban Health & Wellness Centre nurses (61%). Additionally, specialist posts under elderly clinics and dental polyclinics remain vacant, further constraining service expansion under NHM.

In summary, while NHM HR deployment is strong at the primary care and programme management levels, the shortfall of specialists and select paramedical cadres, particularly under urban health services, continues to be a key bottleneck, requiring strategic recruitment and retention measures.

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

SL. No	STAFF	Sanctioned	In position
1	**Nurses and Paramedical Staff**		
	ANMs	24	24
	Staff Nurse existing	130	113
	Laboratory Technicians	24	22
	Other Technicians at DH (ECG/ ECO, EEG, Dermatology, Cyto, PFT etc.)	1	1
	Additional Other Technicians (CLMC Technician)	1	1
	Pharmacists	14	14
	Radiographer/ X-ray technician	1	1

	Physiotherapist/ Occupational Therapist	29	28
2	**Specialists**		
	Obstetricians and Gynaecologists	0	0
	Paediatricians	2	2
	Anaesthetists	1	1
	Surgeons	0	0
	Radiologists	0	0
	Pathologists/ Haemotologists	0	0
3	**Other Specialists**		
	Physician/Consultant Medicine	1	1
	Psychiatrists	1	1
	Others	1	1
	Others - New (Neurologist)	0	0
4	**Dental Staff**		
	Dental Surgeons	5	5
	Dental MO	0	0
5	**Medical Officers**		
	Full time	45	41
	Part time	0	0
6	**AYUSH Staff**		

	AYUSH Mos	54	54
7	**RBSK teams (Exclusive mobile health team & DEIC Staff)**		
	ANM	96	79
	Pharmacists	0	0
8	**DEIC**		
	Paediatrician	1	1
	MO, MBBS	1	1
	MO, Dental	1	1
	Staff nurse	1	1
	Physiotherapist	1	1
	Audiologist & speech therapist	1	1
	Psychologist	1	1
	Optometrist	1	1
	Early interventionist cum special educator	1	1
	Social worker	0	0
	Lab technician	1	1
	Dental technician	1	1
9	**Staff for Obstetric ICUs/HDUs**		
	Anaesthetists	1	0
	Medical Officers	0	0
	Staff Nurses	12	12

	Others	6	6
10	**Staff for MMU/ MHV**		
	Medical Officers (MIST & Endosulphan)	1	1
	Lab technician	1	1
	Others (JHI for MIST)	2	2
11	**Staff for Health & Wellness Centre (H&WC)**		
	Mid-level Service Provider	471	443
	Performance incentive for Mid-level service providers		
12	**Other Staff**		
	Counsellor	18	18
	Psychologist	0	0
	Microbiologists	2	2
	Audiometrician/ Audiologist	5	4
	TB Health Visitor	13	13
	Ophthalmic Assistant/ Refractionist	2	2
	Audiometrics Assistant	1	1
	Instructor for Hearing Impaired Children	1	1
	Medical Records Officer	2	2
13	**Support Staff for Health Facilities**		
	Hospital Attendant	1	1
	Sanitary Attendant	1	1

	Facility based Data Entry Operation (DEO)	12	12
14	**Programme Managers**		
	Nodal Officer HWC	1	1
	District Programme Manager	1	1
	District Accounts Officer	1	1
	MIS Assistant	1	1
	DEIC Manager	1	1
15	**Consultants/ Programme Officers**		
	ABMO	1	1
	AQAO	2	2
	JC (D&C)	1	1
	Additional - JC (M&E)	1	1
	District Engineer	2	2
16	**Programme Coordinators**		
	VCCM (Districts should not recruit this post)	0	0
	District PRO	1	1
	ARSH Co-ordinator	1	1
	ASHA Co-ordinator	1	1
	Palliative Co -ordinator	1	1
	Addl - CLMC Coordinator	1	1
	MIS/ IT Staff	0	0

	Supervisors	0	0
	Accounts Staff	2	2
	Administrative Staff	0	0
	Office Secretary	1	1
	DEO	0	0
	Data Entry Operation	4	4
	Support Staff	6	4
17	**District level HR under DCP**		
	Programme Managers/ Epidemiologists	1	1
	Adl Epidemiologists under XV FC	16	11
	Consultants/ Programme Officers/VBD Consultants	1	1
18	**Programme Coordinators**	**5**	**5**
	Sr Dots Plus TB HIV Supervisor	1	1
	Addl STS	1	1
	Addl STLS	1	1
	Addl District PPM Co Ordinator	1	1
	District Data Manager	1	1
	Adl Data Manager under XV FC	16	9
	Accounts Staff	1	1
	Data Entry Operation	3	3
19	**District level HR under NCD**	**3**	**3**

	Programme Managers	1	1
	Data Entry Operation	2	2
20	**Strengthening of Block PMU & Facilities**		**28**
21	**Block level HR under RMCH+A & HSS**		**28**
	PROs	30	29
	NUHM	0	0
	Human Resources	0	0
22	**ANMs/LHVs**		
	UPHC	35	32
	LHV	1	1
23	**Staff nurse**		
	UPHC	15	15
	Maternity Homes	0	0
24	**Lab Technicians**		
	UPHC	7	7
	Additional LT	0	0
	Total LT in UPHC	7	7
25	**Pharmacists**		
	UPHC	7	7
	Addl Pharmacists	0	0
	Total Pharmacists in UPHC	7	7

26	**Specialists (at UCHC)**		
	Obstetrician / Gynaecologist	0	0
	Paediatrician new	0	0
	Anaesthetist	0	0
	Surgeon	0	0
	Pathologist	1	1
	Radiologist	0	0
	Other Specialists	3	1
27	**Dental Staff**		
	Dentists	2	2
28	**Medical Officers**		
	MO at UPHC		0
	Full-time	7	7
	Part-time	7	6
29	**Support Staff for Health Facilities**		
	Support Staff for UPHC	7	7
	Total Support Staff for UCHC	0	
	Additional DEO cum Accountant	0	0
	Human Resources	2	1
Support Staff for XV FC Grants		0	0

	Specialist for Poly Clinic	10	5
Urban Primary Health Unit(UPHU)			
	Epidemiologist for UPHU	1	0
	Data Manager for UPHU	1	0
Elderly Clinic			
	Specialist for Elderly Clinic	1	0
	Staff Nurse for Elderly Clinic	1	0
Poly Dental Clinic			
	Dental specialist for Dental poly clinic	1	0
	Dental Technician for Dental poly clinic	1	0
360 degree NCD care			
	Staff Nurse for 360 degree NCD care	2	0
UHWC			
	Medical Officer for UHWC	27	24
	Staff Nurse for UHWC	54	33
	MPW for UHWC (Pharmacist)	27	24
	MPW for UHWC (Accountant)	10	10
	Cleaning staff for UHWC	0	0
	JHI	10	10
Total		**1357**	**1284**

**Source: District Report, NHM HR Report*

4.4.2 ASHA workers

A total of 2,289 Accredited Social Health Activists (ASHAs) are in position across the district. Of these, 2,007 are deployed in rural areas, 257 in urban areas, and 25 in hamlets. This distribution reflects a strong rural focus, ensuring last-mile connectivity in villages, while also addressing service needs in urban slums and marginalized hamlet populations.

Table 4.4.2.1 ASHA force of district for year 2024-2025

TOTAL NUMBER OF ASHAs	2289
RURAL	2007
URBAN	257
HAMLET	25

**Source: District ASHA Report*

CHAPTER 5

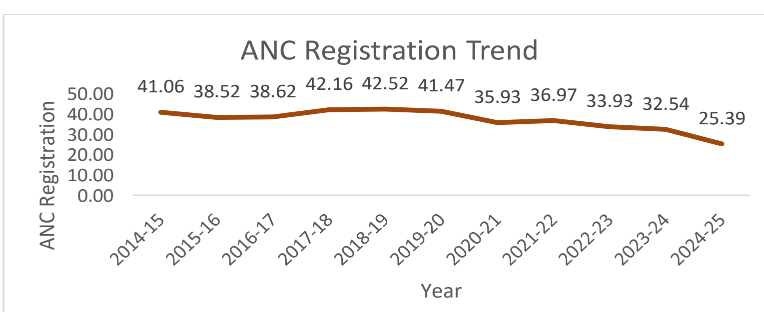
MATERNAL AND CHILD HEALTH AND DISEASE STATUS

In this section, we present a detailed overview of key maternal and child health indicators in Thrissur district. The section covers trends and data on pregnant women registration, early initiation of antenatal care, immunization status of pregnant women, abortion trends, family planning uptake, delivery patterns, caesarean section rates, maternal deaths, childbirth trends, infant and child mortality, and child immunization coverage. Each table and graph provides insights into the district's performance over the period 2014–15 to 2024–25, highlighting areas of progress, ongoing challenges, and critical interventions required to strengthen maternal and child health services. The data sources include HMIS and RCH records, and the accompanying descriptions summarize the trends, enabling a comprehensive understanding of health service utilization and outcomes in the district.

5.1 Pregnant Women Registration

This registration enables timely access to antenatal services, including routine check-ups, laboratory investigations, nutritional supplements, and counselling, while also helping to identify high-risk pregnancies early. ANC registration is a critical indicator under maternal health programmes, as it ensures systematic tracking of pregnant women, continuity of care, and monitoring of pregnancy outcomes, thereby contributing to reductions in maternal and neonatal morbidity and mortality.

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



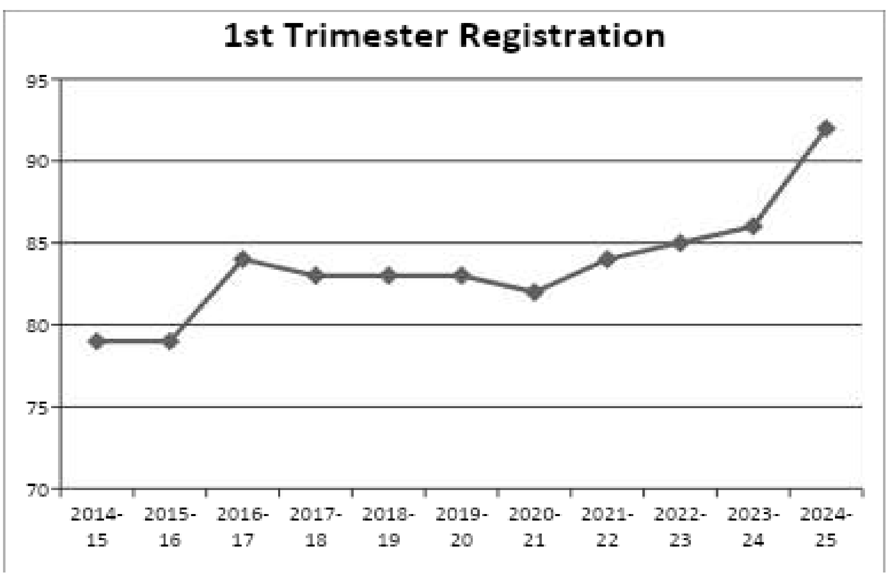
**Data Source: HMIS*

The trend of ANC (Antenatal Care) registration over the last decade shows a gradual decline after an initial period of stability and moderate growth. The most significant decline is observed in the last two years (2023–24 to 2024–25), suggesting possible factors such as reduced service accessibility, data reporting issues, or decreased awareness among beneficiaries.

5.2 Early Initiation of Antenatal Care

The need for early registration of pregnancy for Antenatal Care (ANC) is vital for ensuring the health and well-being of both the mother and the baby. Helps detect high-risk conditions such as anaemia, hypertension, diabetes, or infections at an early stage, allowing timely management and referral, timely initiation of essential services, accurate estimation of gestational age, health education and counselling etc.

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



**Data Source: HMIS*

The trend of first-trimester registration shows a consistent improvement in early antenatal care (ANC) initiation among pregnant women over the last decade. A significant increase to 92% in 2024–25 marks the highest rate in the decade, highlighting effective community outreach, improved health system responsiveness, and better awareness among beneficiaries about the importance of early ANC registration.

5.3 Immunization Status of Pregnant Women

The need for the Td vaccine in pregnant women is primarily for protection against tetanus and diphtheria for both Mother & baby. Td1 is provided as soon as possible, early in pregnancy (ideally after the first trimester). Td2 is provided at least 4 weeks after Td1. Td booster is provided if the women got pregnant within 3 years after last delivery. Generally, the schedule is designed to ensure the mother has protective antibodies that can pass to the newborn to prevent neonatal tetanus.

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

District	No. of PW registered for ANC	No. of PW given Td1	No. of PW given Td2	No. of PW given Td Booster
Thrissur	25391	23048	19224	1869

**Source: HMIS*

5.4 Abortion

An abortion is the termination of a pregnancy. It is broadly classified into two main categories: Spontaneous Abortion (commonly known as miscarriage) and Induced Abortion (the intentional termination of a pregnancy).

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

Year	PW Registered	Total (spontaneous + Induced)	spontaneous	Induced
2014-15	41060	1148	1080	68
2015-16	38521	934	851	83

2016-17	38620	1172	1129	43
2017-18	42164	1927	1193	734
2018-19	42524	1913	1210	703
2019-20	41468	1733	1106	627
2020-21	35925	1758	1179	579
2021-22	36971	1811	1132	679
2022-23	33927	1950	1141	809
2023-24	32542	2419	1007	1412
2024-25	25391	2716	1038	1678

**Source: HMIS*

The overall upward trend in the total number of abortions and the abortion rate is almost entirely attributed to the significant and sudden increase in the number of induced abortions starting in 2017-18, transforming the landscape of abortion services over the decade.

5.5 Family Planning

Family planning is the process by which individuals and couples decide on the number, timing, and spacing of their children and use contraceptive methods to achieve this. It involves the use of reversible or permanent methods to prevent or delay pregnancy, or to achieve pregnancy for those who are experiencing infertility. Family planning is crucial in the current era for achieving individual well-being, public health goals, and sustainable global development.

Table 5.5.1: Male and Female Sterilizations Reported in HMIS (2014-15 to 2024-25)

Period	**NSV**	**Laparoscopic sterilizations**	**Mini-lap sterilizations**	**PPS**	**Post Abortion Sterilization**
2020-21	2	372	450	3460	33
2021-22	33	682	574	3810	43

2022-23	72	1271	718	3320	58
2023-24	70	1175	543	3153	145
2024-25	95	1050	328	2922	86

**Source: HMIS*

The data reflects a strong and balanced mix of sterilization methods, with PPS and laparoscopic sterilizations leading, NSV showing promising growth, and mini-lap methods gradually declining. The pattern indicates both expanding service accessibility and diversification of family planning options for clients.

Table 5.5.2: IUCD Insertions Reported in HMIS (2014-15 to 2024-25)

2020-21	IUCD	2293
	PPIUCD	67
	PAIUCD	6
2021-22	IUCD	2527
	PPIUCD	39
	PAIUCD	3
2022-23	IUCD	2976
	PPIUCD	109
	PAIUCD	37
2023-24	IUCD	2809
	PPIUCD	127
	PAIUCD	13
2024-25	IUCD	2880
	PPIUCD	166
	PAIUCD	77

**Source: HMIS*

All three IUCD methods exhibit a positive trend over the years, with notable gains in postpartum and post-abortion insertions. This suggests enhanced service delivery, better counselling, and increased acceptance of long-acting reversible contraception methods among women.

Table 5.5.3: Distribution of Family Planning Commodities (Public Sector)

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	8305	60661	626	536
2021-22	5181	75152	571	583
2022-23	7888	114168	599	403
2023-24	5898	192866	1045	397
2024-25	11538	260215	2804	956

** Source: HMIS*

Across the five-year period, there is a positive growth in the distribution of all major family planning commodities, particularly condoms and Centchroman pills. The data suggests improved outreach, accessibility, and acceptance of contraceptive methods, contributing to the strengthening of family planning services and reproductive health initiatives.

5.6 Delivery

Table 5.6.1: Trends in Home and Institutional Deliveries (2014-15 to 2024-25)

Year	Public	Private	Home Delivery	Total Delivery	% of Home Delivery
2020-21	11503	26547	19	38069	0.05
2021-22	12618	26233	18	38869	0.04
2022-23	11902	24445	17	36364	0.04
2023-24	9953	21559	14	31526	0.04
2024-25	7719	19056	15	26790	0.05

**Source: HMIS*

From 2020–21 to 2024–25, both public and private institutional deliveries have declined, leading to a notable drop in total deliveries. Despite this, the proportion of home deliveries remains negligible, signifying sustained success in institutional delivery initiatives. The overall downward trend in delivery may be attributed to decreasing birth rates, improved family planning uptake, and demographic transitions in the region.

5.7 Caesarean Section Deliveries

Table 5.7.1: C-Section Rate in Public and Private Hospitals (2014-15 to 2024-25)

Year	Public	Private	C-Section Rate
2020-21	42.4	44.5	43.9
2021-22	43.1	42.5	42.7
2022-23	43.6	43.5	43.5
2023-24	46.5	44.0	44.8
2024-25	46.5	46.0	46.2

**Source: HMIS*

Between 2020–21 and 2024–25, both public and private institutions experienced an upward trend in caesarean section rates, with the overall rate increasing by about 2.3 percentage points.

5.8 Maternal Deaths

A maternal death is defined by the World Health Organization (WHO) as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

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

Year	Maternal Death
2014-15	12
2015-16	14
2016-17	10
2017-18	12
2018-19	15
2019-20	6
2020-21	9
2021-22	22
2022-23	10
2023-24	6
2024-25	11

** Source: District Report*

From 2014–15 to 2024–25, maternal deaths exhibit a fluctuating but gradually increasing trend, with periodic rises followed by reductions. The overall pattern indicates strengthening of maternal health care systems, particularly after 2021–22, with improved outcomes and possibly better emergency obstetric management and surveillance mechanisms.

5.9 Child Birth

Childbirth is a fundamental demographic and health event, the successful outcome of which—the survival and well-being of the mother and infant—is a core objective of the public health system. Data related to childbirth, including live births, maternal death**s**, and infant mortality, form the basis of vital statistics. These statistics are crucial indicators for assessing the health status of a community and the effectiveness of a state's healthcare delivery system.

Table 5.9.1: Trend of Live Births by Gender (Male, Female & Total) – 2014-15 to 2024-25

Year	Male	Female	Total
2014-15	23	22.056	45.056
2015-16	21.982	21.208	43.19
2016-17	21.438	20.2	41.638
2017-18	21.635	21.126	42.761
2018-19	22.337	21.479	43.816
2019-20	21.569	20.561	42.13
2020-21	19.747	18.868	38.615
2021-22	20.222	19.268	39.49
2022-23	18.959	18.025	36.984
2023-24	16.378	15.535	31.913
2024-25	13.827	13.316	27.143

**Source: HMIS*

Between 2014–15 and 2024–25, the total number of live births has shown a clear downward trend, reflecting declining fertility rates and demographic transition in the region. Both male and female births have decreased proportionally, indicating sustained progress in population stabilization efforts and strengthened family planning interventions**.**

5.10 Infant and Neonatal Mortality

Monitoring infant mortality and neonatal mortality are essential for ensuring child survival, guiding health policies, and measuring social progress. It serves as a sensitive barometer of public health success and helps direct efforts toward achieving sustainable development goals related to maternal and child health.

Table 5.10.1: Number of Neonatal Deaths Reported (2014-15 to 2024-25)

Year	**Neonatal Death**
2014-15	133
2015-16	143
206-17	122
2017-18	121
2018-19	129
2019-20	102
2020-21	118
2021-22	122
2022-23	136
2023-24	106
2024-25	95

**Source: HMIS*

The long-term trend shows a gradual decline in neonatal mortality, reflecting progress in maternal and child health services, institutional deliveries, and newborn care facilities in the district.

