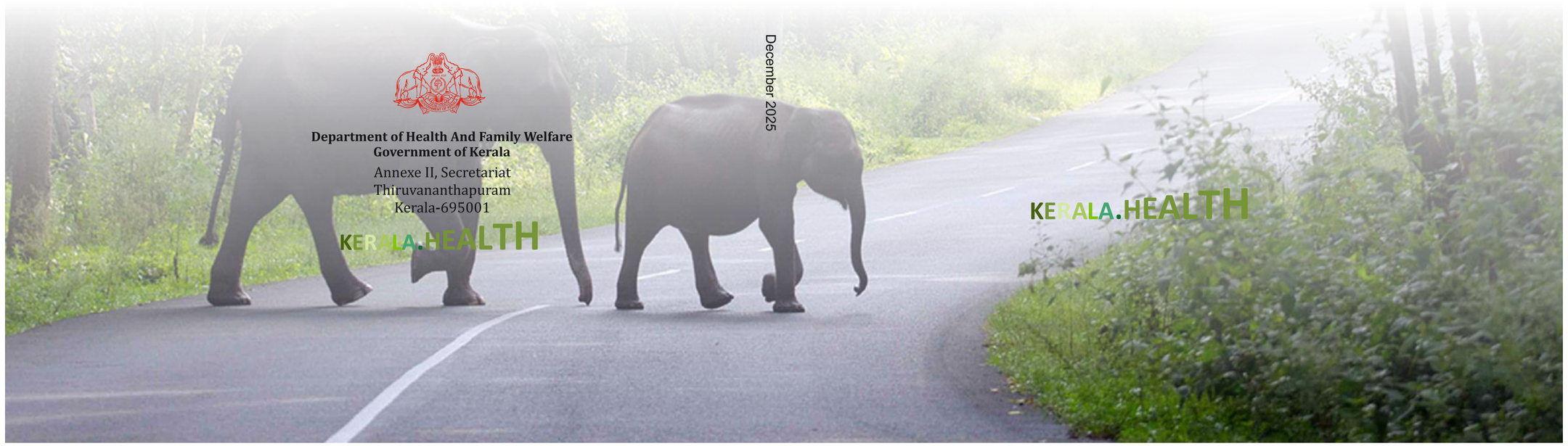
HEALTH@WAYANAD



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

KERALA.HEALTH

December 2025

KERALA.HEALTH

HEALTH@WAYANAD

KERALA.HEALTH

Index

CHAPTER 1 WAYANAD DISTRICT: OVERVIEW **11**

1.1 Wayanad District- An overview 11

1.2 Administrative division 11

1.3 Demographic profile 12

1.4 Age and Sex Distribution 16

1.5 Literacy Rate 18

1.6 Vulnerable population groups 19

CHAPTER 2 WAYANAD DISTRICT - HEALTH SYSTEM **20**

CHAPTER 3 HEALTH INFRASTRUCTURE PROFILE OF THE DISTRICT **25**

3.1 Taluk-wise details of health facilities in Wayanad 25

3.2 Availability of Specialized Centres 26

3.3 Bed Strength in Different Health Facilities 27

3.4 Health Facilities in Rural and Urban Areas 27

3.5 Health facilities converted to FHCs 28

3.6 Delivery points in the district 29

3.7 Other specialized care centres 29

3.8 National Quality Assurance Standards (NQAS) Accredited Facilities 31

CHAPTER 4 HEALTH HUMAN RESOURCES PROFILE **33**

4.1 Health Human Resource – Major Indicators 33

4.2 Availability of Medical Officers 33

4.3 Sanctioned Strength of Health Personnel under the Directorate of Health Services (DHS) 36

4.4 Health Human Resource under the National Health Mission (NHM) 37

CHAPTER 5 MATERNAL AND CHILD HEALTH **42**

5.1 Pregnant Women Registration 42

5.2 Early Initiation of Antenatal Care 42

5.3 Immunization status of Pregnant Women 43

5.4 Abortion 43

5.5 Family Planning 44

5.6 Delivery 47

5.7 Caesarean section deliveries 48
5.8 Maternal Deaths 49
5.9 Child birth 50
5.10 Infant mortality 51
5.11 Child Immunization 52
CHAPTER 6 COMMUNICABLE AND NON-COMMUNICABLE DISEASES 55
6.1 Disease Burden Overview: Common Communicable Diseases 55
6.2 Burden of Non communicable disease in the district 63
6.3 District-specific Outbreaks and Health Concerns 65
CHAPTER 7 CRITICAL OBSERVATIONS IN THE NFHS 5 DATA AND APPROPRIATE 66
CHAPTER 8 DISTRICT MENTAL HEALTH PROGRAMME 80
8.1 District Mental Health Programme 80
8.2 Post-Flood Activities & Training Programs 82
8.3 Landslide activities 82
8.4 DMHP Targeted Interventions 83
CHAPTER 9 TRIBAL HEALTH PROGRAMME 88
9.1 Tribal Health Program 88
CHAPTER 10 FINANCIAL ALLOCATION AND UTILIZATION 90
10.1 Financial allocation and utilization for the last four years 90
10.2 Financial Allocation - DMO 91
CHAPTER 11 NHM ACTIVITIES IN THE DISTRICT 93
11.1 Rashtriya Bal Swasthya Karyakram (RBSK) & Arogya Kiranam (AK) 93
11.2 Hridyam 95
11.3 Mobile Intervention Unit (MIU) 96
11.4 Mobile Health Team (MHT) 96
11.5 Nutrition Rehabilitation Centre to address Severe Acute Malnutrition 97
11.6 Rashtriya Kishore Swasthya Karyakram (RKSK) 97
11.7 Peer Educators Programme -SDC (Student Doctor Cadet) 99
11.8 National Sickle Cell Anaemia Elimination Mission 99
11.9 Family Planning 101

11.10 Biomedical Equipment Maintenance Program (BEMP) 102
11.11 Janani Suraksha Yojana (JSY) 102
11.12 Janani Shishu Suraksha Karyakram (JSSK) 103
11.13 Quality Assurance 103
11.14 Accredited Social Health Activist (ASHA) 106
11.15 AYUSH Integration and Training 107
11.16 State Health App Initiative for Lifestyle Intervention (SHAILI) 107
11.17 District ASHA Review 107
11.18 National Programme for Palliative Care (NPPC) 108
11.19 Karunya Arogya Suraksha Padhathi (KASP) 109
CHAPTER 12 NATIONAL URBAN HEALTH MISSION (NUHM) 112
12.1 National Urban Health Mission (NUHM) 112
CHAPTER 13 NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME 114
13.1 National Tuberculosis Elimination Programme (NTEP) 111
13.2 Components of NTEP 114
13.3 Programme Implementation 114
13.4 Progress in the Tuberculosis Eradication in the District 114
13.5 Major achievements in 2024-25 118
CHAPTER 14 NATIONAL AIDS CONTROL PROGRAMME 121
14.1 National AIDS Control Programme (NACP) implementation in Wayanad 121
14.2 Targeted Interventions 121
CHAPTER 15 OTHER INTERVENTIONS 122
15.1 Aspirational Programmes Driving Change 122
15.2 Gothra Sparsam 125
15.3 Pratheeksha - Shelter for tribal pregnant women 126
15.4 E-Auto for Tribal, Geriatric, and physiotherapy Patients @ Noolpuzha 126
15.5 Smitham 127
15.6 Ammayude Taarat 127
15.7 DIPAM Disability In Paediatric Adult Management 128
15.8 Radio Mattoli 128

CHAPTER 16 MUNDAKAI LANDSLIDE **129**

16.1 Rapid response to landslide crisis: Decisive action by District Medical Office(H) and National Health Mission, under the supervision of Health Department, Government of Kerala 129

16.2 Immediate Interventions-Day 1 130

16.3 Intervention strategy 132

16.4 Other emergency activities initiated 133

16.5 Proactive Leadership by the State Mission Director of NHM and the Director of Health Services 135

Annexures **139**

Message

GOVERNMENT OF KERALA

Pinarayi Vijayan

CHIEF MINISTER

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

MESSAGE

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

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

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

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

Pinarayi Vijayan

The Addl. Chief Secretary (Health)
E-mail : acskeralahealth1@gmail.com

141, 3rd Floor, North Block, Government Secretariat, Thiruvananthapuram Pin 695001 T 0471 2333241, 2333812, 2333610 F 0471 2333489
E chiefminister@kerala.gov.in facebook.com/cmokerala twitter.com/cmokerala
Residence Cliff House T 0471 2318406, 2314853
www.keralacm.gov.in

Smt. Veena George
Minister for Health &
Family Welfare
and Woman & Child Welfare
Development
Government of Kerala

Message

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

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

I appreciate the works done by the District Medical Officer, District Project Manager and health functionaries of Wayanad 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@Wayanad** 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 Wayanad team was the first one to publish such a document. It was planned to do similar series of all the Districts, however due to COVID pandemic it was difficult.

The Department is now in the process to publish Books of all the districts and it will be a Health@District encyclopaedia 2025 edition as a part of the 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@Wayanad** will be a resource book for health functionaries, researchers, students as well as to people to understand the developments in health sector in Wayanad. It will help to assess the progress against the benchmarks set and encourage all to strive to excel. It is noteworthy to see the various initiatives taken in the district for betterment of the service delivery reflecting team work with commitment to achieve the results.

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 T Mohandas, DMO Wayanad, Dr Dinesh P, DSO Wayanad, Dr Sameeha Saidalavi, DPM Wayanad, 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 Wayanad district and all across the state.

Dr Rajan Khobragade IAS

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

Message

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

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

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

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

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

Message

ഡോ. റീന. കെ. ജെ
ആരോഗ്യവകുപ്പ് ഡയറക്ടർ

ആരോഗ്യവകുപ്പ് ഡയറക്ടറുടെ കാര്യാലയം
വഞ്ചിയൂർ.പി.ഒ., തിരുവനന്തപുരം. പിൻ - 695035
ഫോൺ: 0471 2302490
വെബ്സൈറ്റ്: www.dhs.kerala.gov.in
ഇ-മെയിൽ: dhskerala@gmail.com

സന്ദേശം

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

WAYANAD DISTRICT: OVERVIEW

1.1 Wayanad District- An overview

Wayanad District came into existence on 1st November 1980 as the 12th District of Kerala, consisting of Mananthavady, Sulthan Bathery, and Vythiri Taluks. The name '**Wayanad**' is derived from 'Vayal Nadu', which means the land of paddy fields. It is a picturesque plateau situated at a height between 700 meters and 2100 meters above the mean sea level, nested among the mountains of the Western Ghats on the Eastern portion of North Kerala, sharing the borders with Tamil Nadu and Karnataka States. The District was carved out from the Kozhikode and Kannur Districts. The total area of the district is 2131 sq.km, of which is about 885.92. Sq.km (42%) is forest land. Demographic details of Wayanad district are given below.

One important characteristic of the district is its large Tribal (*adivasi)* population, consisting mainly of Paniyas, Kurumas, Adiyars, Kurichyas, Ooralis, Kadars, and Kattunaikkans. They are the different aboriginal tribes of Wayanad. The tribal population in Wayanad constitutes 18.5% of the district population and 36 per cent of the State's tribal population. Major communities found in the district are Paniyan (44.06%), Mullu Kuruman (17.34 %), Kurichiyan (16.10 %), Kattunaikkan (11.33%), Adiyan (7.41%), and Urali Kuruman (3.13 per cent). Kurichyar is the most developed among them. They are small landowners, whereas the members of other tribes are mostly labourers.

Wayanad is the only aspirational district in Kerala with a large population of settlers. People from almost all parts of Kerala have migrated to this fertile land. Wayanad has a small Jain community consisting of Gowders from Karnataka. Almost all sections of Christianity are well represented here. One fourth of the population of Wayanad is constituted by Christians. Muslims constitute another one-fourth of the population, and the rest of the population belongs to Hindus.

1.2 Administrative division

Kalpetta is the headquarters of the Wayanad District. Mananthavady is the only revenue division in the district, and the district has 49 Revenue villages. There are three Assembly Constituencies and Municipalities (Kalpetta, Mananthavady, and Sulthanbathery). The district has 4 development blocks, viz, Mananthavady, Kalpetta, Sulthan Bathery, and

Panamaram, consisting of a total of 23 grama panchayats.

Figure 1.2.1 Administrative map of Wayanad

1.3 Demographic profile

Wayanad district has a total population of 8,17,420, which accounts for 2.45% of Kerala's total population. The district is predominantly rural, with 96.14% of the population residing in rural areas and only 3.86% in urban regions. The sex ratio stands at 1035 females per 1000 males, indicating a favourable gender balance. Children in the 0–6 age

group constitute 11.29% of the total population, with boys and girls comprising 11.70% and 10.90% respectively. The district has a population density of 384 persons per sq. km and recorded a population growth rate of 4.6% during 2001–2011. Wayanad has a significant presence of marginalized communities, with Scheduled Tribes forming 18.53% and Scheduled Castes 3.99% of the population, making it one of the districts with the highest tribal concentration in Kerala. The literacy rate is 89.03%, with male literacy at 92.51% and female literacy at 85.70%, reflecting a relatively high educational attainment, though with a gender gap. In terms of employment, 41.60% of the total population are workers, including 32.23% main workers and 9.37% marginal workers, indicating a largely agrarian and labour-dependent economy with seasonal employment patterns. Overall, Wayanad's demographic profile highlights its rural and tribal character, moderate literacy, balanced sex ratio, and steady population growth.