Table 5.10.2: Number of Infant Deaths Reported (2014-15 to 2024-25)

Year	Infant death
2014-15	192
2015-16	201
206-17	194
2017-18	176
2018-19	203
2019-20	164
2020-21	166
2021-22	162
2022-23	189
2023-24	164
2024-25	127

**Source: HMIS*

The data indicates a gradual and sustained decline in infant mortality over the last decade, reflecting effective implementation of child health programs**,** strengthened facility-based newborn care, and enhanced community-level follow-up of high-risk infants in the district.

Table 5.10.3: Number of Child Deaths (Under 5) Reported (2014-15 to 2024-25)

Year	Child Death
2021-22	178
2022-23	226
2023-24	190
2024-25	157

Data Source: HMIS

The overall trend over these four years shows progressive reduction, suggesting enhanced child healthcare services, immunization coverage, and early disease management in the district.

Table 5.10.4: Infant and Neonatal Mortality Rates in Kerala (2019-20 to 2024-25)

Year	Indicator	Rate
2019-20	IMR	4
	NMR	2
2020-21	IMR	4
	NMR	3
2021-22	IMR	4
	NMR	3
2022-23	IMR	5
	NMR	4
2023-24	IMR	5
	NMR	3
2024-25	IMR	5
	NMR	3

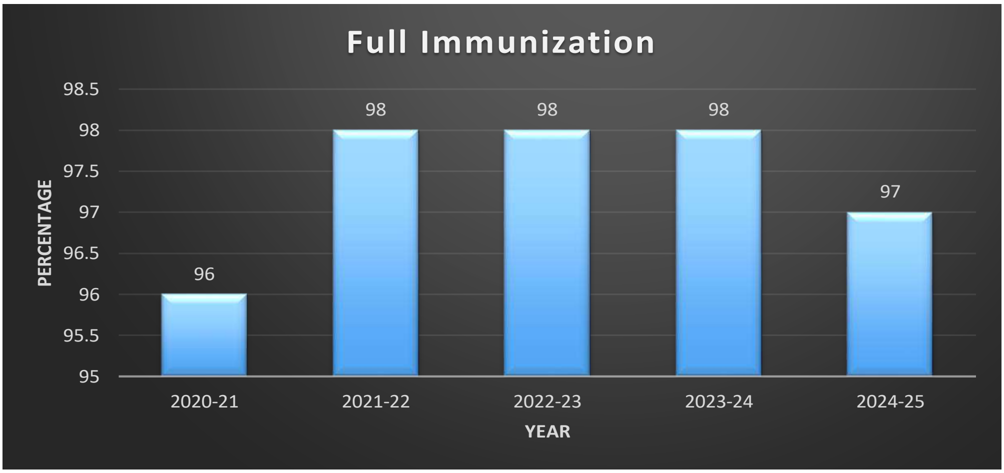
**Source: HMIS*

Both IMR and MMR show small fluctuations over the six years. 2022–23 saw a peak in both rates, possibly due to higher-risk pregnancies, delayed care, or external health factors. Stabilization in 2023–24 and 2024–25 suggests strengthened maternal and child health interventions**,** though continued efforts are needed to reduce both rates further.

5.11 Child Immunization

Immunization is a cornerstone of child health services, aiming to prevent vaccine-preventable diseases and reduce under-five morbidity and mortality. The district has consistently demonstrated high immunization coverage, maintaining rates above 94% and surpassing the national average while aligning with the Universal Immunization Programme (UIP) target of >95%.

Graph 5.11.1: Trend in Percentage of Children Fully Immunized



**Source: HMIS*

The district has maintained high immunization coverage, consistently above 95% over the five-year period.

Table 5.11.1: Antigen-wise Immunization Coverage

Antigen	**Coverage**
BCG%	100
OPV0%	99
HEP Birth dose %	99
OPV1%	99
OPV2%	98
OPV3%	98
MR1%	98

Full Immunization	97
PENTA1%	99
PENTA2%	98
PENTA3%	98
Rota1%	99
Rota2%	98
Rota3%	98
IPV1%	99
IPV2%	98
PCV1%	99
PCV2%	97
PCVB%	96
MR2%	96

Data Source: RCH Portal

All vaccines, including various doses of OPV, PENTA, Rota, IPV, and PCV, show coverage rates between 96% and 100%. This level of performance suggests a robust and highly effective immunization programme. The BCG vaccine (for Tuberculosis) achieved 100% coverage. The lowest coverage rate recorded is 96%, shared by PCVB and MR2 (Measles-Rubella, Dose 2). These are the only two antigens below 97%. The Full Immunization rate stands at 97%. This is a critical indicator, as it reflects the percentage of children who have completed all recommended vaccine doses by a certain age. Achieving 97% is an excellent result and is only slightly lower than the coverage for individual initial doses.

CHAPTER 6

COMMUNICABLE AND NON-COMMUNICABLE DISEASES

6.1 Disease Burden Overview: Common Communicable Diseases

The district exhibits the presence of both endemic and outbreak-prone diseases. Vector-borne and water-borne diseases such as Dengue, Leptospirosis, Malaria, and Acute Diarrheal Disease constitute the major disease burden, stressing the need for preventive measures, vector control, and community awareness. Viral hepatitis and influenza outbreaks indicate the importance of vaccination and surveillance. Sporadic cases of emerging infections highlight the need for continued vigilance and rapid response mechanisms. Overall, the trends underscore the importance of strengthening public health interventions, improving reporting mechanisms, and ensuring timely response to both endemic and epidemic-prone diseases.

6.1.1 Communicable Diseases- Cases Reported

The district has experienced notable variations in the incidence of communicable diseases over the past five years. Among vector-borne diseases, Dengue Fever remains a major public health concern, with cases rising sharply from 143 in 2020 to 2,162 in 2024, showing a significant upward trend. Malaria incidence has increased moderately over the same period, reaching 114 cases in 2024, while Chikungunya has remained negligible with very few cases reported. Leptospirosis cases have also shown a rising trend, from 43 in 2020 to 413 in 2024, indicating seasonal and environmental vulnerability.

Viral hepatitis shows variation across types: Hepatitis A has increased substantially, with 337 confirmed cases in 2024, whereas Hepatitis B and C remain relatively low, and Hepatitis E cases are almost negligible. Other water- and food-borne diseases, such as Acute Diarrheal Disease (ADD), continue to contribute the highest burden, with 51,989 cases reported in 2024, highlighting ongoing challenges in sanitation and safe water access. Typhoid and Shigella remain sporadic but persistent.

Respiratory illnesses, particularly Influenza (H1N1, H3N2, Infl A, Infl B), show a sharp increase in 2024 (1,441 cases), indicating heightened surveillance or outbreak activity. Chickenpox incidence has also risen significantly, reaching 2,619 cases in 2024. Other emerging or high-risk diseases, including Rabies, West Nile Virus, Scrub Typhus, Kala Azar, and Nipah, are either low in incidence or not reported, reflecting effective containment or low prevalence in the district.

Table 6.1.1 Number of Reported Cases of Communicable Diseases in the District (2020–2024)

Sl No	Name of Diseases	2024	2023	2022	2021	2020
1	Dengue Fever: Confirmed	2162	1972	213	299	143
2	Malaria	114	90	66	25	33
3	Chikungunya	0	1	1	4	0
4	Acute Encephalitis Syndrome	0	0	0	0	0
5	Japanese Encephalitis (JE)	0	0	0	0	0
6	Leptospirosis: Confirmed	413	184	174	53	43
7	Hepatitis - A : Confirmed	337	44	15	4	46
8	Hepatitis - B	29	7	25	21	17
9	Hepatitis - C	16	5	7	28	2
10	Hepatitis - E	1	0	1	0	0
11	Cholera	1	0	0	0	0
12	Typhoid	8	9	11	3	2
13	Acute Diarrheal Disease	51989	37209	37432	15583	23421
14	Shigella	6	2	2	0	0
15	Scrub Typhus	3	7	10	0	3
16	Kala Azar	0	0	2	0	0
17	Kysanur Forest Disease	0	0	0	0	0

18	Influenza (H1N1, H3N2, Infl A, Infl B)	1441	121	7	0	0
19	Rabies: Confirmed	1	1	3	0	0
20	Zika	0	0	0	0	0
21	West Nile	1	8	2	0	0
22	Nipah	0	0	0	0	0
23	Chicken Pox	2619	1165	314	80	597

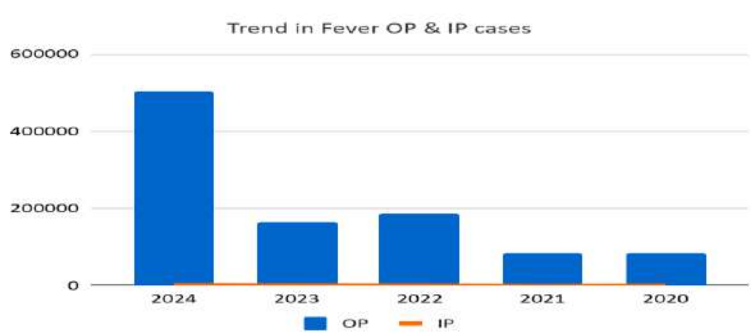
**Source: District Report*

6.1.2 Trend in Fever Outpatient and Inpatient Cases

The district has witnessed a substantial increase in both outpatient (OP) and inpatient (IP) cases of fever over the past five years. Fever OP cases show a marked rise from 83,744 in 2020 to 504,609 in 2024, indicating more than a six-fold increase. This sharp upward trend may reflect seasonal outbreaks, higher disease incidence, improved surveillance, or increased healthcare-seeking behaviour among the population.

Similarly, fever IP cases have steadily increased from 1,386 in 2020 to 3,058 in 2024, suggesting that not only are more patients presenting with fever at outpatient services, but a significant number require hospitalization for more severe illness

Graph 6.1.2 Trend in Fever Outpatient and Inpatient cases reported from all health facilities (2020-2024)



**Source: District IDSP Report*

The consistent growth in both OP and IP cases highlights the ongoing public health challenge posed by febrile illnesses in the district and underscores the need for strengthened preventive measures, early diagnosis, and effective management at both community and hospital levels.

6.1.3 Trend in Top Five Reported Communicable Diseases in the District

The year 2024 witnessed a notable disease burden in the district, dominated by Acute Diarrheal Disease, which recorded 51,989 cases, making it the most frequently reported communicable disease. The high incidence points to ongoing challenges in water quality, sanitation, and hygiene, especially during monsoon seasons. Continuous efforts in ensuring access to safe drinking water, sanitation infrastructure, and community-level behaviour change interventions remain essential to curb these outbreaks.

Chickenpox was the second most reported communicable disease with 2,619 cases, reflecting its high transmissibility and seasonal pattern, often peaking during school reopening periods. Strengthening routine immunization coverage and ensuring isolation of affected cases are key to limiting transmission.

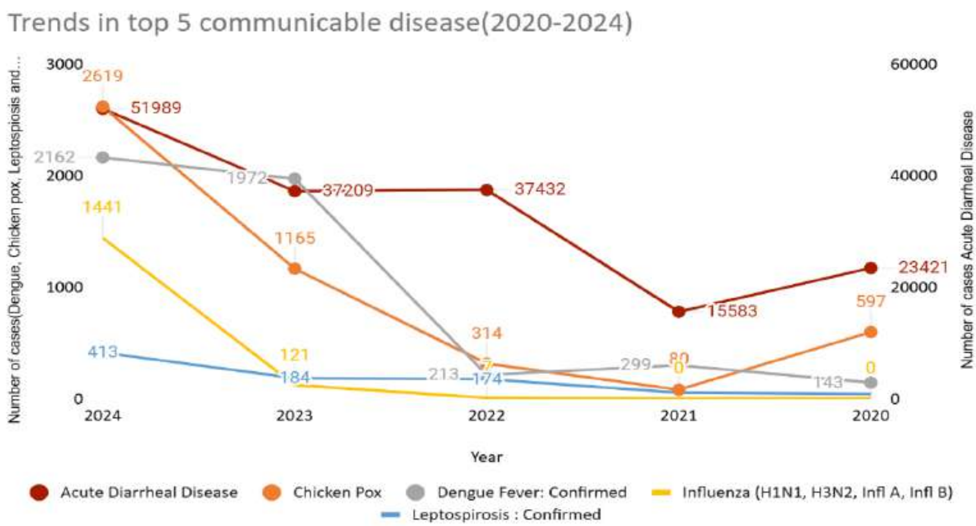
Dengue fever, with 2,162 confirmed cases, continued to be a major vector-borne threat, largely concentrated in urban and peri-urban areas. The increase during post-monsoon months highlights the importance of vector surveillance, source reduction, and public participation in eliminating mosquito breeding sites.

Influenza cases (1,441), including H1N1, H3N2, Influenza A, and B strains, showed a rising trend compared to previous years, emphasizing the need for robust respiratory infection surveillance, timely vaccination drives, and public awareness on respiratory hygiene.

Leptospirosis, though reporting a comparatively lower 413 confirmed cases, remains a recurrent zoonotic concern in flood-prone and agricultural zones. Preventive chemoprophylaxis for high-risk groups, early case detection, and environmental sanitation are vital to control its spread.

Overall, the trend in these top five diseases underscores the necessity for integrated disease surveillance, timely outbreak response, and community-level preventive strategies to mitigate communicable disease transmission within the district.

Graph 6.1.3 Trend in Top Five Reported Communicable Diseases in the District (2020–2024)



**Source: District IDSP Report*

Analysis of the reported cases over the five-year period shows a rising trend in most major communicable diseases in the district. Acute Diarrheal Disease (ADD) shows a consistent and substantial increase, from 23,421 cases in 2020 to 51,989 in 2024, indicating persistent sanitation and water-related challenges. Chickenpox has also exhibited a sharp upward trend, suggesting seasonal outbreaks and improved disease detection. Dengue Fever demonstrates a notable rise, particularly after 2022, reflecting the reemergence and intensification of vector-borne disease transmission, likely influenced by environmental factors and urbanization. Influenza cases, which were almost negligible in 2020–2022, surged in 2024, pointing to emerging respiratory outbreaks and enhanced laboratory reporting. Leptospirosis, although lower in magnitude, shows a steady increase, highlighting flood- and agriculture-associated risk patterns. Overall, the trend indicates that water-borne, vector-borne, and respiratory diseases continue to challenge public health in the district. The increasing trajectory across these diseases underscores the importance of strengthened surveillance, preventive interventions, public awareness campaigns, and timely outbreak management to mitigate disease burden and improve population health outcomes.

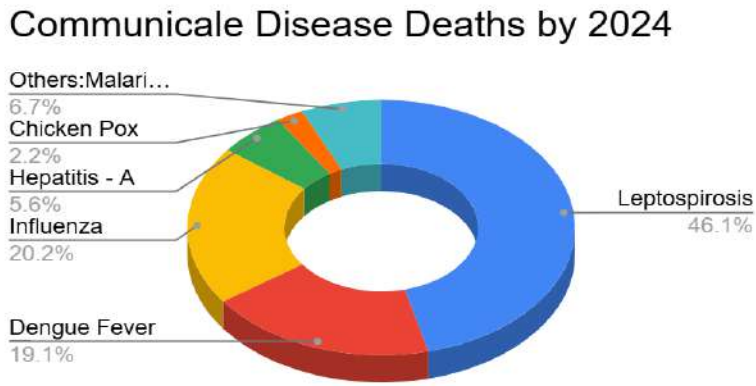
6.1.4 Major Communicable Diseases – Deaths Reported (2024)

Table 6.1.4.1 Disease-wise Distribution of Deaths Due to Communicable Diseases (2024)

<table>
<tr><th>Name of Diseases</th><th colspan="2">No: of Deaths Reported</th></tr>
<tr><td>Dengue Fever: Confirmed</td><td colspan="2">17</td></tr>
<tr><td>Dengue Fever: Probable</td><td colspan="2">2</td></tr>
<tr><td>Malaria</td><td colspan="2">1</td></tr>
<tr><td>Leptospirosis</td><td colspan="2">41</td></tr>
<tr><td>Hepatitis - A</td><td colspan="2">5</td></tr>
<tr><td>Food Poisoning</td><td colspan="2">1</td></tr>
<tr><td>Scrub Typhus</td><td colspan="2">1</td></tr>
<tr><td>Influenza (H1N1, H3N2, Infl A, Infl B)</td><td colspan="2">18</td></tr>
<tr><td>Rabies</td><td colspan="2">1</td></tr>
<tr><td>West Nile</td><td colspan="2">1</td></tr>
<tr><td>Chicken Pox</td><td colspan="2">2</td></tr>
<tr><td rowspan="2">Fever (Undifferentiated)</td><td>OP</td><td rowspan="2">1</td></tr>
<tr><td>IP</td></tr>
</table>

**Source: District IDSP Report*

Graph 6.1.4.1 Distribution of Communicable Disease Deaths by Type – 2024



**Source: District IDSP Report*

In 2024, the district reported deaths from multiple communicable diseases, highlighting both endemic and outbreak-prone threats. Leptospirosis accounted for the highest number of deaths (41 confirmed cases), underscoring the risk associated with flood-prone and agricultural areas where exposure to contaminated water is common. Influenza (H1N1, H3N2, Influenza A, Influenza B) was responsible for 18 deaths, emphasizing the severity of respiratory infections and the need for timely vaccination and early management. Dengue Fever caused 17 confirmed deaths and 2 probable deaths, reflecting its persistent risk in urban and peri-urban populations during post-monsoon periods. Other reported mortalities included Hepatitis A (5 confirmed deaths), Chickenpox (2 deaths), Food Poisoning (1 death), Scrub Typhus (1 death), Malaria (1 death), Rabies (1 confirmed death), and West Nile Virus (1 death), demonstrating the sporadic yet serious outcomes from these infections. No deaths were reported for diseases such as Chikungunya, Japanese Encephalitis, Kala Azar, Cholera, Typhoid, Hepatitis B, C, E, or other emerging infections.

6.2 Burden of Non-Communicable Diseases in the District

NCD data from 2022 to 2024 indicates a significant rise in the prevalence of several chronic conditions across the district. Among cancers, Breast Cancer shows a sharp increase from 582 cases in 2022 to 1,597 cases in 2024, highlighting growing detection or reporting, and emphasizing the need for enhanced screening and early diagnosis programs. In contrast, Cervical Cancer shows a declining trend, from 146 cases in 2022 to 82 in 2024, which may indicate improvements in preventive measures such as screening and HPV vaccination. Lung Cancer and Oral Cancer show fluctuating trends, with lung cancer decreasing from 769 cases in 2023 to 367 in 2024, and oral cancer declining sharply from 1,021 cases in 2023 to 302 in 2024, suggesting the potential impact of public health awareness campaigns and lifestyle interventions. Cardiovascular diseases remain a significant burden. Hypertension exhibits a steady upward trend from 363,450 cases in 2022 to 510,264 cases in 2024, reflecting increasing detection and the growing impact of lifestyle factors. Ischemic Heart Disease (IHD) shows variable trends, with 13,292 cases in 2022, decreasing in 2023, and rising again to 11,450 in 2024. Rheumatic fever shows a declining trend, suggesting effective prevention and management programs. Congenital heart disease shows a significant increase from 149 cases in 2022 to 775 in 2024, highlighting improved diagnosis and reporting in pediatric populations. Diabetes mellitus shows a clear rising trend in both types. Type 2 Diabetes cases increased from 224,330 in 2022 to 351,547 in 2024, while Type 1 Diabetes rose from 5,403 to 8,924 cases over the same period, indicating a growing burden of metabolic disorders and the need for lifestyle interventions, early detection, and consistent follow-up.Neurological disorders are also increasing, with cerebrovascular disorders rising from 4,692 cases in 2022 to 6,769 in 2024. Chronic neurological disorders show a dramatic increase, from 151 cases in 2022 to 1,959 cases in 2024, highlighting the emerging burden of long-term neurological conditions and the need for specialized care and rehabilitation services.Other NCDs such as obesity, common mental disorders, and severe mental disorders show mixed trends. Obesity increased from 5,022 cases in 2023 to 6,569 in 2024 after a decline in 2023, while common mental disorders showed slight fluctuations, decreasing to 8,776 cases in 2024 from 10,561 in 2023. Severe mental disorders are steadily increasing, reaching 493 cases in 2024, reflecting improved diagnosis and reporting, as well as increasing attention to mental health services.