1.3.1 Population Size and Density

Population	: 8, 17,420 (2011 census)
Proportion to Kerala population	: 2.45%
Rural population	: 96.14 %
Urban population	: 3.86%
Male	: 4, 01,684
Female	: 4, 15,736
Sex Ratio	: 1000/1035
Child proportion (0-6 age)	: 11.29%
Boys proportion (0-6 age)	: 11.70%
Girls proportion (0-6 age)	: 10.90%
Density	: 384/sq.km
Rate of Growth of population (decadal)	: 4.71 % (2001-2011)
Scheduled caste population	: 3.99%
Scheduled Tribe population	: 18.53%
Literacy Rate	: 89.03%
Literacy rate (Male)	: 92.51
Literacy rate (Female)	: 85.70
Total workers (marginal + main workers)	: 41.60%

Main workers : 32.23 %

Marginal workers : 9.37%

Table 1.3.1 Population Distribution of District (1911-2011)

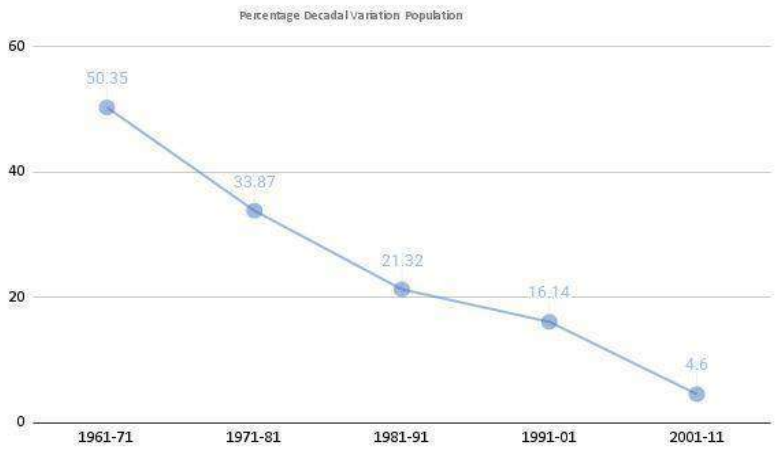
Census Year	Males	Females
1911	45,489	37,060
1921	47,473	37,298
1931	50,877	40,892
1941	57,952	48,398
1951	92,099	77,181
1961	144,635	130,620
1971	215,338	198,512
1981	284,261	269,765
1991	341,958	330,170
2001	391,273	389,346
2011	401,684	415,736

Source: Census data

Table 1.3.1 illustrates the decadal population trend of Wayanad district from 1911 to 2011, disaggregated by sex. The data show a continuous rise in both male and female populations over the century. The male population increased from 45,489 in 1911 to 401,684 in 2011, while the female population grew from 37,060 to 415,736 during the same period. A marked increase is evident from 1951 onwards, reflecting the impact of migration, agricultural expansion, and improved living conditions. Until the mid-20th century, the male population consistently outnumbered the female population. However, by 2011, females slightly exceeded males, indicating an improvement in the sex ratio

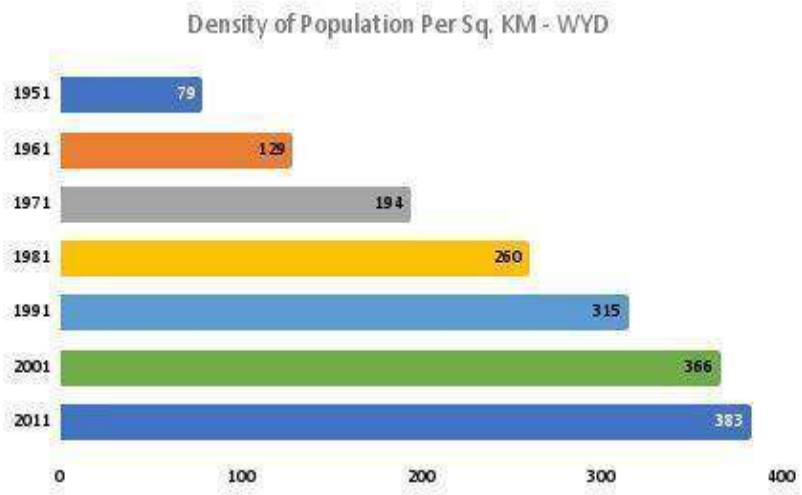
(1035 females per 1000 males). This century-long trend highlights Wayanad's steady demographic growth, influenced by socio-economic changes, improved healthcare, and migration patterns. The data also suggest progress toward gender parity and enhanced population stability in recent decades.

Figure 1.3.1 Decadal Population Growth of the District



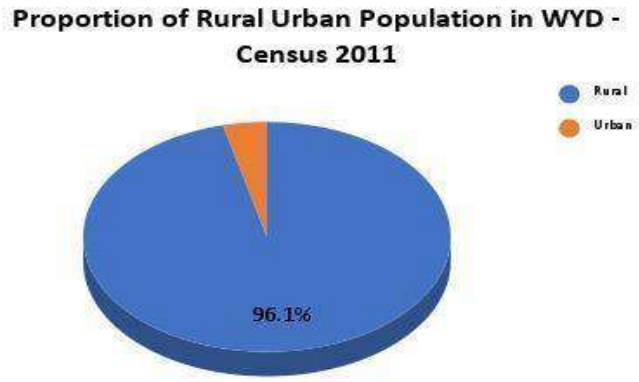
The decadal population growth of the district shows a downward trend, which implies there is a gradual decline in the population over 50 years.

Figure 1.3.2 Density of population per sq. Km (1951 – 2011)



The density of population shows a steady increase over the period of the past 50 years. A sharp increase occurred from 1951 to 1981.

Figure 1.3.3 Rural Urban Difference in Population based on Census 2011

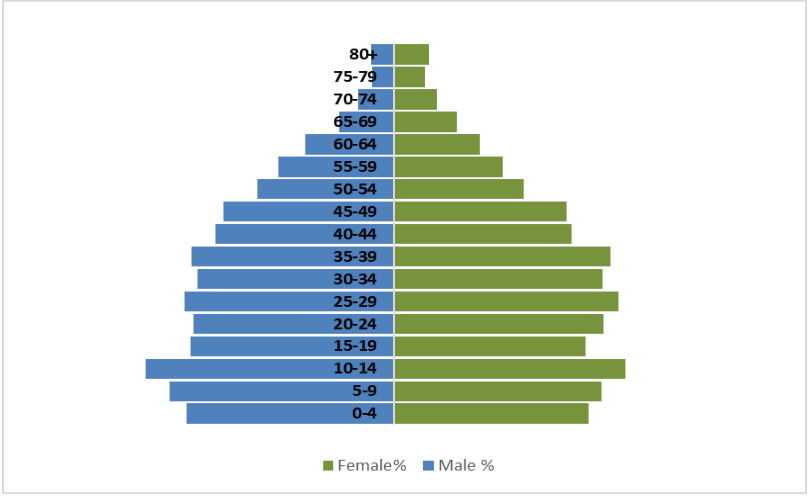


Source: Census data

In Wayanad district, over 96% of the population resides in rural areas.

1.4 Age and Sex Distribution

Figure 1.4.1 ***Age and sex distribution of the Population based on Census 2011population***



Source: Census data

The pyramid has a broad base and a narrow top, indicating a young population with high birth rates and a smaller elderly population. The number of males and females is roughly balanced in most age groups, though the female proportion is slightly higher in the older age brackets, reflecting greater female longevity.

Table 1.4.1 Sex ratio at birth

Year	Sex Ratio at Birth
2020-21	985
2021-22	1003
2022-23	964
2023-24	961
2024-25	997

Source: HMIS

The data on sex ratio at birth from 2020–21 to 2024–25 show fluctuations over the five years. The ratio improved from 985 females per 1000 males in 2020–21 to 1003 in 2021–22, indicating a brief period of gender balance. However, it declined in the following years to 964 in 2022–23 and 961 in 2023–24, before rising again to 997 in 2024–25. Overall, the trend reflects minor year-to-year variations but suggests a general movement toward maintaining gender parity at birth

Table 1.4.2 Sex ratio

Year	Sex Ratio
1991	966
2001	995
2011	1035

Source: Census 2011

The data on sex ratio in Wayanad district from 1991 to 2011 show a consistent

improvement over the two decades. The ratio increased from 966 females per 1000 males in 1991 to 995 in 2001, and further to 1035 in 2011. This upward trend indicates significant progress in gender balance, reflecting improvements in women's health, survival rates, and overall socio-economic conditions in the district.

1.5 Literacy Rate

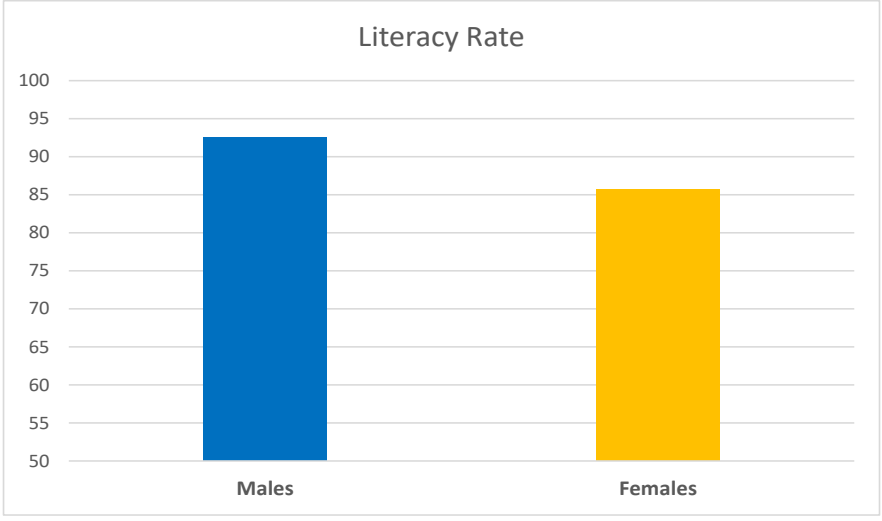
Wayanad recorded a high literacy rate of 89.03%, reflecting Kerala's strong educational standards. Male literacy (92.51%) was slightly higher than female literacy (85.70%), showing a gender gap of about 6.8 percentage points. Despite this gap, both rates are well above the national average, indicating widespread access to education in the district.

Table 1.5.1 Literacy Rate Wayand, 2011

District	Persons	Males	Females
Wayanad	89.03	92.51	85.70

Source: Census 2011

Figure 1.5.1: Male and Female Literacy rate in Wayanad as per the census 2011



1.6 Vulnerable population groups

In 2011, Wayanad had a total population of 817,420 people. The general category formed the majority, Scheduled Tribes made up roughly 18.5%, and Scheduled Castes accounted for about 4% of the population.

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

Population (2011 census)								
Total population			**Sch.castes**			**Sch.tribes**		
Male	Female	Total	Male	Female	Total	Male	Female	Total
401684	415736	817420	16406	16172	32578	74476	76967	151443

Source: Census 2011 data

CHAPTER 2

WAYANAD DISTRICT - HEALTH SYSTEM

DHsDistrict AT A GLANCE

Administrative Divisions	Population	Area
Thaluks – 3 Villages – 49 Municipalities – 3 Corporations – 0 Block Panchayath- 4 Grama Panchayath - 23	Population As per Census 2011 – 8,17,420 Male – 4,01,684 Female – 4,15,736	Total Area (Sq. K) – 2131 Sq. Km Population Density (No per Sq K) - 384 per Sq Km Decadal Population Growth Rate - 4.71 %

Healthcare Infrastructure under DHS

District Level Hospitals		Sub District Level Hospitals		Community Health Centres	
DH – 1 GH – 1 W&C – 0	2	THQH – 2 TH – 0	2	Total CHC – 8 Converted to FHC - 2	8

Primary Health Centres		Janakeeya Arogya Kendram		Other Institutions	
Total PHC –23 Converted to FHC – 21	23	Janakeeya Arogya Kendram - 200	200	School of Nursing – 1 Training Center –1 PH Lab – 1 DVC Units – 1 Offset Press - 0	Blood Bank – 4 Public –2 Private -2 Blood Storage Unit – 3

Reproductive, Maternal, and Child Health Services 2024-25

Pregnant Women Registration: 2024-25

The total number of pregnant women registered in Wayanad is 12,357.