Table 6.2.1 Number of Reported cases of Non-Communicable Disease in the District (2022-2024)

Diseases	**2022**	**2023**	**2024**
Cancers			
Cancer Cervix	146	134	82
Breast Cancer	582	550	1597
Lung Cancer	594	769	367
Oral Cancer	580	1021	302
Cardiovascular disease			
Rheumatic fever	1070	390	300
Hypertension	363450	419298	510264
Ischemic Heart disease	13292	8244	11450
Congenital Heart disease	149	402	775
Diabetes			
Type 1	5403	5210	8924
Type 2	224330	259792	351547
Neurological disorders			
Cerebrovascular disorders	4692	6054	6769
Chronic neurological disorders	151	204	1959
Others			

Obesity	7836	5022	6569
Common Mental disorders	9173	10561	8776
Severe mental disorders	133	462	493

*Source: District NCD Report

The Data emphasizes a rising burden of lifestyle-related, metabolic, cardiovascular, and neurological conditions, with some improvement in cancer prevention.

6.3 District-Specific Outbreaks and Health Concerns – 2024

During the year 2024, a total of 27 disease outbreaks were reported and investigated in Thrissur District under the IDSP through the IHIP. All outbreaks were confirmed and effectively managed with appropriate public-health interventions and rapid response measures.

Table 6.3.1 Major Disease Outbreaks

Major Reported Outbreaks	Diseases Included	Total Outbreaks
Waterborne	Acute Diarrhoeal Disease (including food poisoning cases), Hepatitis A	10
Vector-Borne	Dengue, West Nile Fever	6
Viral disease	Mumps, Chickenpox, H1N1, Mpox	8
Other	Scarlet Fever, Vermamoeba Vermiformis	3
Total (All Diseases)		**27**

**Source: District IDSP Report*

The major outbreaks reported included waterborne, vector-borne, Influenza and viral diseases. Waterborne outbreaks such as Acute Diarrhoeal Disease and Hepatitis A were predominant.

➢ **Waterborne Diseases**

These were the most frequent outbreaks in 2024, mainly linked to contaminated water or food.

- Acute Diarrhoeal Disease (ADD) – 7 outbreaks (Seven outbreaks of Acute Diarrhoeal Disease occurred in areas including Kodungallur, Chalakudy, Perinjanam, Koratty, Thiruvilwamala, and Mala, affecting over 538 individuals.)
- Hepatitis A / Acute Hepatitis – 4 outbreaks (Four outbreaks of Hepatitis A were reported from Koorkenchery, Thekkumkara, and Kuthampully, with around 73 confirmed and probable cases.)

➢ **Vector-borne diseases**

Vector-borne diseases also contributed notably.

- Dengue Fever – 3 outbreaks (Three dengue outbreaks were recorded— Guruvayur (280 probable cases), Ollukkara (76), and Irinjalakuda (19).
- West Nile Fever – 3 Probable cases (Three Probable cases of West Nile Fever were detected from Methala, Vatanappilly, and Vellangallur (one fatality)

➢ **Viral diseases**

Institutional outbreaks of Influenza and other viral diseases were reported from several educational and other institutions across the district. Three mumps outbreaks (Mambra, Varandarappilly, Elanad; 70 cases) and three chickenpox outbreaks (Meloor, Kuthampully, Pariyaram; 71 cases) were investigated.An H1N1 outbreak in Choondal panchayat affected 30 persons, including three laboratory-confirmed cases.Scarlet fever was reported from Thiruvilwamala (86 cases).

➢ **Other notable events included**

Two imported Mpox cases from Vadakkekad, and one case of Verm amoeba (*Vermamoeba vermiformis)* infection from Venkidengu. All events were investigated promptly by the Rapid Response Team. Public-health response involved the formation of RRTs for every outbreak, epidemiological and laboratory confirmation (blood, stool, and water samples), vector control, chlorination, isolation of cases, and community-level awareness drives.

Coordination with local self- government institutions ensured sustained prevention activities.

- **Key Health Concerns**

During 2024, Thrissur district experienced recurrent outbreaks of waterborne and foodborne diseases, particularly during the periods of April–June and October–December. A noticeable rise in vector-borne infections, such as dengue, was recorded, along with the emergence of West Nile Fever. Institutional clusters of vaccine-preventable viral infections, including mumps and chickenpox, were also reported. In addition, sporadic cases of rare and imported infections such as Mpox and amoebic encephalitis were observed. Seasonal influenza (H1N1) cases were reported from multiple areas, underscoring the district's ongoing vulnerability to both endemic and emerging infectious diseases.

CHAPTER 7

CRITICAL OBSERVATIONS IN NFHS-5 DATA

7.1 Comparison of NFHS-4 and NFHS-5 Data and Comparison

Table no: 7.1 Comparison of NFHS-4 and NFHS-5 Data and Comparison with State Status

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 (%)	97.8	96.5
2. Population below age 15 years (%)	18.8	18.3
3. Sex ratio of the total population (females per 1,000 males)	1167	1075
4. Sex ratio at birth for children born in the last five years (females per 1,000 males)	763	1,120
5. Children under age 5 years whose birth was registered with the civil authority (%)	100	96
6. Deaths in the last 3 years registered with the civil authority (%)	95.1	na
7. Population living in households with electricity (%)	100	99.8
8. Population living in households with an improved drinking-water source (%)	93.7	95.7
9. Population living in households that use an improved sanitation facility (%)	99.5	99.7
10. Households using clean fuel for cooking (%)	76.3	67.5
11. Households using iodized salt (%)	99.7	99.2
12. Households with any usual member covered under a health insurance/financing scheme (%)	48.7	38.1

13. Children age 5 years who attended pre-primary school during the school year 2019-20 (%)	30.9	na
Characteristics of Women (age 15-49 years)		
14. Women who are literate (%)	99.4	na
15. Women with 10 or more years of schooling (%)	79.2	76.4
Marriage and Fertility		
16. Women age 20-24 years married before age 18 years (%)	1.0	2.3
17. Births in the 5 years preceding the survey that are third or higher order (%)	0.0	0.0
18. Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	1.0	2.8
19. Women age 15-24 years who use hygienic methods of protection during their menstrual period (%)	87.5	92.7
Current Use of Family Planning Methods (currently married women age 15–49 years)		
20. Any method (%)	69.7	63.8
21. Any modern method (%)	61.5	62.1
22. Female sterilization (%)	52.9	56.9
23. Male sterilization (%)	0.0	0.3
24. IUD/PPIUD (%)	2.9	2.1
25. Pill (%)	0.6	0.4
26. Condom (%)	4.6	2.4
27. Injectables (%)	0.0	0.0
Unmet Need for Family Planning (currently married women age 15–49 years)		
28. Total unmet need (%)	10.9	10.3
29. Unmet need for spacing (%)	4.9	7.4
Quality of Family Planning Services		

30. Health worker ever talked to female non-users about family planning (%)	10.1	19.8
31. Current users ever told about side effects of current method (%)	59.7	47.9
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 (%)	97.1	97.2
33. Mothers who had at least 4 antenatal care visits (%)	82.4	83.1
34. Mothers whose last birth was protected against neonatal tetanus (%)	95.7	95.9
35. Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	78.6	70.3
36. Mothers who consumed iron folic acid for 180 days or more when they were pregnant (%)	70.8	47.9
37. Registered pregnancies for which the mother received a Mother and Child Protection (MCP) card (%)	87.0	82.8
38. Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel member within 2 days of delivery (%)	95.2	85.2
39. Average out-of-pocket expenditure per delivery in a public health facility (Rs.)	5,007	5,053
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 (%)	88.4	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 (%)	30.9	34.7
44. Home births that were conducted by skilled health personnel (%)	0.0	0.0
45. Births attended by skilled health personnel (%)	100.0	100.0
46. Births delivered by caesarean section (%)	45.7	33.7
47. Births in a private health facility that were delivered by caesarean section (%)	43.0	34.4
48. Births in a public health facility that were delivered by caesarean section (%)	51.9	32.5
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 (%)	*	88.3
	*	*
50. Children age 12-23 months fully vaccinated based on information from vaccination card only (%)	*	100.0
51. Children age 12-23 months who have received BCG (%)	*	94.7
52. Children age 12-23 months who have received 3 doses of polio vaccine (%)	*	97.4
53. Children age 12-23 months who have received 3 doses of penta or DPT vaccine (%)	*	93.6
54. Children age 12-23 months who have received the first dose of measles-containing vaccine (MCV) (%)	*	na
55. Children age 24-35 months who have received a second dose of measles-containing vaccine (MCV) (%)	*	na
56. Children age 12-23 months who have received 3 doses of rotavirus vaccine (%)	*	79.1
57. Children age 12-23 months who have received 3 doses of penta or hepatitis B vaccine (%)	87.7	72.4

58. Children age 9-35 months who received a vitamin A dose in the last 6 months (%)	*	85.4
59. Children age 12-23 months who received most of their vaccinations in a public health facility (%)	*	14.6
60. Children age 12-23 months who received most of their vaccinations in a private health facility (%)	*	88.3
Treatment of Childhood Diseases (children under age 5 years)		
61. Prevalence of diarrhoea in the 2 weeks preceding the survey (%)	8.2	0.8
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 (%)	2.3	1.1
66. Children with fever or symptoms of ARI in the 2 weeks preceding the survey taken to a health facility or health provider (%)	89.4	*
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 (%)	69.0	73.1
68. Children under age 6 months exclusively breastfed (%)	*	*
69. Children age 6-8 months receiving solid or semi-solid food and breastmilk (%)	*	*
70. Breastfeeding children age 6-23 months receiving an adequate diet16, 17 (%)	11.5	7.4

71. Non-breastfeeding children age 6-23 months receiving an adequate diet (%)	*	*
72. Total children age 6-23 months receiving an adequate diet (%)	14.3	8.9
73. Children under 5 years who are stunted (height-for-age) (%)	22.0	20.8
74. Children under 5 years who are wasted (weight-for-height) (%)	9.6	15.3
75. Children under 5 years who are severely wasted (weight-for-height) (%)	3.8	9.4
76. Children under 5 years who are underweight (weight-for-age) (%)	17.3	14.0
77. Children under 5 years who are overweight (weight-for-height) (%)	6.1	3.5
Nutritional Status of Women (age 15-49 years)		
78. Women whose Body Mass Index (BMI) is below normal (BMI <18.5 kg/m2) (%)	10.9	8.2
79. Women who are overweight or obese (BMI ≥25.0 kg/m2) (%)	42.8	28.1
80. Women who have high risk waist-to-hip ratio (≥0.85) (%)	71.6	na
Anaemia among Children and Women		
81. Children age 6-59 months who are anaemic (<11.0 g/dl) (%)	48.7	39.4
82. Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl)22 (%)	44.9	42.4
83. Pregnant women age 15-49 years who are anaemic (<11.0 g/dl)22 (%)	*	*
84. All women age 15-49 years who are anaemic (%)	44.4	42.1
85. All women age 15-19 years who are anaemic (%)	36.5	47.9
Blood Sugar Level among Adults (age 15 years and above)		

Women		
86. Blood sugar level - high (141-160 mg/dl) (%)	8.9	NA
87. Blood sugar level - very high (>160 mg/dl) (%)	15.1	NA
88. Blood sugar level - high or very high (>140 mg/dl) or taking medicine to control blood sugar level (%)	28.3	NA
Men		
89. Blood sugar level - high (141-160 mg/dl) (%)	11.0	NA
90. Blood sugar level - very high (>160 mg/dl) (%)	16.6	NA
91. Blood sugar level - high or very high (>140 mg/dl) or taking medicine to control blood sugar level (%)	31.7	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) (%)	14.3	NA
93. Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100mm of Hg) (%)	6.1	NA
94. Elevated blood pressure (Systolic ≥140 mm of Hg and/or Diastolic ≥90 mm of Hg) or taking medicine to control blood pressure (%)	31.4	NA
Men		
95. Mildly elevated blood pressure (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	18.1	NA
96. Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100mm of Hg) (%)	8.2	NA
97. Elevated blood pressure (Systolic ≥140 mm of Hg and/or Diastolic ≥90 mm of Hg) or taking medicine to control blood pressure (%)	36.8	NA
Screening for Cancer among Women (age 30-49 years)		
98. Ever undergone a screening test for cervical cancer (%)	3.0	NA

99. Ever undergone a breast examination for breast cancer (%)	2.8	NA
100. Ever undergone an oral cavity examination for oral cancer (%)	0.9	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 (%)	2.3	NA
102. Men age 15 years and above who use any kind of tobacco (%)	17.8	NA
103. Women age 15 years and above who consume alcohol (%)	0.2	NA
104. Men age 15 years and above who consume alcohol (%)	26.2	NA

*****Source: NFHS-4 and NFHS-5 Report*

*Note: *This data not collected in NFHS-4; NA- Not Available*

The NFHS-5 findings highlight that Thrissur district has made remarkable progress in several social and health indicators compared to the previous round. Female literacy has become nearly universal, and a greater proportion of women have completed higher levels of education, reflecting the district's strong educational environment and awareness levels. The civil registration system has also strengthened, with almost all births and deaths being officially recorded. Improvements are evident in living standards, as seen through the increased use of clean cooking fuel, better sanitation coverage, and wider health insurance protection for households.

Maternal and child health services continue to perform strongly in Thrissur, with nearly universal access to antenatal and postnatal care and a high proportion of institutional deliveries. The uptake of iron and folic acid supplements during pregnancy has improved, indicating better maternal nutrition awareness and programme outreach. However, the rising proportion of caesarean deliveries, particularly in public facilities, calls for greater attention to clinical justification and promotion of normal deliveries wherever possible.

While service utilization is strong, some emerging challenges require immediate focus. The district has experienced a concerning decline in the sex ratio at birth, which may reflect underlying gender bias. Anaemia among women and children has increased, revealing persistent nutritional deficiencies despite good service access. Although undernutrition indicators have shown improvement, the simultaneous rise in overweight and obesity points to a growing double burden of malnutrition.

Non-communicable diseases are becoming an area of concern, with an increasing prevalence of elevated blood pressure and blood sugar among adults, indicating lifestyle changes and dietary imbalances. In the area of family planning, overall use of contraceptive methods has improved, but there remains a heavy reliance on female sterilization, suggesting the need for more diversified choices and enhanced male participation.

Overall, Thrissur continues to demonstrate strong health system performance and effective service delivery. Continued attention is needed to promote gender equity, improve nutritional outcomes, encourage balanced modes of delivery, and strengthen prevention and control measures for non-communicable diseases. With sustained effort, the district can further consolidate its position as one of Kerala’s best-performing regions in public health.

CHAPTER 8

DISTRICT MENTAL HEALTH PROGRAMME

8.1 Programme Overview

DMHP was launched under NMHP in 1996 (in the IX Five-Year Plan), based on the 'Bellary Model'. Its Components include:

- Early detection & treatment.
- Training: Short-term training to general physicians for diagnosis and treatment of common mental illnesses with a limited number of drugs under the guidance of a specialist. The health workers are being trained in identifying mentally ill persons.
- IEC: Public awareness generation.
- Monitoring: The purpose is for simple Record Keeping.

The main aim is to provide community mental health services and integration of mental health with general health services through decentralization of treatment from specialized mental hospital-based care to primary health care services. Community-based services, which include:

- Training of the mental health team at identified nodal institutions.
- Increase awareness & reduce stigma related to Mental Health problems.
- Provide service for early detection & treatment of mental illness in the community (OPD/ Indoor & follow-up).
- Provide valuable data & experience at the level of the community, at the state & center for future planning & improvement in service & research.

In 2008, the Government of India revised and consolidated, adding new components to DMHP:

- Life skills education & counselling in schools
- College counselling services
- Workplace stress management
- Suicide prevention services

8.2 DMHP Programmes

8.2.1 Comprehensive Mental Health Programme

The programme had envisaged

- To start a rehabilitation centre for both male & female psychiatric patients

- To start the school training and counselling programme
- To set up counselling centres in schools

8.2.2 Day Care Centre

- Day care centers started under the comprehensive mental health programme in the financial year of 2013-14.
- Male & Female day care centre functioning at Aranattukara near Nethaji ground.
- The patients were 15 numbers in each day care center. The functioning time is 9 am to 4pm.
- Occupational therapy units like medicine cover making, carpet making, hand wash, floor cleaner, toilet cleaner, dish wash, toilet soap, washing soap, and detergent powder are functioning to enhance the skills of the day care inmates.

8.2.3 DMHP Clinics

District Mental Health Clinics act as the operational arm to deliver equitable, accessible, and affordable mental healthcare right to the community doorstep, moving away from a hospital-centric model to a decentralized, integrated approach.

Table 8.2.3.1 List of Mental Health Clinics

Sl. No.	Status	Name of Health Center
1.	CHC	Elinjipra
2.	CHC	Vadanappilly
3.	CHC	Thiruwillamala
4.	PHC	Nadathara
5.	THQH	Chalakkudy
6.	CHC	Pazanji
7.	CHC	Valappad
8.	GH	Irinjalakkuda
9.	THQH	Chavakkad

10.	FHC	Karalam
11.	CHC	Vadakkekkad
12.	PHC	Madakkathara
13.	CHC	Vaniyampara
14.	CHC	Cherpu
15.	PHC	Meloor
16.	PHC	Arimpoor
17.	THQH	Kodungalloor
18.	TH	Chelakkara
19.	THQH	Kunnamkulam
20.	CHC	Puthenchira
21.	PHC	Vettilappara
22.	CHC	Mattathur
23.	TH	Puthukkad
24.	CHC	Erumapetty
25.	DH	Wadakkanchery
26.	CHC	Mala
27.	BPHC	Aloor
28.	PHC	Vallatholenagar

**Source: District DMHP Report*

Table 8.2.3.2 DMHP Clinic Schedule

Clinic	Day	Time
CHC Elanjipra / THQH Chalakudy	1st Monday	10 AM - 12 PM & 12.30 PM - 2.30 PM
GH Irinjalakuda	2nd Monday	10 AM - 1.00 PM
FHC Meloor / FHC Vettilappara	3rd Monday	10 AM - 11.30 AM & 12 PM - 2.00 PM
CHC Mattathoor	4th Monday	10 AM - 1.00 PM
CHC Vadanappilly / CHC Valappad	1st Tuesday	10 AM - 11.30 AM & 12 PM - 2.00 PM
THQH Chavakkad	2nd Tuesday	10 AM - 12.30 PM
THQH Kodungallur	3rd Tuesday	10 AM - 2.00 PM
THQH Pudukkad	4th Tuesday	10 AM - 1.00 PM
CHC Thiruwillamala	1st Wednesday	10 AM - 1.00 PM
FHC Karalam / CHC Cherpu	2ndWednesday	10 AM - 11.30 AM & 12 PM - 1.30 PM
FHC Arimbur	3rd Wednesday	09.30 AM - 10.30 AM
CHC Mala / FHC Aloor	4th Wednesday	10 AM - 01 PM & 1.30 PM - 03 PM
FHC Nadathara/ FHC Vaniampara	1st Thursday	10 AM - 11.30 AM & 12.30 PM - 2.00 PM
CHC Vadakkekkad	2nd Thursday	10 AM - 1.00 PM
THQH Chelakkara	3rd Thursday	10 AM - 1.00 PM
GH Wadakkanchery / CHC Erumapetty	4th Thursday	9.30 AM - 12 PM & 12.30 PM - 2 PM

FHC Madakkathara	2nd Friday	10 AM - 11 AM
CHC Pazhanji/ THQH Kunnamkulam	1st Saturday	9.30 AM - 11.30.AM & 12 PM - 2 PM
CHC Puthenchira	3rd Saturday	10 AM - 1.00 PM
FHC Vallathol Nagar	4th Saturday	10 AM - 1.00 PM

**Source: District DMHP Report*

8.3 Sampoorna Manasika Aarogyam (SMA)

The programme addresses all mental illnesses and provides treatment at the FHC level. In the Thrissur district, 36 FHCs are selected under the SMA programme. SMA training programmes are conducted for ASHAs and health workers, and three camps are conducted under the initiative of DMHP. Drugs are intended by the concerned FHCs.