12,357

Pregnant Women-Anaemia 2024-25

42% pregnant women were identified as anaemic through VIVA testing.

42%

Rising C-Section Rates in the District 2024-25

Wayanad district has 37% C-section rate in both public and private sectors, which is less compared to the state.

37%

Maternal Deaths 2024-25	**Preterm Births 2024-25**	**Underweight Newborns 2024-25**
Total Maternal Deaths Reported in the District was less when compared to previous year. **1** 	**The proportion of preterm births in the district is 7%.** **7%** 	**The proportion of newborns weighing less than 2.5 kg in the district - 18%.** **18%** 
Delivery 2024-25	**Home Delivery 2024-25**	**Live Birth 2024-25**
Institutional Delivery in the district – 9919 **Public – 3410** **Private – 6509** 	**Home Delivery Reported in the district – 24** **No of Migrant Home Delivery - 3** 	**Total Live Birth Reported – 9981** **Male – 5062** **Female – 4919** **Sex Ratio at Birth - 972** 

CHILD IMMUNIZATION 2024-25		
% Birth Dose	**6 Weeks Vaccines Coverage (%)**	**10 Weeks Vaccines Coverage (%)**

Hep B0 – 99%

OPV 0 – 99%

BCG – 100%

OPV1 - 98%

Pentavalent 1 - 98%

Rotavirus 1 - 98%

PCV1 - 98 %

IPV 1 - 97%

OPV2 - 97%

Pentavalent 2 - 97%

Rotavirus 2 - 97 %

% 14 Week Vaccines

OPV3 - 97%

Pentavalent 3 -97 %

Rotavirus 3- 97%

IPV 2 - 97%

PCV2 -97%

% Children Fully Immunized

MR1 - 97%

FULLY IMMUNIZED - 96%

(children aged between 9 and <12 months)

MR 2 Coverage (%)

MR2 - 95%

Communicable diseases reported in the District 2024

Cases Reported

Dengue72

Malaria-10

Chikungunya- 1

West Nile-0

Zika- 0

JE- 0

0

Dengue Death

Cases Reported

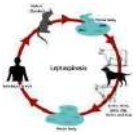
Kala Azar-0

Scrub Typhus - 12

Leptospirosis-129

15

Leptospirosis Death



Cases Reported

Cholera - 10

Typhoid- 1

Acute Diarrheal Disease - 22546

2

ADD Death

Communicable diseases reported in the District 2024

Chicken Pox Cases-896

MPox Cases-1

0

Chicken Pox Death

Rabies Cases Reported-0

Shigella cases-1

Amoebic Meningo Encephalitis - 0

0

Rabies Death

Cases Reported

Hepatitis A - 45

Hepatitis B-12

Hepatitis C-1Hepatitis E - 1

3

Hepatitis A Death

CHAPTER 3

HEALTH INFRASTRUCTURE PROFILE OF THE DISTRICT

3.1 Taluk-wise details of health facilities in Wayanad

In Wayanad, the District Hospital, Mananthavady, serves as the tertiary healthcare centre. The Taluk Hospitals at Vythiri and Sulthan Bathery, along with the General Hospital, Kalpetta, provide secondary-level care within the district. At the primary level, there are two Urban Primary Health Centres and eight Urban Health and Wellness Centres serving the urban population.

Table 3.1.1 Number of Health Facilities in District

Type of Facility	Number
24×7 PHC Converted to FHC	9
PHC Converted to FHC	14
UPHC	2
CHC	6
CHC Converted to FHC	2
THQH	2
DH	1
GH	1
DTBC	1
Mobile Unit	8
Speciality (Others)	1
Grand Total	47

JAK	200
UHWC	8
Total	**302**

Source: District data

3.2 Availability of Specialized Centres

Nallorenad Cancer Care Hospital is the speciality center catering to patients in and around Wayanad district, where financial and geographical constraints often prevent people from accessing services from other districts. The hospital has a general outpatient department (OPD), dental unit and a six-unit dialysis center, as well as 12-bedded curative chemotherapy day-care unit, radiotherapy unit, a 10-bedded isolation ward, a six-bedded *Abhayam* palliative chemotherapy care unit and 10-bedded neutropenia wards. The hospital also provides secondary palliative care through home visits and outreach activities under all national programs. Cancer awareness camps are also regularly conducted.

Table 3.2.1: Available facilities at Nallorenad Cancer Care Speciality Hospital

General OP Block	Cancer chemotherapy Block	Radiotherapy Block	Dialysis Block	IP Block
OPD, office wing, pharmacy, and dental unit	Day-care chemotherapy unit, laboratory	Telecobalt machine, CT simulator machine, Mammography machine, 50 kW X-ray Machine, 100 mA portable X-ray machine	Six-unit haemodialysis facility	Neutropenia ward with standard facilities

kW: kilowatt, mA: milliampere

Source: District data

3.3 Bed Strength in Different Health Facilities

In the district, a total of 1,021 out of the sanctioned 1,342 beds are functional.

The District Hospital has the highest bed capacity, followed by the Sub-District Hospitals and Community Health Centres.

Table 3.3.1 Bed strength by type of facility

Facility type	Number of functional beds	Number of sanctioned beds
CHC	202	242
DH	506	750
PHC	69	164
SDH	244	186
Total	**1021**	**1342**

Source: District Data

3.4 Health Facilities in Rural and Urban Areas

Wayanad district has a total of 235 health facilities under DHS, with 210 in rural areas and 25 in urban areas, reflecting the district's predominantly rural population.

Sub-Centres (SCs) form the largest category, with 180 in rural and 20 in urban regions, emphasizing the focus on primary healthcare accessibility in villages.

Primary Health Centres (PHCs) are mostly rural (21 facilities) with 2 in urban areas, serving as the first referral point. Community Health Centres (CHCs) are exclusively rural (8 facilities), providing secondary-level care to rural populations. District Hospitals (DHs) are located only in urban areas (2 facilities), catering to advanced healthcare needs. Sub-District Hospitals (SDHs) are evenly distributed with 1 each in rural and urban areas, offering intermediate-level care.

Overall, the distribution highlights strong rural healthcare coverage, with urban facilities concentrated on higher-level services, reflecting a healthcare system designed to meet both primary and specialized needs in line with population distribution.

Table 3.4.1: Distribution of health facilities in rural and urban areas

Facility type	Number of facilities in rural areas	Number of facilities in urban areas	Grand Total
CHC	8	0	8
DH	0	2	2
PHC	21	2	23
SDH	1	1	2
SC	180	20	200
Total	**210**	**25**	**235**

Source: District data

3.5 Health facilities converted to FHCs

In Wayanad district, a total of 25 health facilities have been upgraded to Family Health Centres. This initiative is to strengthen primary healthcare services to the population. This is to focus on accessible, continuous, and quality health care in the district.

In total, nine 24×7 PHCs converted to FHCs. Two CHCs and 14 regular PHCs were converted to FHCs.

Table 3.5.1 Number of facilities converted to FHCs

Facility converted to FHC	Total
24x7 PHC	9
CHC	2

PHC	14
Total	**25**

Source: District data

3.6 Delivery points in the district

In the district, there are five delivery points within the public healthcare system and 16 within the private healthcare system.

Table 3.6.1 Type-wise distribution of delivery points in the public health facilities, Wayanad

Type of Facility	Number
CHC	1
SDH	2
DH/GH	2
W&C	0
MCH	0
Total	**5**

Source: District data

3.7 Other specialized care centres

District Early Intervention Centre (DEIC)

The District Early Intervention Centre (DEIC) in Wayanad is situated at Kalpetta. The DEIC aims to improve the survival and developmental outcomes of children aged 0-18 years, through early identification and management of Defects at Birth, Deficiencies, Diseases, Developmental delays including disabilities (the '4 Ds'). It also ensures linkage to appropriate care, support, and treatment services to address these challenges.

Early intervention seeks to detect health or developmental challenges at the earliest possible stage to prevent or reduce the severity of disabilities. When a disability is already established, the focus shifts to enhancing the child's development, helping the child reach their maximum potential, and preventing further decline in functional ability.

The services provided at the DEIC include:

1. Medical services – Diagnostic evaluation and treatment of children with diseases and deficiencies.
2. Dental services – Management of oral health problems among children from birth to six years, especially Early Childhood Caries.
3. Physiotherapy – Interventions to promote self-help skills, adaptive behaviour, play, sensory, motor and postural development. These services aim to prevent or reduce difficulties and related functional problems, and address issues such as sensory integration, or-motor coordination, and feeding difficulties.
4. Psychological services – Interventions to assess a child's development, learning and mental health through psychological testing and evaluation, and to provide counselling, consultation, parent training, behaviour modification, and guidance on appropriate educational programmes.
5. Cognition services – Identification of cognitive delays and provision of interventions to enhance cognitive, adaptive, and learning abilities.
6. Speech-language pathology – Support for children with communication delays or motor impairments affecting speech or swallowing.
7. Audiology – Identification and management of hearing loss, both congenital and acquired, in children from birth to six years.
8. Vision services – Screening and intervention for children with visual disorders or developmental affecting vision.

3.7.1 Nutrition Rehabilitation Centre

Severely acute malnourished and moderately acute malnourished children are identified from the field by staff including Mid-level Healthcare Providers (MLHPs) and admitted to Sulthan Bathery Nutrition Rehabilitation Centre (NRC) and treated.

3.8 National Quality Assurance Standards (NQAS) Accredited Facilities

In the district, a total of 10 institutions have obtained National Quality Assurance Standards (NQAS) accreditation. Six FHCs have scored above 95%. Ayush Arogya Mandir Subcentre (AAM-SC) Vadakanad of FHC Noolpuzha is the first AAM in the state to undergo the NQAS assessment.

Assessment was done for 12 packages, namely pregnancy care and child birth, neonate and infant health Services, childhood and adolescent health services, family planning, Management of Communicable Diseases, Management of simple illness including minor ailments, Management of non-communicable diseases, Elderly and palliative health care.

Table 3.8.1 NQAS-accredited facilities as on 31st March 2025

SL No.	Date of NQAS assessment done	Name of institution	Marks obtained (%)
1	27th, 28th - September	FHC Moopainadu	96
2	5th, 6th - December	FHC Vellamunda	89
3	7th December 2024	HWC Vadakkanadu	-
4	9th January 2025	HWC Muthanga	88
5	10th, 11th - January 2025	FHC Vengappally	89
6	20th, 21st - January 2025	UPHC Munderi	95
7	24th, 25th - February 2025	FHC Chethalayam	93.57

8	3rd, 4th March 2025	FHC Cheeral	87.84
9	24th, 25th March 2025	FHC Vazhavatta	95.85
10	26th March 2025	HWC Madakkunnu	97.24

Source: District data

CHAPTER 4

HEALTH HUMAN RESOURCES PROFILE

4.1 Health Human Resource – Major Indicators

Doctors are deployed across administrative, general, and specialist cadres within the district to ensure comprehensive healthcare delivery. Junior Public Health Nurses are positioned at the district level to strengthen field - level services and enhance community outreach. Maternal and Child Health services are provided by dedicated staff, ensuring focused care for women and children. Ophthalmology services are available within the district, contributing to accessible eye care. The system is supported by nursing professionals, pharmacy staff, and personnel responsible for the supply and management of essential medicines.

Public health staff primarily operate at the field level, playing a vital role in identifying community-level health needs, opportunities, and challenges, thereby supporting effective planning and implementation of health interventions.

Other staff include technical officers, clerical staff, engineers, media and education and employees posted in various institutions in transport sections.

Table 4.1.1 Key service capacity ratios in the public healthcare system,

Indicator	Ratio
Bed-to-population	1:598
Doctor-to-bed ratio	1:6
Doctor-to-population ratio	1:3392

Source: Census 2011

4.2 Availability of Medical Officers

Wayanad district's health workforce comprises administrative, general, and medical staff. There are 14 sanctioned posts in the administrative category (3 Deputy Directors, and 9 Assistant Directors), 135 in the general staff category, 121 sanctioned posts for Assistant Surgeons, 9 for Assistant Surgeons (Dental), 5 for Civil Surgeons, and 92

specialist doctors. This distribution ensures a balance between management and healthcare service delivery within the district.

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

Category	Sanctioned
Administrative	14
Additional Director	0
Deputy Director	3
Assistant Director	9
JAMO	2
General	135
Assistant Surgeon	121
Assistant Surgeon Dental	9
Civil Surgeon	5
Civil Surgeon Dental	0
Speciality	92
Total	**390**

Source: District data

Major specialties in the district include Obstetrics and Gynaecology (15), Paediatrics (14), General Medicine (9), General Surgery (9), Anaesthesia (7), ENT (7), and Ophthalmology (7). Other specialties, such as Blood Bank (3), Dental (2), Dermatology & Venereology (3), Psychiatry (3), Orthopaedic Surgery (4), and Tuberculosis and Chest (4), complement these services.