8.4 Coastal Mental Health

- Medical camp and field activities focusing on substance use abuse and adolescent health.
- Providing life skill training for adolescents and the formation of a support group
- Training for health workers, ASHA, Anganwadi workers of the coastal area on the SMA questionnaire, followed by a house visit.

8.5 Tribal Mental Health Programme

Focusing on medical camp, field activities regarding substance abuse, adolescent mental health and treatment gap and drop out, Providing life skill training for adolescents and the formation of a support group, Training for health workers, ASHA, Tribal promoters, Anganwadi workers of the tribal area on the SMA screening questionnaire, followed by a house visit.

The following FHCs are selected under the tribal mental health programme.

- FHC Elanad
- FHC Mattathur
- FHCThonnurkara

- FHC Vanniyampara
- FHC Varandharappilly
- FHC Puthur
- FHC Vettilappara

8.6 Amma Manas

- Maternal Mental Health (Ammamanass) – This Programme is initiated for pregnant women and new mothers of the new born.
- It deals with the mental health issues of women pre-natal and post-natal.
- The programme aims to address postpartum issues after delivery.
- Mothers receive counselling services while the moderate and severe cases are referred to the District Mental Health Programme.
- The Programme integrates Maternal Mental Health into the Reproductive and Child Health Programme.

8.7 School Mental Health Programme

- School Mental Health Programme under the Comprehensive Mental Health Programme
- It aims to improve the mental health and well-being of School Children.
- SMHP includes counselling, awareness, capacity building, career building and personality development.
- Providing information about mental health issues, substance abuse, behavioural problems, learning disability, suicide prevention, exam stress management and parenting.

8.8 Jeevan Raksha (Suicide Prevention)

Training for community gatekeepers (doctors, health workers, police personnel, LSG elected and religious leaders on suicide prevention and DSH reporting. Toll-free No.14416 (TELE MANAS) is provided to the public as a helping aid in moments of distress.

CHAPTER 9

TRIBAL HEALTH PROGRAMME

9.1 Programme overview

According to Census 2011, Thrissur district has a total tribal population of 4,974 persons, comprising 2,373 males and 2,601 females, indicating a favorable sex ratio among the tribal communities. The presence of 358 children under the age of five underscores the need for targeted maternal and child health interventions in these specific areas. The distribution indicates that tribal settlements are uneven across the district, with concentrations in specific areas.

Table 9.1.1 Distribution of Tribal Population in Thrissur District (as per census 2011)

Sl No	Name of Institutions	Population	Male	Female	Under 5 Children
1	Vellanikkara	419	205	214	13
2	Vaniyampara	699	359	340	50
3	Puthur	295	140	155	17
4	Thekkumkara	38	21	17	1
5	Mattathur	365	185	180	26
6	Varanthrapally	557	252	305	39
7	Elanad	276	124	152	30
8	Thonoorkkara	89	46	43	7
9	Elinjipra	527	243	284	13
10	Vettilapara	1683	786	897	160
11	Engandiyur	26	12	14	2
	Total	**4974**	**2373**	**2601**	**358**

**Source: District Report*

Vettillapara accounts for the largest share of the tribal population, with 1,683 persons (33.8% of the total), followed by Vaniyampara (699 persons), Varantharapally (557 persons), Elinjipra (527 persons), and Vellanikkara (419 persons). Smaller settlements such as Engandiyur (26 persons) and Thekkumkara (38 persons) represent scattered and potentially vulnerable tribal households.

A significant proportion of children under five years of age are concentrated in Vettillapara (160 children, nearly 45% of all tribal under-five children in Thrissur), followed by Vaniyampara (50 children) and Varantharapally (39 children). This pattern underscores the need to prioritize child nutrition, early education, and immunization programs in these key regions.

Table 9.1.2 Tribal Settlements

Sl No	Name of Institution	No of Tribal Settlements
1	Vellanikkara	2
2	Vaniyampara	3
3	Puthur	4
4	Thekkumkara	1
5	Mattathur	2
6	Varanthrapally	8
7	Elanad	3
8	Thonoorkkara	1
9	Elinjipra	2
10	Vettilapara	15
11	Engandiyur	3
Total		**44**

**Source: District DMHP Report*

9.2 Tribal Mobile Medical Units

Thrissur district operates a well-equipped Tribal Mobile Medical Unit (TMMU), staffed by a doctor, a nurse, and a pharmacist. The team visits 42 tribal colonies across the district every month, functioning under the Family Health Centre (FHC) at Vettilapara, which also supplies the required medicines. Their service route begins at Malakkapara and extends through the tribal belt up to Vaniyampara, covering two colonies per day.

Prior to each visit, the team coordinates with the respective FHCs and local coordinators to facilitate field activities such as immunization, with support from the facility staff. In addition to providing routine outpatient consultations and dispensing medications, the team refers patients to the nearest FHC, Taluk Hospital (TH), or Taluk Headquarters Hospital (THQH), as appropriate.

The unit also conducts health education and awareness sessions on topics such as communicable and non-communicable diseases, hygiene, healthy lifestyle practices, and other preventive health measures. According to the medical officer in charge of the TMMU, iron deficiency anemia and malnutrition continue to be prevalent health concerns among the tribal population.

CHAPTER 10

FINANCIAL ALLOCATION AND UTILISATION FOR THE LAST FOUR YEARS

The National Health Mission (NHM) is a flagship program of the Government of India aimed at achieving universal access to equitable, affordable, and quality healthcare services that are accountable and responsive to people's needs.

10.1 Financial Allocation to NHM

- The NHM is a Centrally Sponsored Scheme, meaning funds are shared between the Central Government and the State/Union Territory governments, typically in a 60:40 ratio (90:10 for North Eastern and Himalayan States).
- Significant Budget Head: NHM is historically the largest scheme within the Ministry of Health and Family Welfare's (MoHFW) budget, comprising a substantial portion of the overall health sector allocation.
- Recent Allocations: The allocation to NHM has shown a general upward trend over the years. For instance, the Budget Estimate for NHM was approximately ₹37,226 crores in FY 2025-26 (as per latest available data).
- Funding Challenge: Despite increasing allocations, the funds often remain below the projected demand requested by the Ministry for the period, indicating a continued need for greater investment to meet the ambitious goals of the Mission.

The National Health Mission (NHM) provides funds to enable States and Union Territories to develop and implement Programme Implementation Plans (PIPs) tailored to local health priorities. This approach promotes decentralized, community-owned health service delivery through two key sub-missions:

- **National Rural Health Mission (NRHM):** Focuses on improving healthcare delivery in rural areas, with special attention to vulnerable populations and high-focus states.

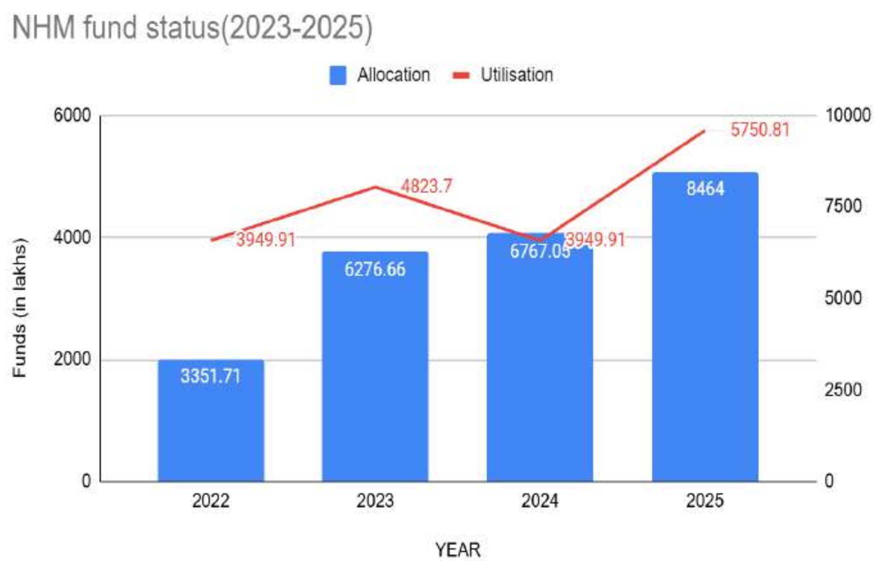
- **National Urban Health Mission (NUHM):** Addresses the healthcare needs of the urban poor and other vulnerable sections of the population.

Table 10.1.1 Fund Allocation and Percentage of utilization

Sl No	Programme	(In Lakhs)		
		Budget	**Expenditure**	**% of utilization**
I	RCH (including RI, IPPI, NIDDCP)	1066.56	694.59	65.12%
II	Health System Strengthening (HSS) Rural	5775.49	4430.27	76.71%
III	NUHM (Health System Strengthening (HSS)) Urban	1077.64	429.47	39.85%
IV	National Disease Control Programmes (NDCP)	341.52	139.34	40.80%
V	Non Communicable Disease Control Programme (NP-NCD)	202.79	57.13	28.17%
	TOTAL	**8464**	**5750.8**	**67.94%**

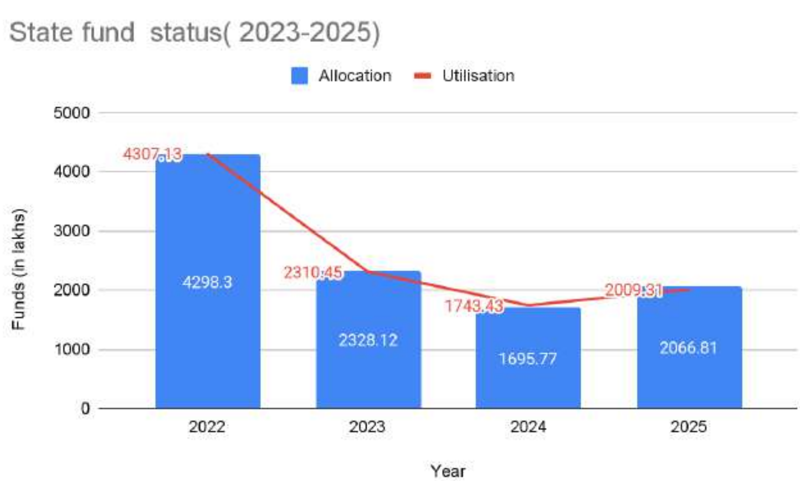
**Source: District Report*

Graph 10.1.1 NHM Fund Status



** Source: District Report*

Graph 10.1.2 State Fund Status



** Source: District Report*

The utilisation pattern of NHM and State funds during 2022–2025 reveals a distinct contrast. For NHM funds, 2022 was the only year of overspending, followed by consistent underutilisation despite increasing allocations. By 2025, even with the highest allocation of ₹8,464 lakhs, utilisation stood at only ₹5,750.81 lakhs. Overall, out of ₹24,859.42 lakhs allocated under NHM, ₹18,474.33 lakhs were utilised, leaving ₹6,385.09 lakhs unspent, which translates to nearly 26% underutilisation.

In comparison, State funds were utilised far more efficiently, with allocations and utilisations remaining closely aligned throughout the period. Minor fluctuations occurred—slight overspending in 2022 and 2024, and minimal underutilisation in 2023 and 2025—but overall absorption was almost complete. Out of ₹10,389 lakhs allocated, ₹10,370.32 lakhs were utilised, leaving only ₹18.68 lakhs unspent, reflecting over 99.8% utilisation efficiency.

CHAPTER 11

NATIONAL HEALTH MISSION PROGRAMMES

The National Health Mission (NHM) Thrissur was officially registered as a society under the name *Arogyakeralam Thrissur* on May 9, 2007, and initially operated from the District Medical Office (Health) in Thrissur. Subsequently, it was relocated to the Old District Hospital compound at Swaraj Round.

The mission functions based on decisions taken by two main administrative bodies:

- Governing Body – chaired by the District Panchayat President.
- Executive Committee – chaired by the District Collector.

These bodies meet at scheduled intervals to make key decisions regarding the mission's activities. At the district level, programme implementation and support are led by the District Programme Monitoring and Supporting Unit, under the leadership of the District Programme Manager. At the block level, Public Relations Officers (PROs), doctors, and paramedical staff deployed by NHM play a crucial role in supporting the district's health initiatives.

11.1 Maternal Health

11.1.1 Pradhanmantri Surakshit Matritva Abhiyan (PMSMA)

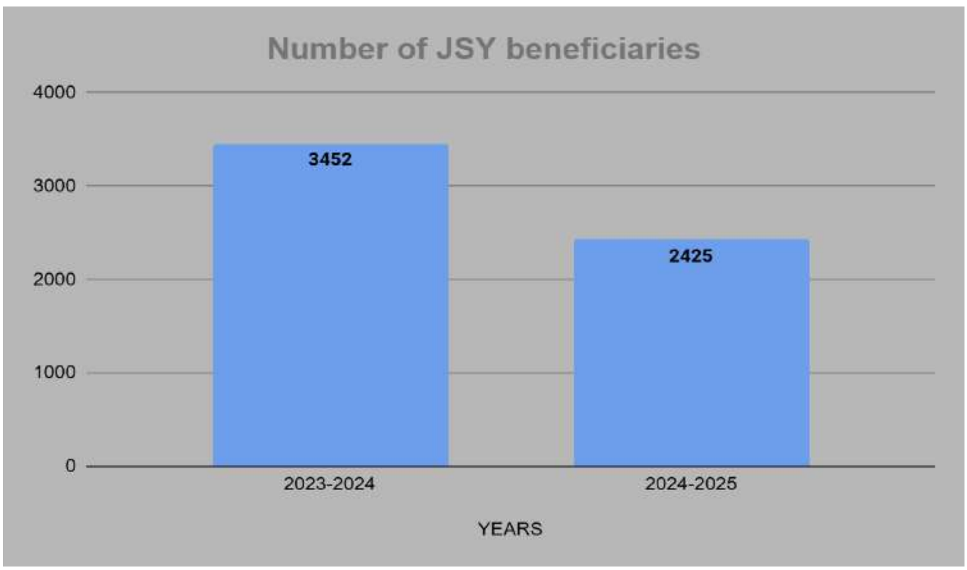
The programme aims to decrease Maternal Mortality and Infant mortality. With this aim, on the 9th of each month, a special Antenatal check-up clinic will be conducted in selected high-risk areas with public and private participation. The programme will also provide investigations with the purpose of identifying high-risk pregnancies and managing complications. The selected institutions in Thrissur district are Vettilappara, Perinjanam, Vaniyampara, Mattathur & Vadakkekad. The programme has already been inaugurated on 2016 November 9th at Chavakkad

11.1.2 Janani Suraksha Yojana (JSY):

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NHM). It promotes institutional delivery among pregnant women, especially with weak socio-economic status, i.e. women from Scheduled Castes, Scheduled

Tribes and BPL households. Under the programme, the beneficiaries are entitled to get financial assistance of Rs. 700 in rural areas and Rs. 600 in urban areas. The number of women availing benefits under the Janani Suraksha Yojana (JSY) has shown a significant increase, rising from 2,425 beneficiaries in 2023–2024 to 3,452 beneficiaries in 2024–2025. This upward trend reflects improved awareness, enhanced outreach by ASHAs and health workers, and better access to institutional delivery services in the district.

Graph 11.1.2.1 Beneficiaries of JSY (2023-2024 and 2024-2025)

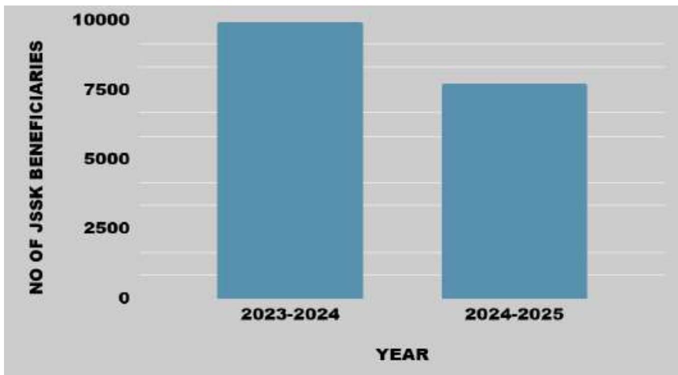


**Source: District Report*

11.1.3 Janani Shishu Suraksha Karyakram [JSSK]

It is a major initiative evolved to reduce maternal and infant mortality. The program aims to ensure that pregnant women and newborns receive completely free and cashless services in government health institutions across rural and urban areas.. An amount of Rs. 1600 for normal delivery and Rs. 3650 for C-sections is given to the hospital that ensures transportation facility [Mathryaan]. The number of beneficiaries under the Janani Shishu Suraksha Karyakram (JSSK) has declined from 9,937 in 2023–2024 to 7,719 in 2024–2025, marking a reduction of nearly 22.3%. This downward trend may reflect challenges such as reduced service utilization, reporting gaps, or barriers in access to free maternal and child health services (transport, diagnostics, medicines). The decline highlights the need for a detailed review of programme implementation and strengthened community-level awareness to ensure eligible mothers and newborns fully benefit from JSSK entitlements.

Graph 11.1.3.1 JSSK Beneficiaries (2023-2024 and 2024-2025)



**Source: District Report*

11.1.4 Maternal Death Near Miss Surveillance Response (MDNMSR):

For the reduction of MMR, the Maternal Death Near Miss Surveillance Response Meeting is being conducted every month on a fixed day (3rd Tuesday) under the chairmanship of the District Collector. During the COVID Pandemic, all meetings were conducted through an online platform, and presently, meetings are held once in 3 months.

11.1.5 Surakshit Matritva Aashwasan (SUMAN):

The program aims to ensure zero preventable maternal and newborn deaths in the district by creating a responsive health care system which strives to achieve zero maternal and infant deaths through quality care provided with dignity and respect. Currently, 52 institutions are SUMAN-accredited facilities in the district.

Table 11.1.5.1 SUMAN Accredited Institutions

Sl.no	Institutions	Sl.no	Institutions	Sl.no	Institutions
1.	TH Pudukkad	19	CHC Alappad	37	FHC Methala
2.	TH Chelakkara	20	CHC Mattathur	38	FHC Pariyaram
3.	CHC Mullassery	21	CHC Vatanappilly	39	FHC Kakkad
4.	FHC Thalikkulam	22	CHC Valappad	40	FHC Ayyanthole
5.	FHC Punnayur	23	CHC Kadappuram	41	GH Irinjalakuda
6.	FHC Velur	24	CHC Vellanikkara	42	DH Wadakkanchery
7.	FHC Desamangalam	25	CHC Pazhanji	43	THQH Kodungallur
8.	FHC Poyya	26	FHC Paralam	44	THQH Chavakkad
9.	FHC Kodakara	27	FHC Madavana	45	THQH Chalakudy
10.	FHC Mundur	28	FHC davilangu	46	TH Kunnamkulam
11.	FHC Nenmanikkara	29	FHC Thekkumkara	47	GMCH Thrissur
12.	UFHC Anappuzha	30	FHC Karalam	48	GH Thrissur
13.	UFHC V R Puram	31	FHC Manalur	49	CHC Perinjanam
14.	UFHC Kacheri	32	FHC Nalukettu	50	CHC Pazhayannur
15.	UFHC Gosayikunnu	33	FHC Melur	51	FHC Mathilakam

16.	UFHC Paravattani	34	FHC P. Vemballur	52	FHC Thiruvilwamala
17.	UFHC Guruvayur	35	FHC Mambra		
18.	UFHC Porkalengadu	36	FHC Aloor		

**Source: District Report*

11.2. CHILD HEALTH

11.2.1 Rashtriya Bal Swasthya Karyakram (RBSK):

RBSK nurses are deployed across the district to ensure early detection, treatment, and follow-up for health conditions among children under 18 years of age. Annual training is provided to enhance the effectiveness of the screening programme, with special focus on immunization sites and Anganwadi centres.

Referral services and follow-up care are thoroughly monitored to ensure appropriate management of identified conditions. Block-level plans are implemented to achieve comprehensive (100%) screening coverage. RBSK nurses are assigned based on the distribution across 86 panchayats, one corporation, and seven municipalities, considering the size of the target population in each health block. Currently, 96 RBSK nurses are posted to conduct screenings for children aged 0 to 18 years. For 2024–2025, the RBSK programme aims to cover a total of 4.76 lakh children, with 39.6% belonging to the 0–6 years group and 60.4% in the 6–18 years group. This indicates that the majority of the beneficiaries fall under the school-going age group, emphasising the importance of school-based health interventions under RBSK. In 2024–2025, the district has a total of 4,001 educational and childcare institutions. A majority are Anganwadi Centres (2938; 73%), forming the backbone of early childhood care. Schools from Lower Primary to High School and above together account for 1,002 institutions, while KG/Play schools contribute a smaller share (61). This distribution highlights the strong presence of AWCs in the district, ensuring widespread coverage for the 0–6 years RBSK target group, while schools provide access to the 6–18 years group.

Table 11.2.1.1 RBSK Screening Status

Year	Total number of deliveries	Total number of Newborns Screened	No of Conditions identified
2024-2025	7677	7529	335

**Source: District RBSK Report*

During 2024–25, a total of 7,677 deliveries were reported in the district, with 7,529 newborns screened under the newborn screening programme, reflecting a high coverage rate of over 98%. Among the screened infants, 335 conditions were identified, indicating the effective functioning of early detection services. This demonstrates the district's strong commitment to comprehensive newborn care, ensuring that congenital and metabolic conditions are identified and managed promptly to improve long-term child health outcomes. In Thrissur district, special focus is also given to 41 tribal areas, where screening camps are conducted more frequently to identify new cases and ensure follow-up for previously detected conditions.

11.2.2 Shalabham

Shalabham (newborn screening) is conducted at all delivery points and includes checks for Visible Birth Defects (VBD), pulse oximetry screening, and screening for inborn errors of metabolism prior to discharge. To ensure full coverage, five Shalabham nurses have been appointed across delivery facilities. Dedicated *Shalabham corners* are set up and systematically maintained to provide safe and professional physical examinations and screenings for all newborns. Shalabham corners are set up at all delivery points of the district.

11.2.3 Comprehensive Lactation Management Centre (CLMC)

A CLMC has been established at the Government Medical College, Thrissur, located near the labour room and newborn care unit. The centre collects donor breast milk from healthy lactating mothers, which is then screened, tested, pasteurized, and stored. This milk is supplied to sick, premature, or low birth weight babies to support their nutritional needs and prevent complications related to prematurity.

To support the smooth functioning of the CLMC, six NHM staff have been assigned specifically for this purpose. According to recent data, 2,030 infants have benefited from this facility in the district. CLMC now caters to beneficiaries from the private sector too. Videos, leaflets, public functions, press releases and boards were displayed to promote CLMC.

Table 11.2.3.1: CLMC DATA 2024-2025

No of mothers donated milk	Milk collected	No of babies benefited
1027	1272223 ml	2030

**Source: District report*

During 2024–25, a total of 1,027 mothers donated human milk, contributing 1272223 ml to the district's human milk bank. This initiative significantly supported neonatal care, with 2,030 babies benefiting from donor milk. The data highlight the district's strong commitment to promoting breastfeeding and ensuring optimal nutrition for vulnerable and preterm infants through effective human milk banking services.

11.2.4 District Early Intervention Centre (DEIC)

The primary aim of the District Early Intervention Centre (DEIC) is to minimise delays and prevent disabilities in children aged 0 to 18 years through early identification and timely intervention. DEIC primarily functions as a referral hub, providing support to children diagnosed with health conditions during routine health screenings.

DEIC Thrissur was initially established in 2014 at the General Hospital, Thrissur. In 2022, it was relocated to the District Hospital, Wadakkanchery. The new facility was constructed with support from the Kerala Social Security Mission. The centre is well-staffed with a multidisciplinary team comprising a paediatrician, staff nurse, optometrist, physiotherapist, dental surgeon, clinical psychologist, and audiologist to ensure holistic care for children. In addition to clinical services, the DEIC offers free medicines and diagnostic investigations to ensure accessibility for all children in need. Specialized follow-up programs are also in place for *Hridyam* beneficiaries and children with growth hormone deficiencies, reflecting the district's commitment to long-term child health monitoring. The presence of a dedicated CVI (Cerebral Visual Impairment) room further enhances the scope of rehabilitative and supportive care provided through the centre.

Table 11.2.4.1 DEIC Case load

YEAR	NEW CASES	FOLLOW-UP CASES	TOTAL CASES
2024-25	1373	4048	5421

**Source: District Report*

In the year 2024–25, a total of 5,421 cases were managed under the program, comprising 1,373 new cases and 4,048 follow-up cases. This reflects the district's continued focus on comprehensive care and systematic follow-up of beneficiaries, ensuring sustained treatment and monitoring for improved health outcomes.

11.2.5 HRIDYAM

A distinctive initiative by the Government of Kerala focuses on supporting children with Congenital Heart Disease (CHD). This initiative includes a web-based registry for tracking CHD cases across the state. It facilitates monitoring of programme progress, helps identify challenges in implementing established protocols, and provides insights into case status, system response times, and the overall outcomes of the intervention. During 2024–25, a total of 211 children were registered under the Hridyam program, of which 79 underwent corrective cardiac surgery, reflecting on district's strong commitment to early identification, referral, and surgical management of congenital heart diseases through effective coordination with tertiary care centres.

11.2.6 Mobile Intervention Unit (MIU)

The Mobile Intervention Unit (MIU) was launched in Thrissur on November 17 as part of the DEIC's outreach initiative in collaboration with the Kerala Social Security Mission (KSSM). Its objective is to provide services to differently abled children aged 0 to 18 years.

Currently, two MIUs are operational in the district:

- MIU 1, linked to District Hospital, Wadakkanchery, covers 11 health institutions.

- MIU 2, attached to the General Hospital, Irinjalakuda, covers 15 health institutions.

Children are referred to the MIU through multiple sources, including DEIC, REIC(Regional Early Intervention Centre), NIPMR(National Institute of Physical Medicine and Rehabilitation), RBSK nurses, ASHA workers, and other health personnel. Services are delivered through 26 fixed centres across the district and include support from Developmental Therapists, Physiotherapists, Audiologists and Speech Therapists, Special Educators, and Clinical Psychologists.

Table 11.2.6.1 MIU Status

YEAR	NEW CASES	FOLLOW-UP CASES	TOTAL CASES
2024-25	1997	3137	5134

*Source: District Report

In 2024–25, a total of 5,134 cases were managed under the program, comprising 1,997 new cases and 3,137 follow-up cases.

11.3. Adolescent Health

11.3.1 Rashtriya Kishore Swasthya Karyakram (RKSK)

To promote the holistic development of adolescents, five adolescent counsellors are currently deployed at Adolescent Friendly Health Clinics (AFHCs). This marks a significant shift from traditional clinic-based services to a more proactive approach focusing on promotion, prevention, and engaging adolescents within their everyday environments, such as schools, families, and communities. AFHCs were restructured as adolescent-friendly with IECs and positive messages.

The programme is driven by key community-based strategies, including outreach activities by counsellors, facility-based counselling, Social and Behaviour Change Communication (SBCC), and the strengthening of AFHCs at all levels of healthcare delivery.

The district has established 5 Adolescent Friendly Health Clinics (AFHCs), each supported by a dedicated adolescent counsellor, ensuring accessibility of adolescent health services. In addition, 200 peer educators have been selected and trained, strengthening community-level awareness and outreach among adolescents through peer-led in

Table 11.3.1.1 Adolescent Services (2024-2025)

Total number of counselling services	**A total number of adolescents received awareness sessions.**
19657	136621

**Source: District Report*

During 2024–25, a total of 19,657 counselling services were provided, and 1,36,621 adolescents participated in various awareness sessions. This indicates the district's strong focus on adolescent health promotion and psychosocial support through structured counselling and educational initiatives.

11.3.2 Peer Educators Programme

In 2024–25, 200 Peer Educators were selected from four health blocks in Thrissur district. The training was launched as a district-level initiative, involving nodal teachers and Adolescent Health (AH) counsellors. Trained resource persons facilitated the sessions and coordinated various activities to engage and motivate the peer educators effectively. An awareness magic show and ventriloquism were performed during the district-level training.

11.4. ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

The Accredited Social Health Activist (ASHA) is a trained female community health worker instituted under the National Rural Health Mission (NRHM) of India. ASHAs serve as a vital link between the community and the public health system, especially in rural and underserved areas. Their primary role is to promote health awareness, facilitate access to healthcare services, and support maternal and child health initiatives.

Table 11.4.1 Distribution of ASHA workers in the District (2024-2025)

Distribution Of ASHAs	Number of ASHAs
Rural	2007
Urban	257
Hamlet	25
Total	**2289**

**Source: District ASHA Report*

The district has a total of 2289 ASHA workers, with the majority (approximately 87.6%) deployed in rural areas. Urban areas have 257 ASHAs (~11.2%), while hamlet areas have a minimal presence with 25 ASHAs (~1.1%). This distribution indicates a strong focus on rural health outreach, aligning with the government's strategy to strengthen primary healthcare in remote areas. As per the new orders issued for the year 2017–2018, ASHAs (Accredited Social Health Activists) were reorganised on a "one ASHA per ward" basis. In panchayats where the number of ASHAs exceeded the number of wards, the existing ASHAs were retained, and new ASHAs were selected only in areas with fewer workers. Additionally, an order was issued to appoint two ASHAs in municipal or corporation divisions with populations exceeding 2,500, and three ASHAs in areas with populations above 5,000. This helped fill the shortfall of ASHAs across all regions.

11.4.1 Hamlet ASHA Concept

To strengthen health activities in tribal areas, the Hamlet ASHA concept was introduced. Two women were shortlisted from tribal colonies by the *Oorukoottam* and local self-government representatives. One among them was selected through a two-day process to serve as a Hamlet ASHA. The selected candidates underwent 14 days of residential training to prepare for fieldwork. Initially, ASHA services were rendered voluntarily, but over time, wage fixation and periodic increments have contributed to the financial security of ASHAs.

11.4.2 ASHA Monthly Review Meetings

A district-level ASHA review meeting is conducted in the first week of every month to evaluate ongoing activities. Each ASHA from every health institution (including Urban Family Health Centres) attends. General issues are discussed, and new government orders and circulars are read and explained. At least one training session on a relevant topic is also included. Senior officials, including the DMO and DPM, attend these meetings to communicate important updates.

11.4.3 ASHA Module Trainings

Regular training sessions are conducted to keep ASHAs updated. The eighth module, for instance, focused on AYUSH and included practical classes in the afternoons following theoretical sessions.

By 2022, nine module trainings had been rolled out in Kerala. Due to increased fieldwork during the COVID-19 pandemic, there was resistance to additional training. However, this concern was taken seriously by the district administration and discussed in the Executive Committee. Based on the District Collector's suggestion, KILA (Kerala Institute of Local Administration) was approached and agreed to conduct the ninth module training as a three-day residential program, exclusively in Thrissur.

The initiative was enthusiastically received by ASHAs, who expressed immense gratitude to the district leadership.

11.4.4 Residential Training Innovations

Once residential training was approved, several innovative measures were planned. Training dates were fixed based on KILA's availability, and ASHAs were allowed to select their preferred dates via Google Forms. Participants were then assigned to batches, and Medical Officers/Superintendents were informed accordingly.

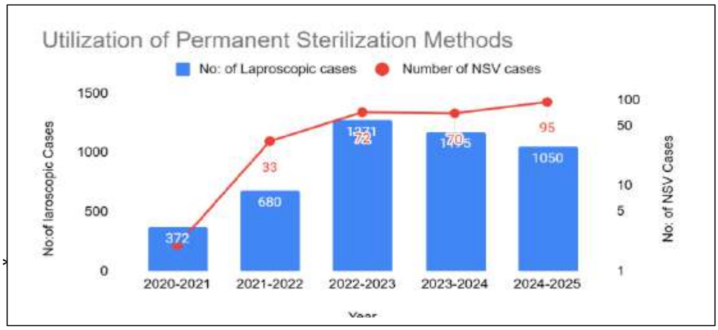
This format enabled ASHAs from various blocks and panchayats to interact and learn collaboratively without disrupting their institutional duties. The training also included non-module topics such as Yoga, Self-defence, HBNC (Home-Based Newborn Care), and HBYC (Home-Based Young Child Care).

KILA provided all participants with notepads, jute bags, seed pens, and accommodation. ASHAs fully committed themselves for the three days, setting aside their household responsibilities and field duties. Training at a prestigious institution like KILA gave them a renewed sense of confidence and recognition.

11.5. Family Planning

Family Planning (FP) refers to the conscious effort by individuals or couples to plan the number and spacing of their children through the use of various contraceptive methods and fertility management techniques.

Graph 11.5.1 Utilization status of Permanent Sterilization Methods (2020-2025)



Source: HMIS

Between 2020–21 and 2024–25, laparoscopic surgeries increased from 372 to 1271 before slightly declining to 1050, reflecting improved surgical capacity. NSV cases showed a steady rise from 2 to 95, indicating growing acceptance of male sterilization. However, female sterilization still dominates the family planning landscape, highlighting the need for continued promotion of male participation.

Table 11.5.1: Status of Utilization of Temporary contraceptive methods

Year	Contraceptive Condoms	Oral pills	IUCD
2020-21	60661	8305	2293
2021-22	75152	5181	2527
2022-23	114168	7888	2976
2023-24	192866	5898	2809
2024-25	261175	11536	2870

Year	Contraceptive Condoms	Oral pills	IUCD
TOTAL	**704022**	**38808**	**13475**

Source: HMIS

The Table highlights that temporary contraceptive methods, particularly condoms, dominate family planning practices in Thrissur district, accounting for the majority of uptake. Oral pill usage indicates variability, while IUCD adoption is steady but comparatively low. Overall, the district demonstrates progressive improvement in family planning coverage, but efforts are needed to promote male participation (increase NSV acceptance), enhance awareness and counselling to balance the use of temporary and permanent methods and to strengthen follow-up and accessibility of a wider basket of contraceptive choices.

11.6. Biomedical Equipment Maintenance Program (BEMP)

All equipment, excluding immunization (cold chain) equipment, under DHS institutions and SNCUs (Special Newborn Care Units) of Government Medical Colleges, is covered under this programme.

For DHS institutions, Kerala Medical Services Corporation Limited (KMSCL) carried out the tender procedures and appointed a third-party service provider, currently Cyrix Healthcare Limited, to implement the Biomedical Equipment Maintenance Programme (BEMP) using NHM funds.

A dashboard is maintained collaboratively by the third-party service provider, KMSCL, and NHM. The third-party provider has barcoded all biomedical equipment in SNCUs at MCHs, GHs, DHs, THQHs, THs, CHCs, FHCs, and Sub-Centres. Each hospital has been provided with a user ID and password to access and monitor the equipment data on the dashboard.

This programme includes:

- Barcoding
- Servicing
- Preventive Maintenance (PM)

- Calibration

Users can register complaints 24/7 via a toll-free IVRS (Interactive Voice Response System) managed by KMSCL and a third-party service provider. Complaints are attended to by Cyrix engineers within the stipulated time. Equipment under warranty is repaired by the supplier, and after the warranty expires, the equipment is added to BEMP.

Programme reviews are conducted:

- Monthly at the district level by the DPM, DMO, KMSCL, and the third-party
- Quarterly at the state level by officials from KMSCL, NHM, and the third-party

11.6.1 Equipment Procurement

Equipment approved under the ROP (Record of Proceedings) is primarily procured by issuing an Administrative Sanction (AS) to KMSCL at the state level. KMSCL conducts the tendering process, procures the equipment, and arranges for supply and installation in the respective hospitals under approved programmes.

After verifying satisfactory equipment performance, the Equipment is entered into stock at the hospital level, invoices are generated and verified, and payments are made to vendors by KMSCL.

11.6.1.1 Equipment Proposals and Planning

For the PIP (Project Implementation Plan), a gap analysis is conducted at the hospital level to identify equipment shortages and infrastructure needs. Based on this analysis, a comprehensive list of required equipment is prepared by each facility, scrutinised at the district level, and subsequently forwarded to the state for review and approval.

Equipment proposals are prepared annually under various health programmes and initiatives, including:

- FRUs/Delivery Points – to strengthen maternal and child health services and reduce MMR and IMR.

- Operation Theatres and Labour Rooms – for setting up and upgrading facilities as per IPHS standards.

- Laparoscopes – to support family planning and sterilisation services.

- Diagnostic Equipment – under the Aardram Mission to improve diagnostic capabilities.
- Public Health Laboratory and Critical Care Unit (CCU) equipment – under PM-ABHIM.
- Equipment for BPHCs, FHCs, and Sub-Centres, and dialysis machines – funded through the 15th Finance Commission Grant.

At the district level, procurement activities for DPMSU, NUHM, and other programmes are undertaken through the Government e-Marketplace (GeM) portal, quotations, or tendering processes. Funds are mobilised from multiple sources, including NHM, State budget allocations, and CSR initiatives.

Table 11.6.1: Call status under BEMP (2024-2025)

Description	Total Call Registered	Total Call rectified	Pending calls	Percentage of rectified calls
22-23	3005	2936	69	97.70%
23-24	5395	5295	100	98.14%
24-25	6214	6017	197	96.82%

**Source: District Report*

The data indicate a steady increase in the number of biomedical equipment maintenance calls over the years, reflecting the expansion of medical infrastructure and equipment across health facilities. Despite this rising workload, the rectification rate remains consistently high, exceeding 96% in all years, which demonstrates the efficiency of the district's biomedical maintenance system.

However, there is a slight increase in pending calls in 2024–2025 (197 cases) compared to previous years, possibly due to equipment ageing, higher caseloads, or delays in spare part procurement. Strengthening preventive maintenance mechanisms and timely follow-up could further enhance equipment uptime and service delivery.

11.6.2 Compliance with the norms of AERB for equipment under the Radiology department

Figure: 11.6.2.1, Compliance with AERB norms

Total Number of Hospitals having Radiology Equipment: 16

Total Number of Hospitals having AERB Compliance: 16

Compliance to the norms of AERB: 100%

**Source: District Report*

All radiology equipment in the district is required to comply with the Atomic Energy Regulatory Board (AERB) norms to ensure radiation safety and quality standards. The Radiology departments across major hospitals, including district and taluk hospitals, maintain valid AERB registration and certification for their X-ray, CT, and other radiological equipment.

Periodic quality assurance (QA) tests, radiation safety audits, and dosimetry monitoring of personnel are undertaken as per AERB guidelines. Radiation safety officers (RSOs) are designated in facilities handling radiological equipment to oversee compliance.

In 2024–2025, most institutions were found to be compliant with AERB requirements, with renewal of licenses and equipment calibration conducted in a timely manner. However, a few facilities reported delays in license renewal or pending QA certification due to administrative or technical reasons. Follow-up action has been initiated to ensure 100% compliance in the upcoming year.

11. 7. Integrated Disease Surveillance Programme

IDSP program aims to strengthen disease surveillance in the country by establishing a decentralized surveillance system for epidemic-prone diseases to detect the early warning signals, so that timely and effective public health actions can be initiated in response to health challenges in the District.