Table 4.2.2 Number of Speciality and Super Speciality Doctors under DHS

Speciality	Sanctioned
Anaesthesia	7
Blood Bank	3
Dental	2
Dermatology & Venerology	3
ENT	7
Forensic Medicine	1
General Medicine	9
General Surgery	9
Microbiology	0
Obstetrics and Gynaecology	15
Ophthalmology	7
Orthopaedic Surgery	4
Paediatrics	14
Physical Medicine and Rehabilitation	1
Psychiatry	3
Radiological diagnosis/Radiotherapy	3
TB and Chest (Respiratory Medicine)	4

Source: District data

4.3 Sanctioned Strength of Health Personnel under the Directorate of Health Services (DHS)

Wayanad district has a total of 1,713 sanctioned health personnel across various categories. These include 241 doctors (14 administrative, 135 general, 92 specialty), 291 nursing staff, 249 JPHNs/MCH officers, and support staff in laboratories (69), pharmacy and medical supply (78), and public health (196). Additional personnel are posted in specialities such as dental (8), ophthalmology (16), tuberculosis (3), leprosy (3), transport (4), with 547 staff classified under other categories. The distribution reflects a comprehensive workforce supporting clinical, administrative, and public health services in the district.

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

Category/Division	Number
Doctors (Administrative Cadre)	14
Doctors (General Cadre)	135
Doctors (Speciality)	92
Nursing Service	291
JPHN to MCH Officer	249
JPHN/Nursing School	8
Dental	8
Laboratory (General)	69
Pharmacy and medical Supply	78
Leprosy	3
Public Health	196
Tuberculosis	3

Ophthalmology	16
Transport	4
Others	547
Total	**1713**

Source: District data

4.4 Health Human Resource under the National Health Mission (NHM)

In total, 79 categories of health personnel are in position in the district under the National Health Mission (NHM). NHM personnel contribute significantly to health service delivery in the district.

Table 4.4.1 Health Human Resource under NHM

Sl. No.	Category	In Position
1	Medical Officer	36
2	Medical Officer (UHWC)	7
3	DGO	1
4	Anaesthesiologist	1
5	Paediatrician	1
6	JC HWC	1
7	MO- Part time	2
8	Dental Surgeon	4
9	Homoeo MO	20
10	ISM MO	3
11	Unani MO	1

12	Staff Nurse	112
13	Staff Nurse (BCCPN) (Palliative)	14
14	Staff Nurse (*Shalabham*)	4
15	Staff Nurse (UHWC)	16
16	Pharmacist	17
17	Pharmacist (UHWC)	8
18	Lab Technician	36
19	Lab Technician (BPHU)	4
20	Counsellor-RKSK	5
21	Counsellor-DMHP	2
22	Counsellor-GBVM Female Coordinator	1
23	RBSK Nurse	40
24	JPHN	10
25	Optometrist	6
26	Audiologist	6
27	Audiometric Assistant	1
28	Dietician	5
29	Physiotherapist	14
30	Epidemiologist	1
31	Epidemiologist (BPHU)	4

32	Data Manager	1
33	Data Manager (BPHU)	4
34	JHI	2
35	JHI (UHWC)	3
36	Sr. DOTS Plus TB/HIV Supervisor-	1
37	STS	2
38	STLS	2
39	Driver	1
40	TBHV	4
41	DEIC Manager	1
42	Clinical Psychologist	1
43	Dental Hygienist	1
44	Special Educator	2
45	Radiation Technologist	2
46	Radiation Physicist	1
47	Social Worker	4
48	Microbiologist	1
49	Radiographer	9
50	Cook	1
51	District Programme Manager	1

52	District Accounts Officer	1
53	Office Secretary	1
54	District PRO	1
55	Junior Consultant Biomedical	1
56	RBSK /AH Coordinator	1
57	JC(Engg)	2
58	PRO / PRO Cum LO	11
59	Jr.Consultant Quality	2
60	JC Documentation	1
61	JC MIS	1
62	JC (M&E)	1
63	ASHA Coordinator	1
64	Urban Health Coordinator	1
65	VBD Consultant	1
66	Accountant	5
67	District Field Coordinator	1
68	Supportive staff (NUHM)	2
69	CDEO & DEO	17
70	Office Assistant	1
71	Sanitary Attendant	1

72	Hospital Attendant	1
73	DEO Cum Accountant (UHWC)	2
74	MLSP	197
75	Specialist for Polyclinic	1
76	Staff Nurse for Elderly Clinic	1
77	Dental Specialist for Dental polyclinic	1
78	Dental Technician for Dental polyclinic	1
79	Staff Nurse (NCD care)	2

Source: District data

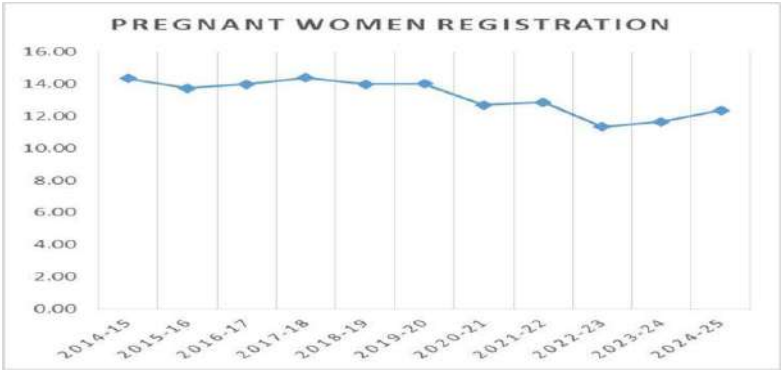
CHAPTER 5

MATERNAL AND CHILD HEALTH

5.1 Pregnant Women Registration

The registration of pregnant women in the district shows a very slow, declining trend from 2014 onwards, with a slight rise from 2022 onwards.

Figure 5.1.1 Trend in pregnant women registration in the District (2014-15 to 2024-25)



Source: HMIS

5.2 Early Initiation of Antenatal Care

The early registration of pregnant women has gradually increased since 2014, with the highest level observed in 2025.

Figure 5.2.1 Early registration of pregnant women

Source: HMIS

5.3 Immunization status of Pregnant Women

A total of 12357 pregnant women were registered for antenatal care during the year. Among them, 8339 women received the first dose of Td, while 7405 women received the second dose. 1039 women received the booster dose for Td.

Table 5.3.1. Td immunization status of pregnant women (2024-2025)

Td immunization status of pregnant women				
District	**No. of PW registered for ANC**	**No. of PW given Td1**	**No. of PW given Td2**	**No of PW given Td booster**
Wayanad	12357	8339	7405	1039

**Source: HMIS*

5.4 Abortion

Spontaneous abortions remained relatively stable but showed a slight decline after 2018–19, whereas induced abortions increased significantly from 58 in 2014–15 to 803 in 2024–25. This rise may reflect better reporting, improved access to safe abortion services, or changing reproductive behaviour.