11.7.1 Profile of Communicable Diseases

Outpatient visits in the state showed a steady rise, increasing from 62.7 lakh in 2022 to 76.6 lakh in 2024, indicating high healthcare utilization. Among reported symptoms, fever and acute respiratory infections (ARI) remained the most common, though ARI cases showed a notable decline in 2024. Vector-borne diseases presented a mixed trend: malaria persisted at low levels with one death in 2024, while dengue surged sharply from 433 cases in 2022 to a probable 7,371 in 2024, accompanied by rising confirmed cases and deaths. Leptospirosis continued as a major public health concern with 413 confirmed cases and 41 deaths in 2024. Hepatitis A showed an outbreak pattern, with 458 cases and 5 deaths, while influenza H1N1 escalated significantly to 960 confirmed cases and 12 deaths in 2024 after relatively low levels in previous years. Typhoid and hepatitis B remained prevalent but without mortality, whereas scrub typhus appeared sporadically with occasional fatalities. These trends underscore the need for vigilant surveillance and timely public health response.

Table 11.7.1 District disease profile (2022-2025)

Disease Status		2022 (Jan-Dec)		2023 (Jan-Dec)		2024(Jan-Dec)		2025 (Jan-March)*	
		Case	Death	Case	Death	Case	Death	Case	Death
No of OP		6267919	0	6876281	0	7667185	0	1931100	0
Fever		190632	0	166352	0	218665	0	48471	0
ARI		422836	0	382660	0	332240	0	85648	0
ADD (Acute Diarrheal Disease)		37589	0	37788	0	51989	0	11237	0
Cholera	P	0	0	0	0	0	0	0	0
	C	0	0	0	0	1	0	0	0
Malaria	P	0	0	0	0	0	0	0	0
	C	66	0	90	0	114	1	18	0
Hepatitis-A	P	17	0	72	1	121	0	16	0
	C	15	0	44	0	337	5	108	1
Hepatitis-B	P	0	0	0	0	0	0	0	0
	C	25	0	7	0	29	0	2	0

Typhoid	P	8	0	19	0	85	0	22	0
	C	11	0	9	0	8	0	7	0
Leptospirosis	P	231	16	247	3	255	0	29	0
	C	174	20	184	26	413	41	26	5
Dengue	P	433	1	3752	2	7371	2	436	0
	C	213	2	1972	17	2162	17	122	0
CG	P	0	0	0	0	0	0	0	0
	C	1	0	1	0	0	0	0	0
Scrub Typhus	P	2	0	0	0	0	0	0	0
	C	10	2	7	1	3	1	1	0
H1N1	P	0	0	0	0	0	0	0	0
	C	7	2	121	7	960	12	21	2

** Source: IDSP/DHS data* Major Non-Communicable Diseases in the District

Table 11.7.2 Disease Status in the State (Rate per 100,000 Population, 2022–2025) – Cases and Deaths

Case and Death Rate per 100000 population								
	2022		2023		2024		2025 (Jan-March) *	
	Case	Death	Case	Death	Case	Death	Case	Death
Dengue Fever	6.4	2	59.6	17	65.32	17	1.97	0
Malaria	2	0	2.7	0	3.44	1	0.1	0
Chikungunya	0	0	0	0	0	0	0	0
Leptospirosis	5.3	20	5.6	26	12.48	41	0.38	5
Hepatitis A	0.5	0	1.3	0	10.18	5	0.31	1
Hepatitis B	0.8	0	0.2	0	0.88	0	0.03	0
Typhoid	0.3	0	0.3	0	0.24	0	0.01	0
ADD	1130.9	0	1124.1	0	1570.66	0	47.45	0
Scrub Typhus	0.3	2	0.2	1	0.09	1	0	0
H1N1	0.2	2	3.7	7	29	12	0.88	2

Fever	5702.6	0	4958.4	0	6606.19	0	199.58	0
Cholera	0	0	0	0	0.03	0	0	0
Diphtheria	0	0	0	0	0	0	0	0
Enteric Fever	0	0	0	0	0	0	0	0
Measles	0.1	0	4.3	0	1.48	0	0	0
Pneumonia	0	0	0.1	2	0	0	0	0
Whooping Cough	0	0	0	0	0	0	0	0
Nipah	0	0	0	0	0	0	0	0

** Source: IDSP/DHS data* Major Non-Communicable Diseases in the District

11.7.2 Trend Analysis of Communicable Disease Burden in Thrissur District-Period: 2022-2024

- Fever: Cases have fluctuated, decreasing from 190,632 in 2022 to 166,352 in 2023, then rising to 218,665 in 2024.
- ADD cases remained relatively stable between 2022 and 2023 (37,589 and 37,788, respectively) before increasing to 51,989 in 2024
- ARI (Acute Respiratory Infection): A similar trend is observed, with cases decreasing from 422,836 in 2022 to 382,660 in 2023, then to 332,240 in 2024.
- Dengue: Presumptive cases saw a massive spike from 433 in 2022 to 3,752 in 2023 and 7,371 in 2024. Confirmed cases also increased significantly from 213 in 2022 to 1,972 in 2023 and 2,162 in 2024. Deaths related to dengue were notable in 2023 and 2024, with 17 deaths each year.
- Leptospirosis: Confirmed cases increased from 174 in 2022 to 184 in 2023 and 413 in 2024. Deaths were highest in 2024, with 41 fatalities.
- Hepatitis A confirmed cases have significantly increased from 15 in 2022 to 337 in 2024, with a notable number of deaths (5).
- H1N1: Confirmed cases surged from 7 in 2022 to 121 in 2023 and 960 in 2024. Deaths peaked in 2024 with 12 fatalities.

- Malaria: There's a noticeable increase in malaria cases from 66 in 2022 to 90 in 2023, and further to 114 in 2024.

11.8. National Vector Borne Disease Control Program (NVBDCP)

The National Vector Borne Disease Control Programme (NVBDCP) is one of the most comprehensive and multi-faceted public health activities in the country and is concerned with prevention and control of vector-borne diseases, namely Malaria, Filariasis, Kala-azar, Dengue and Japanese Encephalitis (JE). As the district is approaching the elimination of Filaria and Kala azar by 2025, intensified vector control activities are being implemented at a faster pace. Coordination of preventive activities for the control of vector-borne diseases, reporting of new cases identified, and strengthening of health education is being practised.

Table 11.8.1 NVBDCP Status

Year	No of camps	Health Education & IEC	Migrants screened	Malaria	Microfilaria	Kala azar
2024	221	221	12290	10	97	0

**Source: District Report*

In the year 2024, a total of 221 camps were conducted under the programme, all of which included Health Education and IEC activities. During these camps, 12,290 migrants were screened as part of active surveillance measures. The screening identified 10 cases of malaria and 97 cases of microfilaria, while no cases of kala-azar were reported. These activities reflect the district’s continued emphasis on early detection, preventive education, and community engagement in controlling vector-borne diseases.

11.9 National Viral Hepatitis Control Programme

The National Viral Hepatitis Control Programme (NVHCP) was launched by the Ministry of Health and Family Welfare, Government of India, on the occasion of World Hepatitis Day, 28th July 2018. This integrated initiative aims at the prevention and control of viral hepatitis in India, aligning with Sustainable Development Goal (SDG) 3.3, which targets the elimination of viral hepatitis as a public health threat by 2030.

The programme provides a comprehensive framework addressing all major types of hepatitis (A, B, C, D & E), covering the spectrum from prevention, early detection, diagnosis, and treatment to monitoring of treatment outcomes. In the district, GMCH Thrissur and GH Thrissur have been designated as nodal centres for treatment under the NVHCP, ensuring accessibility of specialized care to the community.

Table 11.9.1 NVHCP Status (2024-2025)

Disease Status	**Year**	
	2024(Jan-Dec)	**2025(Jan-March)**
Total No. of persons screened for Hepatitis B	49954	11962
Total No. of persons found positive for Hepatitis B	268	55
Total No. of patients found eligible for treatment of Hepatitis B	28	10
Total No. of patients put on treatment of Hepatitis B	24	10
Total No. of persons screened for Hepatitis C	48539	12394
Total No. of persons found positive for Hepatitis C	253	19
Total No. of patients found eligible for treatment of Hepatitis C	37	9
Total No. of patients put on treatment of Hepatitis C	37	9
Total Number of Hep C patients completed treatment	17	4

**Source: District NVHCP Programme*

During the period from January 2024 to March 2025, a total of 61,280 persons were screened for Hepatitis B. Out of these, 313 individuals tested positive, and 36 patients were found eligible for treatment, with 36 patients initiated on treatment.

Similarly, for Hepatitis C, a total of 61,940 persons were screened, out of which 274 individuals tested positive. Among them, 44 patients were found eligible for treatment, and 44 patients were initiated on treatment. Importantly, 20 patients successfully completed treatment during this period.

The data indicate that the programme is actively identifying cases through regular monthly screening and ensuring linkage to care and treatment. The treatment initiation rate is 100% among those eligible, reflecting effective follow-up mechanisms. However, the relatively lower number of patients completing Hepatitis C treatment compared to those initiated highlights the need for strengthened patient retention and adherence support mechanisms

11.10. National Rabies Control Program

To address the issue of rabies in the country, the National Rabies Control Programme was approved during the 12th FYP (Five-Year Plan) by the Standing Finance Committee meeting held on 03.10.2013 as a Central Sector Scheme to be implemented under the Umbrella of NHM. The Programme had two components – Human and Animal Components in the 12th FYP.

The IDRV/IMRV programme in Thrissur recorded a high patient load of 72,030 cases between January 2024 and March 2025, with dog bites remaining the leading cause of exposure. A total of 9,223 Category III victims received ARS, and 44,329 patients completed PEP, reflecting strong compliance and effective follow-up. Pre-exposure prophylaxis was provided to 819 high-risk individuals, strengthening preventive coverage. However, 323 hypersensitivity reactions following ERIG administration were reported, peaking in September–November 2024, indicating the need for enhanced pharmacovigilance and safety monitoring.

Table 11.10.1 Patient Load for the year 2024-2025

YEAR -2024			**IDRV/IMRV THRISSUR**					
Sl.no	**Month**	**Total Patients**	**Animal bite**		**No. of Category III victims given ARS**	**Number of Patients completed PEP IN the current month**	**No. of persons who took Pre-Exposure Prophylaxis**	**No of Local Hypersensitivity reactions reported after ERIG Administration**
			Dog	**Cat**				
1	January	5292	1828	3249	926	3710	26	0
2	February	4303	1463	2662	820	2049	148	0
3	March	4715	1729	2821	925	3149	55	0
4	April	4570	1676	2716	290	2674	24	0
5	May	5182	1801	3160	960	2863	38	0
6	June	5531	1923	3394	1085	3143	42	0
7	July	5127	1874	3002	702	3087	67	0
8	August	5419	1995	3183	977	3144	56	52
9	September	4835	1821	2839	859	2781	31	73
10	October	5037	1702	3122	917	2597	35	93
11	November	5380	1954	3189	1006	2612	62	93

12	December	5882	2302	3381	203	2840	105	6
Year -2025								
13	January	5716	2156	3380	291	2747	19	0
14	February	5743	2196	3376	295	2278	60	6
15	March	5298	1847	3256	37	2659	61	0

**Source: NRCP Monthly DHS Report*

11.11 National Leprosy Eradication Programme (NLEP)

NLEP stands for National Leprosy Eradication Programme. It is a health scheme in India that aims to reduce the burden of leprosy and prevent disabilities.

Objectives of NLEP: Reduce the prevalence of leprosy, reduce the percentage of Grade II disability among new cases, improve awareness about leprosy and its curability, prevent disability, and reduce stigma and discrimination

Sparsh Leprosy Awareness Campaign (SLAC) is a nationwide campaign in India to raise awareness about leprosy and eliminate the stigma associated with it. The campaign is part of the National Leprosy Eradication Program (NLEP).The focus of SLAC is to make the community aware of the importance of early detection of leprosy, followed by complete treatment in order to prevent physical disabilities.

11.11.1 Leprosy Case Detection Campaign (LCDC)-ASWAMEDHAM 6.0

Aim: - To detect all hidden, untreated cases of leprosy in the community by Active Surveillance and treatment initiation.

Aswamedham Campaign 6.0 - The campaign successfully identified 33 new leprosy cases, ensuring early detection and initiation of treatment. The distribution of MCR chappals and self-care kits, along with medical camps, reflects a comprehensive approach addressing both clinical management and patient welfare.

- MCR CHAPPAL – Issued to 20 Patients.
- Self-care kit – Issued to 32 Patients.

- 12 Medical camps conducted.

Table: 11.11.1 Case Detection -2024 Status

Year	Multibacillary cases	Paucibacillary cases	Total
2024	29	4	33

**Source: District Report*

In 2024, a total of 33 new leprosy cases were detected in the district, of which 29 (87.9%) were multibacillary (MB) and 4 (12.1%) were paucibacillary (PB). The predominance of multibacillary cases due to delayed detection or late health-seeking behaviour highlights the need to strengthen active case finding, contact tracing, and community awareness to ensure early diagnosis and treatment for effective disease control.

11.12 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

The Government of Kerala has launched the Prevention and Control of Non-communicable Diseases programme on April 7th, 2010, World Health Day, under the auspices of the Health Services Department and NHM. This Programme aims at the prevention and control of non-communicable diseases and thereby the reduction in the burden of NCD in the state. In Thrissur district, this programme was launched in 2012. In the initial stage, NCD Clinics are implemented in 24 CHCs with relevant staff, including Medical Officer, Dietician, Staff Nurse, and DEO cum accountant. At the PHC level, this clinic is conducted by a Medical Officer, Staff nurse /JPHN/JHI. In CHC's clinic is conducted 6 days a week, and in PHC 's weekly once (on Thursday). At the early stages, screening is done through camps at various places. In January 2015, the staff under NPCDCS were reallocated to District or Subdistrict level hospitals and were functioning on all days. As part of this programme, international days like Diabetes Day, Stroke Day, Cancer Day, Food Safety Dayetc, are conducted with rallies, Cookery shows, Awareness classes, and Screening camps etc. As part of this programme, SWAAS Clinic, COPD Clinic are done in district hospitals and selected FHCs. Cancer care units are functioning in the General Hospital Thrissur, THQH Kodungallur and DH Wadakkanchery.

During the flood season and the COVID-19 pandemic season NCD Drugs are distributed to the beneficiaries through ASHA Workers and Health volunteers.

Table 11.12.1 NCD status of the district (2022-2025)

Disease	**2022**		**2023**		**2024**		**2025 (Jan-March)**	
	Case	Death	Case	Death	Case	Death	Case	Death
Accidental injuries	43556	0	60143	0	81020	0	18435	0
Cancers								
Cancer Cervix	146	0	134	0	82	0	17	0
Breast Cancer	582	2	550	0	1597	0	309	0
Lung Cancer	594	8	769	1	367	0	43	0
Oral Cancer	580	4	1021	3	302	0	42	0
Cardiovascular disease								
Rheumatic fever	1070	0	390	0	300	0	17	0
Hypertension	363450	3	419298	2	510264	1	158437	0
Ischemic Heart disease	13292	13	8244	2	11450	0	5747	8
Congenital Heart Disease (CHD)	149	0	402	0	775	0	300	0
Others								
Diabetes								
Type 1	5403	0	5210	0	8924	0	256	0
Type 2	224330	2	259792	6	351547	1	95886	0
Neurological disorders								
Cerebrovascular disorders	4692	13	6054	9	6769	3	3744	0
Chronic neurological disorders	151	0	204	1	1959	0	130	0
Others								
Obesity	7836	0	5022	0	6569	0	2721	0
Psychic disorders								
Common Mental disorders	9173	0	10561	0	8776	0	3546	0
Severe mental disorders	133	0	462	0	493	0	15	0
Road Traffic Accident								

	8469	7	8843	1	7596	0	2601	0
Snake bite								
	14	0	242	0	458	0	49	0

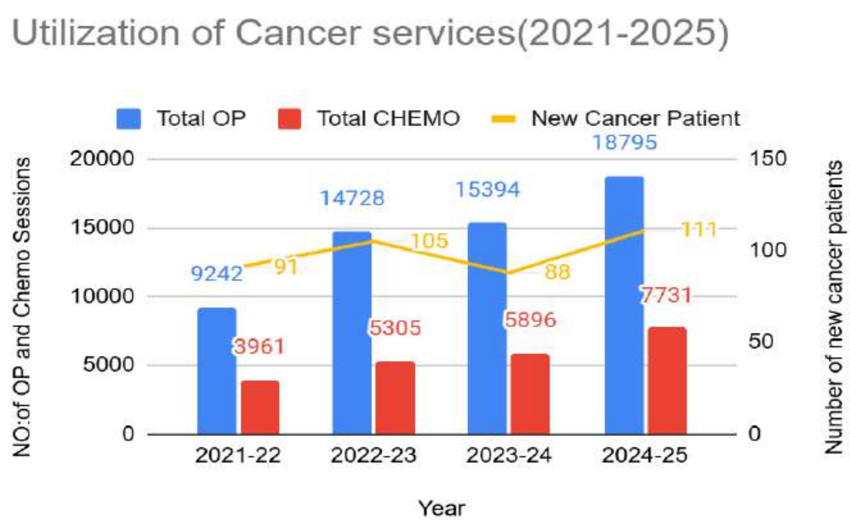
**Source: District NCD Report*

Non-Communicable Diseases continue to contribute substantially to the district's morbidity burden, with hypertension and diabetes remaining the most prevalent conditions. Cancers, particularly breast and oral, show fluctuating trends with a peak in 2023 followed by a decline. Cardiovascular diseases, especially ischemic heart disease and cerebrovascular disorders, remain significant causes of mortality. Road traffic accidents and accidental injuries add a considerable burden of trauma-related cases. Notably, while cervical cancer is declining, chronic neurological disorders are rising sharply. These findings emphasize the urgent need for strengthened NCD screening, early detection programs, and injury prevention strategies, alongside better management of hypertension and diabetes at the community level.

11.12.1 Details of Patients Availing Services In The Cancer Unit- Thrissur District

Cancer care services in the district show a strong upward trend in utilization. Outpatient visits and chemotherapy sessions have nearly doubled in four years, suggesting improved access and service expansion. The number of new cancer patients shows year-to-year variation but with a peak in 2024–25, possibly due to strengthened screening and awareness programs. The rising service demand highlights the need for scaling up oncology infrastructure, timely chemotherapy availability, and strengthened referral pathways to manage the increasing cancer burden effectively.

Graph 11.12.2.1 Utilization of Cancer Services



**Source: District Report*

11.13. NPHCE –National Programme for Elderly Health Care

The NPHCE programme is implemented in Thrissur with NPCDCS. This programme is implemented weekly in CHCs and PHCs. Through this programme conducting a routine health assessment of the elderly persons is conducted based on simple clinical examination relating to eye, BP, blood sugar, etc. Public awareness on promotional, preventive and rehabilitative aspects of geriatrics during health and village sanitation day/camps. A 10-bedded geriatric ward is functioning in the General Hospital, Thrissur. Geriatric wards and clinics are functioning in District Hospitals every day of the week

11.14 National Programme for Prevention and Control of Deafness (NPPCD)

NPPCD was launched with the purpose of early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness in them, also aimed at the rehabilitation of the hearing impaired. This programme is being implemented by the Ministry of Health and Family Welfare with the technical support of the Directorate General of Health Services

The implementation of extension centres was carried out in a phased manner to ensure gradual coverage and efficient service delivery.

- The first phase established centres at Chavakkad and Kodungallur, strengthening outreach in coastal and northern areas of the district.
- The second phase expanded services to Chalakudy, enhancing access for the midland regions.
- The third phase included Wadakkanchery, covering the highland areas and improving overall district-level accessibility to health services.

This phased expansion reflects a strategic approach to decentralised healthcare delivery, ensuring equitable distribution of health services across all geographical zones.

Under the programme, the ENT specialist provides comprehensive care, including medical management of ear problems, surgical interventions for needy patients, hearing assessments, and speech and language therapy. The programme also emphasizes capacity building for healthcare professionals and community outreach through screening camps and awareness sessions, ensuring both clinical care and preventive health education in ENT.

11.15. NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISUAL IMPAIRMENT (NPCB&VI)

National Programme for Control of Blindness and Visual Impairment (NPCB& VI) was launched in 1976 as a 100% centrally sponsored programme with a goal of achieving a prevalence rate of 0.3 % of the population. The four-pronged strategy of the programme is:

- Strengthening service delivery
- Developing human resources for the eye camp
- Promoting outreach activities and public awareness
- Developing constitutional capacity

The Implementation of the programme was decentralized in 1994-95 with the formation of the District Health Society in each district of the country. The primary purpose of the District Health society is to plan, implement and monitor blindness control activities in the district as per the pattern of assistance approved for the NPCB. The District Society is expected to enhance the coverage and improve the quality of eye care service in the district. Important functions of the District Health Society are to organize screening of school children for the detection of refractive errors and other eye problems, and provide free glasses to poor children (Nursery to plus two).

11.15.1 DISTRICT PERFORMANCE REPORT

Cataract surgeries in Thrissur district showed a decline in overall performance in 2024–25, with achievement dropping from 168% to 90%. While government hospitals improved their output, the significant reduction in private sector surgeries was the main factor behind the shortfall. Strengthening collaboration with private providers and sustaining public sector growth will be essential to achieve future targets.

Table 11.15.1.1 Cataract Surgery Status in Thrissur District

Particulars	**2023- 2024**	**2024 April to 2025 March**
No. of Cataract Surgeries done	Govt: 2234 Private: 11739 NGO (Free and Paid) =4733	Govt: 2585 Private: 8330 NGO (Free and Paid) =4397
% of Achievement	168 %	90%

**Source: District NPCBI&VI Report*

11.15.2 SCHOOL HEALTH (EYE SCREENING)

Detection of refractive errors and eye problems, and provide glasses to poor children (nursery to plus two), Screening and free spectacles for near work to Old people. Mobile ophthalmic unit conducts 12 camps per month in various places of Thrissur District. DR camps are also conducted by the Mobile Ophthalmic Unit. For improving Cataract surgery, provide drugs and consumables to major hospitals

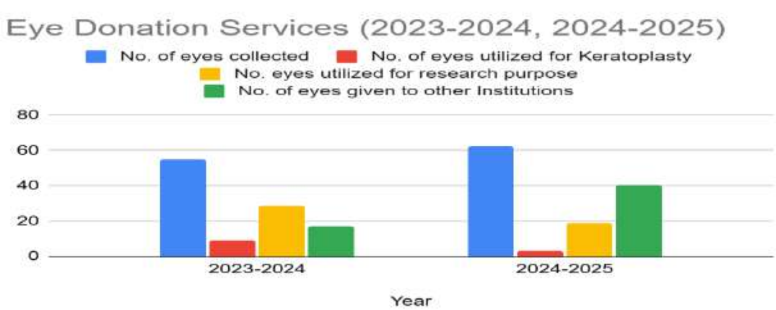
Table 11.15.2.2 School Health-Eye screening Services status (2023-2025)

Year	No. of School Children examined	No. Refractive errors detected	No. of glasses prescribed	No. of glasses supplied	No. of Teachers Trained	Spectacles provided for old age
2023-2024	58790	5701	2585	557	637	1585
2024-2025	66596	4139	2941	332	463	940

**Source: District NPCBI&VI Report*

Another objective of the project is to promote eye donation. People are being made aware of the importance of eye donation and what needs to be done to donate eyes through social media. In addition, the collected eyeballs are used for research or keratoplasty, for which a grant-in-aid is being provided to the eye bank.

Graph no :11.15.2.1: Eye Donation Services (2023 to March2025)



**Source: District NPCBI&VI Report*

11.16. NTCP-National Tobacco Control Programme

The district has been actively implementing a comprehensive Tobacco Control Programme aimed at reducing tobacco use and raising awareness among the public. This initiative focuses on prevention, cessation support, and strict enforcement of anti-tobacco measures in alignment with national health priorities. Regular training sessions have been conducted for diverse categories of staff, including health professionals, law enforcement officers, and police personnel, to enhance their capacity in addressing tobacco-related issues.Awareness campaigns have been carried out across institutions, supported by the installation of "**No Tobacco**" signboards in all public facilities. A dedicated enforcement squad is functioning effectively in the district, ensuring strict implementation of tobacco control laws and reducing public tobacco use. 11.16.1 Tobacco Cessation Services

Break-Off Clinics (Tobacco Cessation Clinics) have been established in selected Sub-Centres, providing counselling-based cessation support to individuals willing to quit tobacco. As of 15th November 2024, 32 cessation clinics are currently functioning, with further expansion planned. Since the programme's initiation in 2022, a total of 47 Tobacco Cessation Clinics has been set up in Health and Wellness Centres (HWCs) across Thrissur district.

However, challenges remain, as many clinics have become non-functional due to staff transfers and human resource gaps, affecting service continuity. To ensure sustainability, efforts are being made to strengthen human resource allocation, minimize disruption from staff transfers, enhance community engagement through targeted awareness campaigns, and integrate cessation services more effectively into existing Ayushman Arogya Mandirs and Health and Wellness Centres.

Table 11.16.1 Tobacco Counselling and cessation Services status (As on March 2025)

Number of patients who received counselling from cessation clinics	1817
The number of patients utilised nicotine replacement therapy	151
Number of visits conducted by the enforcement squad	17333
Number of challans issued and amount collected as fine for violation of Section IV	Challan-925; amount- Rs. 120200
Number of challans issued and amount collected as fine for violation of Section VI A	challan-0; amount-0
Number of challans issued and amount collected as fine for violation of Section VI B	challan-0; amount-0
Number of challans issued and amount collected as fine for violation of Section VII	challan-0; amount-0

**Source: District Report*

11.17. National Programme for Palliative Care (NPPC)

11.17.1 Primary Palliative Care Services

Primary Palliative Care focuses on individuals who are not in advanced stages of illness but require symptom management and support in home- or community-based settings. Services include home care visits, catheterizations, and the provision of basic pain management. A total of 107 units are functioning across the district to provide these services.

11.17.2 Secondary Palliative Care (SPC)

Secondary Palliative Care is directed towards patients in advanced stages of illness. It involves specialized interventions and follow-up care, such as advanced pain management, morphine therapy, and holistic support for patients with terminal or life-limiting illnesses. At present, 34 units are providing secondary palliative care in the district.

11.17.3 Physiotherapy Care Services

Physiotherapy plays a crucial role in palliative care by enhancing comfort, improving mobility, and reducing physical limitations. It supports patients experiencing pain, fatigue, and functional decline due to chronic or terminal conditions. Currently, 25 units provide physiotherapy services across the district.

11.17.4 District Palliative Care Training Centre

Capacity-building and training are integral for sustaining high-quality palliative care services. The District Palliative Care Training Centre has actively engaged in educating healthcare providers and community volunteers. So far, 25 Kudumbashree volunteers have been trained in palliative care, while 21 nursing officers have successfully completed the foundational course (two batches at the District Palliative Care Training Centre and one batch at the Palliative Care Society).

11.18. Ayushman Arogya Mandirs

The district has successfully operationalized all Ayushman Arogya Mandirs (AAMs) under the Ayushman Bharat – Health and Wellness Centre (AB-HWC) initiative, ensuring universal access to quality primary healthcare services. These facilities act as the first point of contact for the community and deliver comprehensive primary healthcare, covering preventive, promotive, curative, rehabilitative, and palliative care.

11.18.1 AAM Infrastructure in the District

Rural**:**

- AAM-PHCs (Primary Health Centres): 79
- AAM-SHCs (Sub Health Centres): 471

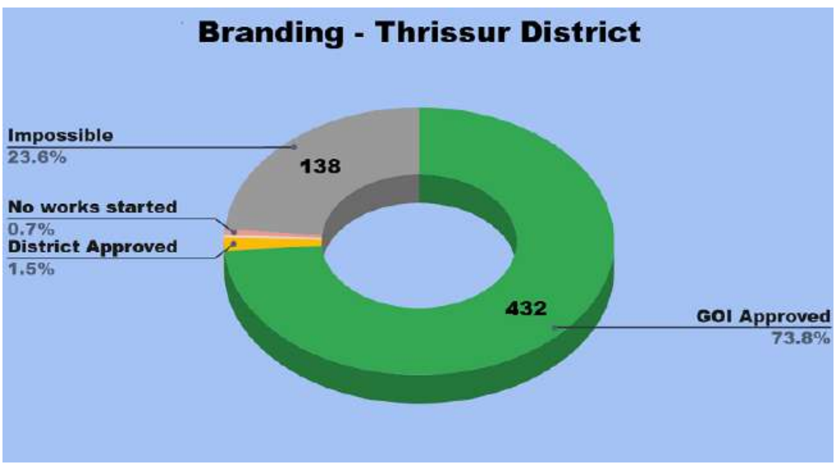
Urban:

- AAM-UPHCs (Urban Primary Health Centres): 7
- AAM-SHCs (Urban Sub Health Centres):24

11.18.2 Branding of Ayushman Arogya Mandirs

Branding of 73.8 institutions has been approved by the Government of India, while 1.5 % of institutions have received approval from the district authorities. Branding work has not yet started in 0.7% of institutions, and in 23.6% of institutions, branding is not possible due to the absence of their own building.

Graph 11.18.2.1: Branding Status of Thrissur District



**Source: AAM Portal, District Report*

The functional status of all AAMs, combined with increasing OPD utilization, improved NCD coverage, and effective teleconsultation services, has significantly strengthened primary healthcare delivery in the district. A total of 9,489 e-Sanjeevani teleconsultations were successfully conducted, providing timely specialist consultations to patients, particularly in remote areas. Regular monitoring of key performance indicators (KPIs) ensures continuous improvement and supports the vision of "Swasth Bharat, Samriddh Bharat".

11.19. Quality Assurance Programme

The Quality Assurance Programme aims to ensure the delivery of safe, effective, and patient-centered healthcare services across all health facilities. It encompasses multiple initiatives designed to improve service standards, infrastructure, and clinical outcomes, including:

- National Quality Assurance Standards (NQAS) – Establishes comprehensive quality benchmarks for public health facilities.
- Kayakalp – Promotes cleanliness, hygiene, and infection control in healthcare settings.
- Labour Room Quality Improvement Initiative (LaQshya) – Focuses on enhancing the quality of care in labour rooms and improving maternal and neonatal outcomes.
- Modernized Understandable Standardized Quality Assurance Norms and Tools (MusQan) – Provides simplified, standardized tools for continuous quality monitoring.
- Mother-Baby Friendly Health Initiative (MBFHI) – Ensures safe, respectful, and supportive care for mothers and newborns.

11.19.1 National Quality Assurance Standards (NQAS)

National Quality Assurance Standards have been developed keeping in mind the specific requirements for public health facilities as well as global best practices. NQAS is currently available for District Hospitals, CHCs, PHCs, and Urban PHCs. Standards are primarily meant for providers to assess their own quality for improvement through pre-defined standards and to bring up their facilities for certification.

The National Quality Assurance Standards are broadly arranged under 8 "Areas of Concern", which include

1. Service Provision
2. Patient Rights

3. Inputs

4. Support Services

5. Clinical Care

6. Infection Control

7. Quality Management

8. Outcome.

Table 11.19.1 NQAS Accreditation Status (As on march 2025)

Facility	Total Number	Accredited Facilities(National + State)	Achievement (%)
DH/GH	3	1	33
SDH(TH/THQH)	6	1	16.6
CHC	22	1	4.5
PHC	81	18	22
UPHC	7	7	100
SC	471	1	0.2

**Source: District Report*

11.19.2. KAYAKALP

The aim of the initiative is to improve and promote the cleanliness, hygiene, waste management, and infection control practices in public health care facilities and incentivize exemplary performing facilities.

Objectives of Kayakalp include

1. To inculcate a culture of ongoing assessment and peer review of performance related to hygiene, sanitation, and infection control.

2. To incentivize and recognize public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness, infection control, and sanitation.
3. To create and share sustainable practices related to improving cleanliness in public health facilities, which lead to positive health outcomes.

Table 11.19.2: Kayakalp Peer Assessment Status (2024-2025)

Facility	Total Number	Score >= 70% in peer assessment (number)	Score >= 70% in peer assessment (percentage)
GH	2	2	100
DH	1	0	0
SDH	6	4	67
CHC	22	6	27
PHC	81	51	63
UPHC	7	7	100
SC	471	91	19

Source: District Report

11.19.3 LaQshya & MusQan

LaQshya was launched with the objective of reduction in the maternal and newborn mortality & morbidity due to occurrence of complication during and immediately after delivery, to improve Quality of Care during the delivery and immediate post-partum care, stabilization of complications and ensure timely referrals, and enable an effective two-way follow-up system to enhance satisfaction of beneficiaries visiting the health facilities and provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility. It is programmed to benefit every pregnant woman and newborn delivering in public health institutions.

LaQshya and MusQan state assessment completed institutions:

- GH Thrissur
- GH Irinjalakuda

11.19.4 Mother and Baby Friendly Hospital Initiative (MBFHI)

The MBFHI (Mother and Baby Friendly Hospital Initiative) accreditation in Kerala is a certification process for hospitals to demonstrate their commitment to promoting breastfeeding and providing quality care for mothers and newborns. This initiative, spearheaded by the State Government of Kerala, aims to improve breastfeeding rates and enhance maternal and child health outcomes.

MBFHI-accredited facilities:

- MCH Thrissur
- GH Irinjalakuda
- THQH Chalakudy

CHAPTER 12

NATIONAL URBAN HEALTH MISSION (NUHM)

The National Urban Health Mission (NUHM) is designed to address the health needs of the urban poor, particularly slum dwellers, by ensuring access to essential primary healthcare services. In Thrissur district, the NUHM framework has been effectively implemented through a network of urban health facilities. The district has a total of 7 Urban Primary Health Centres (UPHCs) and 24 Urban Health and Wellness Centres (UHWC/AAMs), all of which are fully functional. All of the 7 UPHCs are NQAS Accredited. UPHCs are occupied with speciality services. These centres provide a wide range of services, including:

- Maternal and Child Health (MCH) services
- Family Planning and Reproductive Health Services
- Communicable Disease Control (tuberculosis, vector-borne diseases, etc.)
- Non-Communicable Disease (NCD) care through population-based screening and follow-up
- Health Promotion and Preventive Care through outreach and community engagement activities

The services are especially targeted towards slum populations, migrant workers, and other vulnerable groups, ensuring equitable access to affordable healthcare. By integrating curative, preventive, promotive, and outreach services, NUHM facilities in Thrissur district are playing a vital role in strengthening primary healthcare delivery in urban areas and contributing to the larger vision of Universal Health Coverage (UHC).

12.1 NUHM – Community Process and Service Utilization Status

The community process under NUHM in Thrissur district is functioning effectively with 123 Mahila Arogya Samithis (MAS) constituted, trained, and operational, and all 123 MAS accounts opened. A total of 257 ASHAs are in position, each covering approximately 1,000 population/households, while each JPHN supervises around 10,000 population.

During 2023–24, 396 Urban Health and Nutrition Days (UHNDs) were planned, out of which 377 were conducted. In 2025–26 (up to March 2025), 66 UHNDs have already been held. Special outreach medical camps have also been strengthened, with 34 camps conducted in 2024–25 and 4 camps held in 2025–26 (up to March).

Table 12.1.1 NUHM – Community Process and Service Utilization Status (2024-2025)

Community process		Approved	In position
No. of Mahila Arogya Samithi (MAS) constituted		123	123
No. of MAS Accounts opened		123	123
No. of MAS trainings/ orientations held		123	123
No. of ASHAs		257	257
No. of UHNDs held in 2024-25	2024-25	396	377
	Till (March 2025)	396	66
No. of special outreach medical camps	2024-25	NIL	34
	2025-26 (March 2025)	NIL	4
Population and households assigned per ASHA		1000	1000
Population and households assigned per JPHN		10000	10000
NGO Support in the Community process, if any		NIL	

**Source: District NUHM Report*

Overall, the data highlights strong community participation, consistent ASHA engagement, and growing trust in diagnostic and NCD services, although continued focus is required to ensure full coverage of UHNDs.

CHAPTER 13

NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME (NTEP)

The National TB Elimination Programme (NTEP), formerly the Revised National Tuberculosis Control Programme (RNTCP), is India's flagship initiative aimed at eliminating tuberculosis (TB) by 2025 under the broader National Health Mission (NHM). Its strategic framework is built around the four pillars: Detect – Treat – Prevent – Build, ensuring a comprehensive approach to TB control.

13.1 Key Components of NTEP

Early Detection and Diagnosis

- Active case finding, contact tracing, and screening of high-risk populations.
- Use of diagnostic tools such as CBNAAT, sputum microscopy, and chest X-rays.

Treatment and Care

- Standardised treatment regimens for drug-sensitive and drug-resistant TB.
- Directly Observed Treatment (DOT) to ensure adherence.
- Nutritional and social support for TB patients.

Prevention and Awareness

- Vaccination with BCG and preventive therapy for high-risk groups.
- Community awareness campaigns to reduce stigma and promote early care-seeking.

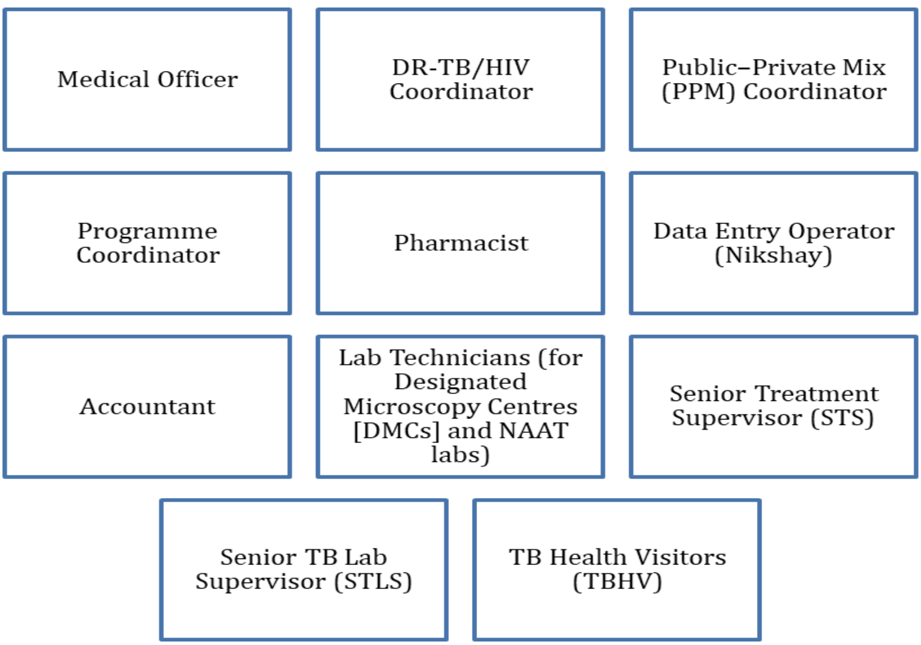
Capacity Building and System Strengthening

- Training of healthcare providers and strengthening laboratory networks.
- Digital tools and surveillance systems for TB monitoring and reporting.
- Public-private partnerships to expand coverage and improve service delivery.

13.2 District-Level Structure for NTEP Implementation

At the district level, NTEP activities are coordinated through the District TB Centre (DTC). The District TB Officer (DTO), based at the DTC, is responsible for planning, supervision, monitoring, and overall programme execution.

Supporting staff at the district level typically include:



This structured team ensures effective implementation of TB control activities, including case detection, treatment adherence, monitoring, reporting, and community engagement.

13.3 TB Status

Table 13.3 TB Status of Thrissur District

Year	TB CASES	Death
2023-2024	1927	187
2024-2025	2021	206

Source: District TB Report

In Thrissur district, the number of reported TB cases increased slightly from 1,927 in 2023–24 to 2,021 in 2024–25. Correspondingly, TB-related deaths also rose from 187 to 206, indicating persistent challenges in case management and treatment adherence. These trends highlight the need for strengthened active case finding, early diagnosis, effective treatment monitoring, and community awareness to achieve TB elimination targets under the NTEP.

13.4 CB-NAAT Testing

Cartridge-Based Nucleic Acid Amplification Test (CB-NAAT) is a rapid molecular test used to detect tuberculosis and identify rifampicin resistance, an indicator of multidrug-resistant TB. Using a preloaded cartridge, it provides automated results within 2 hours, enabling early diagnosis and timely initiation of treatment, making it a key tool in the NTEP for effective TB control.

Table 13.4.1 CB-NAAT Testing Status

Year	No. of tests conducted	Positive cases	Percentage
2020-21	5414	389	7.2
2021-22	3236	322	10
2022-23	7630	489	6.4
2023-24	6128	409	6.7
2024-25	9486	544	5.7

*Source: District TB Report

13.5 Fund Allocation For NTEP

The allocation of funds under the NTEP in Thrissur district has shown a steady increase over the years, reflecting the growing focus on TB elimination activities. The funds rose from ₹75.80 lakhs in 2020–21 to a peak of ₹144.30 lakhs in 2023–24, followed by a slight dip to ₹141.65 lakhs in 2024–25. This consistent investment highlights the commitment towards strengthening diagnostic, treatment, and surveillance mechanisms for TB control.

Table no:13.5.1 Fund allocation

Year	Amount (in lakhs)
2020-21	75.80
2021-22	113.68
2022-23	134.18
2023-24	144.30
2024-25	141.65

**Source: District TB Report*

13.6 Challenges in NTEP

Adherence issues among tribal and destitute populations: Treatment adherence continues to be a major challenge among vulnerable groups such as tribal communities and destitute individuals. Factors such as poor access to healthcare facilities, lack of awareness, nomadic lifestyles, and limited social support contribute to irregular follow-up and defaulting from TB treatment regimens.

Lack of documentation among destitute patients: Many destitute TB patients lack basic documentation, including valid identity proof or bank account details, which hinders the Direct Benefit Transfer process. Without financial support and access to rehabilitation services, these individuals struggle with treatment continuation and post-treatment care.

Inadequate sample transportation mechanisms: There is an urgent need to scale up sample transportation initiatives at the LSGD level. Inadequate and inconsistent transportation mechanisms result in delayed diagnosis and treatment initiation, particularly in remote and rural areas.

Inadequate imaging facilities: A significant number of peripheral health centres lack essential diagnostic equipment such as X-ray and imaging machines. This hampers the early detection of TB, especially extra-pulmonary cases, and contributes to underdiagnosis and delayed interventions.

Technical malfunctions in NAAT machines: Frequent technical issues and breakdowns in NAAT (Nucleic Acid Amplification Test) machines, especially TrueNat modules, disrupt the diagnostic workflow. Delays in machine repairs and maintenance further exacerbate the problem, affecting timely diagnosis and case management.

Drug shortages and expiry challenges: There is an ongoing shortage of key anti-TB drugs, including those used in Drug-Sensitive TB (DSTB), Drug-Resistant TB (DRTB), and TB Preventive Therapy (TPT). In addition, many drugs supplied have short expiry durations, leading to wastage and stock management difficulties at field level.

Limited community and CSR engagement: Mobilising community support through the Nikshay Mitra initiative and engaging local industries or corporate entities under Corporate Social Responsibility (CSR) remains a challenge. Low participation and limited awareness restrict the potential of these partnerships to support patient welfare, nutritional support, and treatment adherence.

CHAPTER 14

NATIONAL AIDS CONTROL PROGRAMME

14.1 National AIDS Control Program (NACP) Implementation

The National AIDS Control Programme (NACP) is a comprehensive public health initiative launched by the Government of India to prevent and control the spread of HIV/AIDS, ensure universal access to prevention, care, support, and treatment services, and ultimately achieve the goal of ending AIDS as a public health threat by 2030.

The implementation of NACP is coordinated by the National AIDS Control Organisation (NACO) under the Ministry of Health and Family Welfare (MoHFW), Government of India. The programme is executed through a three-tier structure:

National Level: NACO provides policy direction, funding, technical support, and strategic guidance.

State Level: State AIDS Control Societies (SACS), such as the Kerala State AIDS Control Society (KSACS), oversee programme implementation, monitoring, and resource management within states.

District Level: District AIDS Prevention and Control Units (DAPCUs) and DISHA (District Integrated Strategy for HIV/AIDS) ensure coordination of field-level activities, service delivery, and community engagement.

14.1.1 Service Facilities

The district has a well-distributed network of service delivery points. The presence of multiple Integrated Counselling and Training Centres (ICTCs) and Link Anti-retroviral Therapy (ART) centres indicates active testing and follow-up mechanisms.

Table 14.1.1.1-Service Facilities-NACP

Name of HIV service delivery centres	No. of HIV service delivery centers
Targeted interventions	4
Integrated counselling and testing centres	9
Designated STI & RTI clinic	2

ART Centre	2
Link ART	4
Blood Banks (Government)	2
Blood Banks (Private)	17

Source: District Report

14.2 Targeted Interventions Projects in Thrissur

Thrissur hosts Targeted Intervention projects aimed at vulnerable populations including Female Sex Workers (FSWs), Men who have Sex with Men (MSMs), Transgender individuals, Injecting Drug Users (IDUs), and migrants.

Table 14.2.1 Targeted Intervention Projects

Indicator	FSW	MSM	TG
Total No. of TI Projects	1	1	1
Total registration till March 2025	1186	1564	740
New registration 2024-25	275	189	123
New registration for the 1st quarter	80	44	35
Total HIV Screening during 2024-25	2224	1434	1335
HIV-positive found	0	0	0
Total HIV Screening during 2024-25	2224	1434	1335
Total number of alive HRG-positive* individuals currently registered at ART centres	1	28	6
Total HRG-positive individuals currently on ART	1	28	5
Total STI Screening during 2024- 25.	3944	2544	1992
STI Cases diagnosed and treated	32	4	18
Total STI Screening during 2024-25	3944	2544	1992
Total syphilis screening during 2024-25	2224	1262	1149
Syphilis positive cases	1	4	1
Total syphilis screening during 2024-25	2224	1262	1149

Source: District Report

Thrissur hosts Targeted Intervention projects aimed at vulnerable populations including Female Sex Workers (FSWs), Men who have Sex with Men (MSMs), Transgender individuals, Injecting Drug Users (IDUs), and migrants. Across the three Targeted Intervention projects, consistent efforts are visible in HIV, STI, and syphilis screening among High-Risk Groups (HRGs). Despite substantial screening numbers, no new HIV-positive cases were reported during 2024–25, indicating effective preventive outreach or potential under-detection. A small number of STI and syphilis cases were identified and treated, showing that regular screening activities are functional. The data also highlights that a limited number of HRGs are currently on ART, suggesting scope for improved linkage and follow-up mechanisms within these projects.

14.3 Testing of General Clients

A total of 1,59,951 general clients were screened for HIV across FICTC, PPP, and CBS centres during 2024–2025. Out of these, 127 clients tested positive, reflecting a positivity rate of 0.07%. The low positivity rate suggests effective preventive interventions and awareness activities, though continued emphasis on targeted screening and follow-up remains essential to sustain progress in HIV control.

Table 14.3.1 Testing of General Clients at ICTCs in Thrissur from April to March 2025

ICTC	FICTC &PPP	CBS	TOTAL	General clients positive	% positive
75928	78508	5515	159951	127	0.07

Source: SIMS data, District Report

14.4 Prevention of Parent to Child Transmission of HIV

During 2024–2025, a total of 22,603 antenatal women were tested for HIV under the Prevention of Parent to Child Transmission (PPTCT) programme across ICTC, Facility-Integrated Counselling and Training Centre (FICTC), and PPP centres. Only one ANC case was detected positive, indicating extensive screening coverage and effective preventive strategies to curb mother-to-child HIV transmission in the district. Continuous counselling and early testing remain crucial to maintain and improve this low positivity trend.

Table 14.4.1 Prevention of Parent to Child Transmission of HIV

ICTC	FICTC And PPP	Total	ANC positive
10203	12400	22603	1

Source: District Report

14.5 People Living with HIV

During 2024–2025, a total of 127 individuals were identified under the People Living with HIV/AIDS (PALS) category, comprising 95 males and 32 females. The higher number of male cases indicates a continued need for targeted awareness and preventive measures among men, while also ensuring timely diagnosis, treatment adherence, and psychosocial support for all individuals living with HIV.

Table 14.5.1 PALS Data

Year	Male	Female	Total
2024-2025	95	32	127

Source: District Report

14.6 Blood Collection

During the year 2024–2025, a total of 59,840 units of blood were collected across the district. This reflects a strong performance of both government and private blood banks in maintaining an adequate blood supply to meet transfusion demands. Continuous promotion of voluntary blood donation and ensuring quality screening and storage practices remain vital for sustaining safe and sufficient blood availability.

14.6.1 Blood units collected during 2024-2025

Year	No of Blood Units Collected
2024- 2025	59,840

**Source: District Report*

The district has demonstrated steady progress in HIV prevention, testing, and treatment services during 2024–2025. The wide network of ICTC, FICTC, PPP, and ART centres has enabled comprehensive coverage for both general and high-risk populations. The low HIV positivity rate and the minimal number of ANC positive cases under the PPTCT programme highlight the effectiveness of ongoing awareness, screening, and counselling initiatives.

Annexures

ANNEXURE 1

Institution image

Figure 1 Govt. Medical College Thrissur

Figure 2 General Hospital Thrissur

Figure 3 General Hospital Irinjalakuda

Figure 4 District Hospital Wadakkanchery

Figure 5 THQH Kodungallur

Figure 6 THQH Chalakudy

Figure 7 THQH Chavakkad

Figure 8 THQH Kunnamkulam

Figure 9 TH Chelakkara

Figure 10 TH Pudukkad

Community Health Centres

Figure 11 CHC Alapad

Figure 12 CHC Mala

Figure 13 CHC Elnjipra

Figure 14 Anandapuram

Figure 15 CHC Vatanapilly

Figure 16 CHC Tholur

Figure 17 CHC Cherpu

Figure 18 CHC Erumapetty

Figure 19 CHC Cherpu

Figure 20 CHC Pazhayannur

Figure 21 CHC Ollur

Figure 22 CHC Perinjanam

Figure 23 CHC Vadakkekad

Figure 24 CHC Puthenchira

Figure 25 CHC Vellanikkara

Figure 26 CHC Mullassery

Figure 27 CHC Pazhanji

ANNEXURE 2

BCC ACTIVITIES DURING THE YEAR 2024-2025

MATERNAL HEALTH:

AROGYAM ANANDAM AKATTAM ARBUDHAM CAMPAIGN:

Under the head maternal health, IEC activities for promotion of *Arogyam Anandam Akattam Arbudham* campaign were planned and implemented. The campaign focused women in the active age group in the first phase to protect them from common cancers among women i.e, cervical and breast cancers. To improve the visibility of the campaign, boards were displayed at health institutions and roll up standees at district level offices. Jingles were aired through FM stations that has highest reach in the district. Pre-launch activities were conducted at Sakthan Bus stand that attracted the media. District level inauguration was held at CHC Vellanikkara were students also participated in the promotional activities. Boards on Cervical cancer screening and breast cancer screening were displayed till FHC level and posters were displayed at JAKs. Reels, Video bytes of experts like oncologists and success stories were produced and circulated to motivate women to get screened

Figure Ente Keralam Exhibition-Arogyam Anandam stall

SUMAN ACCREDITATION:

Branding of 26 health institutions that got accredited for SUMAN were completed during the year 2024-2025, the total accredited institutions being 52 in the district. An Acrylic board with SUMAN logo,board that displays the services available through SUMAN accreditation and inclusion of SUMAN in citizen charter were done in accredited institutions.

WOMEN'S DAY:

Women's day was observed by appreciating ladies staff working under NHM on March 8th,

CHILD HEALTH:

WORLD BREAST FEEDING WEEK OBSERVANCE:

World Breast Feeding Week was observed with an inaugural session at District Collectorate. The programme was attended by collectorate staff and inaugurated by District Collector. The inaugural session was followed by leaflet release, handing over of sterile bottles for storing expressed breast milk and awareness sessions by Paediatricians. The week observance got a closure with programme at Govt. Medical College, CLMC. Public function with the participation of LSGD authorities, appreciated mothers who had donated breast milk and staff of CLMC, and supported the theme by giving thumb impression on thumb impression board. Awareness sessions were conducted at antenatal and postnatal wards of delivery points of the district and painting competition for HSS students were conducted at block level. Breast Feeding Room of collectorate was renovated and jingles were aired through Club FM that has highest reach in the district. Celebrity child Chakki's Video on Breast Feeding was produced and circulated.

NATIONAL NEWBORN CARE WEEK OBSERVANCE:

National Newborn Care Week was conducted with a public function at General Hospital Irinjalakuda were LSGD authorities participated. Newborn care kit was distributed to the newborns admitted during the week and table stands with IEC on Shalabham Newborn care screening were given to authorities. This was followed by an awareness class. An online reels competition, *"Unnikkoru Tharattu"* was held during the week.

CHILDREN'S DAY:

Children's day was observed on November 14th participating the beneficiaries of DEIC, Thrissur. MLA of Wadakkanchery constituency participated in the inaugural session held at Vazhani Dam and cultural programmes of kids were conducted.

INTERNATIONAL DAY FOR DISABLED.

The day was observed at DEIC, Thrissur with an inaugural session in which MLA participated and cultural programmes and games of the beneficiaries and their parents were conducted. To lighten up the day a performance of DABBA Beats BAND [A band of children performing with instruments made from racks] was also conducted.

STOP DIARRHOEA CAMPAIGN:

The district-level inauguration of the STOP Diarrhoea campaign was conducted at CHC Erumapetty and awareness classes were conducted at health institutions.

Advertisement on child health programmes

A half page advertisement on child health programmes was given in Mathrubhumi special supplement during Pooram and 25000 copies were circulated to people visiting the Pooram Nagari.

WORLD DOWN SYNDROME DAY:

Awareness video was made with the involvement of DEIC staff and beneficiaries and circulated through social media handles.

Photo documentation of services provided by ASHAs were done and forwarded to the state office for sharing on the website.

ADOLESCENT HEALTH:

Peer educators training was held in the district for which wide publicity was given through visual, print, social media. An awareness program with magic and ventriloquism events was conducted during the training and AFHCs were restructured with IECs and adolescent friendly messages.

FAMILY PLANNING:

Wall paintings displaying messages on temporary and permanent methods of family planning were done at GH Irinjalakuda ,TH Puthukad , UHWC Paravattani, and UHWC Elthuruthu.

WORLD POPULATION DAY OBSERVANCE:

World Population Day was observed with an inaugural session at district level at CHC Vellanikkara and an awareness session was conducted along with the inaugural session.

TARGETING THE NATURAL GATHERING: pen drives were provided to PROs to display IEC videos in the institutions. Motion poster to promote services of UHWC were circulated. E-posters on NWAS achievement and on inauguration by Health Minister was also circulated. E poster on JAK services and video documentary of UFHC and UHWC was also done.

HEALTH DAYS OBSERVATION:

World Health Day, World Malaria Day, World Dengue Day, World AIDS Vaccine Day, World No Tobacco Day, International Yoga Day, World Menstrual Hygiene Day, World Blood Donor Day, World Club Foot Week Observance, World Population Day, World Breast Feeding Week, IDCF, World Rabies Day, World Heart Day, International Day for Elderly, Global Handwashing Day, World Diabetic Day, Children's Day, AMR week, Newborn Care Week, and International Day for Persons with Disability were observed with involvement of all the staff, LSGD and elected representatives. District Level Inauguration, awareness programmes like rallies, mimes, competitions, awareness classes, medical camps, cookery show, yoga sessions, food expo and cultural events were conducted.

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Medical Aid Center at Collectorate

World Club Foot Week

International day for Persons with Disability

DAY OBSERVANCES UNDER NATIONAL DISEASE CONTROL PROGRAMMES

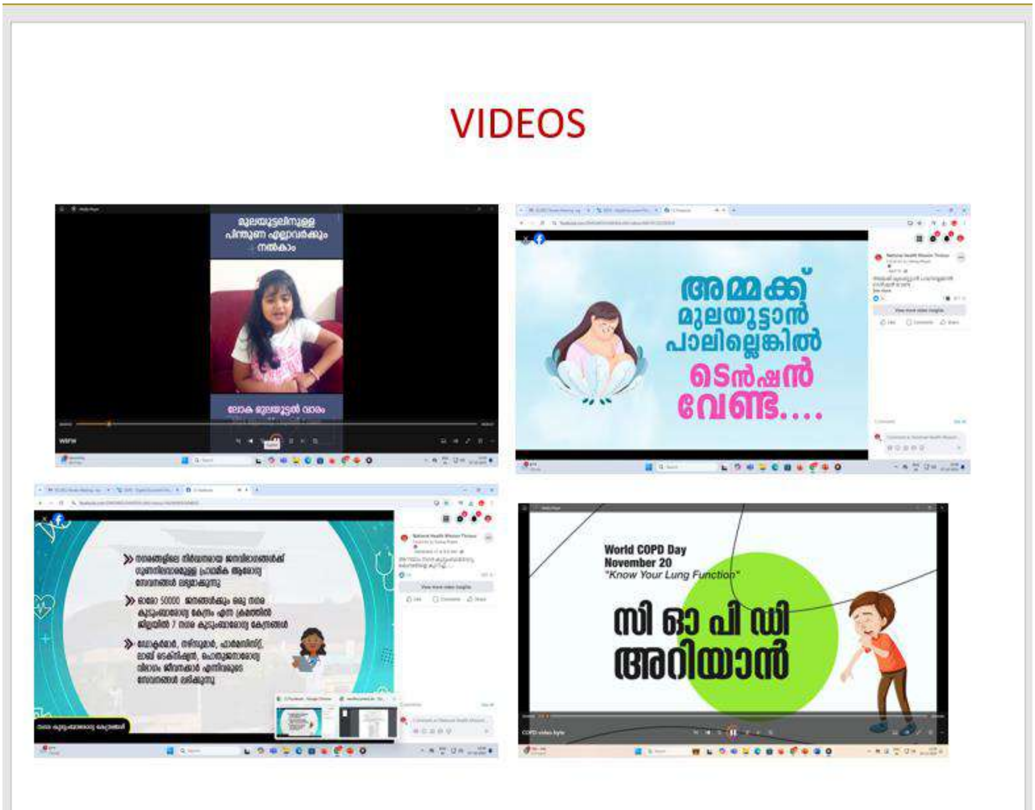
E-posters:


POSTERS
DONATE
HUMAN BREAST MILK
SAVE LIVES
24 X 7 HOURS AVAILABLE
RECEIVE
PASTEURIZED
DONOR
HUMAN MILK
24X 7 HOURS AVAILABLE
RECEIVE DONOR
HUMAN MILK FOR
YOUR BABY
Safety Assured
24x7 Hours Available

POSTERS


NSS UNITS 41 & 162
DEPARTMENT OF ZOOLOGY
SREE KERALAVARMA COLLEGE
NATIONAL HEALTH MISSION, THRISSUR
WORLD AIDS VACCINE DAY
2024
"Uniting For A Future Free From HIV / AIDS"
INTERACTIVE SESSION
DR. AJAYRAJAN
18/5/2024 • 2.30 PM
"Breaking Rabies Boundaries"

Awareness Videos



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