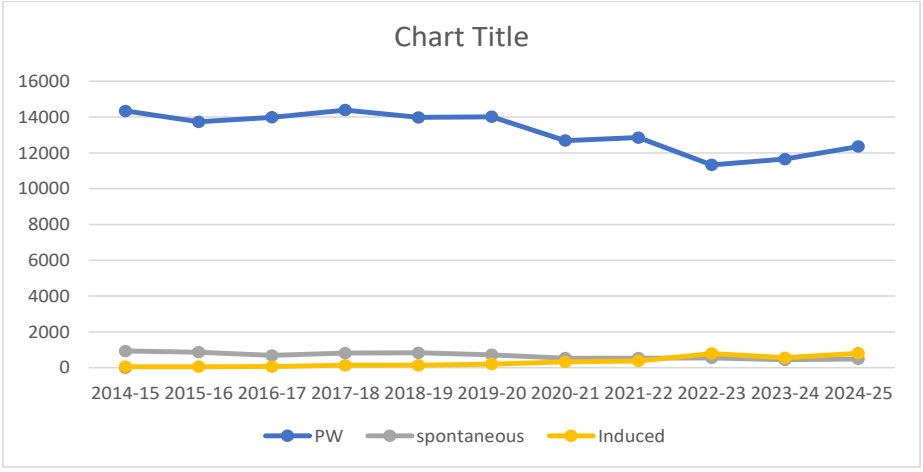
Table 5.4.1 Trends in Spontaneous and Induced abortions (2014-2015 to 2024-2025)

Year	PW	Total (spontaneous + Induced)	spontaneous	Induced
2014-15	14343	988	930	58
2015-16	13735	924	866	58
2016-17	13986	746	681	65

2017-18	14391	943	812	131
2018-19	13980	968	830	138
2019-20	14015	915	718	197
2020-21	12686	856	531	325
2021-22	12853	905	529	376
2022-23	11327	1334	545	789
2023-24	11652	994	440	554
2024-25	12357	1292	489	803

**Source: HMIS data*

Figure 5.4.1 Trends of abortion over the years (2014- 15 to 2024-25)



5.5 Family Planning

Post-Partum Sterilization (PPS) remains the most common method, with cases ranging from 818 to 1,513. Mini-lap and laparoscopic sterilizations also show steady performance, with notable increases in 2022–23 and 2023–24. Non-Scalpel Vasectomy (NSV) numbers are comparatively low, indicating limited male participation in family planning. Post-Abortion Sterilization (PAS) services have shown a gradual rise over the

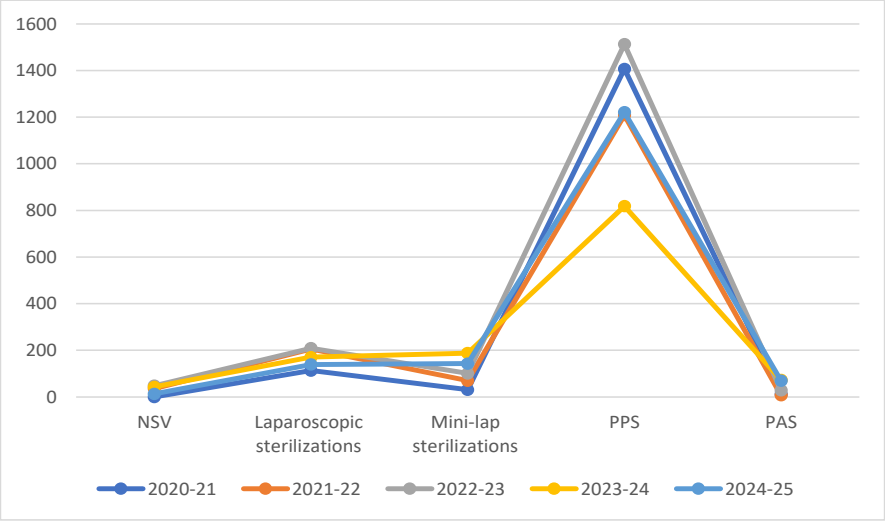
years. Overall, the data reflect sustained female-oriented sterilization efforts and highlight the need to encourage male involvement in permanent contraceptive methods.

Table 5.5.1 Male and Female sterilizations (2020-21 to 2024-25)

Period	NSV	Laparoscopic sterilizations	Mini-lap sterilizations	PPS	PAS
2020-21	0	113	31	1407	12
2021-22	36	205	70	1209	7
2022-23	48	209	101	1513	28
2023-24	43	171	188	818	73
2024-25	13	139	143	1221	69

**Source: HMIS*

Figure 5.5.1 Male and Female sterilizations reported in HMIS at the state level from 2020-21 to 2024-25



Source: HMIS

IUCD insertions ranged from 922 to 1,405, with the highest number recorded in 2022–23. Post-Partum IUCD (PPIUCD) insertions were highest in 2021–22 (231) but declined in the subsequent years. Post-Abortion IUCD (PAIUCD) numbers remained consistently low throughout the period. Overall, the trend reflects a steady uptake of IUCDs as a long-term family planning method, although PPIUCD and PAIUCD utilization remains limited, indicating scope for strengthening counselling and postpartum contraceptive services.

Table 5.5.2 IUCD Insertions reported in HMIS (2020-21 to 2024-25)

Period	FP elements	Wayanad
2020-21	IUCD	931
	PPIUCD	130
	PAIUCD	1
2021-22	IUCD	1136
	PPIUCD	231
	PAIUCD	0
2022-23	IUCD	1405
	PPIUCD	218
	PAIUCD	16
2023-24	IUCD	922
	PPIUCD	138
	PAIUCD	2
2024-25	IUCD	1114
	PPIUCD	119
	PAIUCD	9

**Source: HMIS*

The distribution of family planning commodities in Wayanad from 2020–21 to 2024–25 shows fluctuations across different methods. Condom distribution increased substantially from 28,624 in 2020–21 to over 1 lakh pieces in later years, indicating wider acceptance of barrier methods. Combined oral pill cycles ranged between 3,492 and 5,917, showing moderate and consistent use. Distribution of Centchroman (weekly) pills and Emergency Contraceptive Pills (ECPs) varied annually, reflecting demand-based utilization. Overall, the data suggest sustained family planning activities with a growing preference for temporary contraceptive methods.

Table 5.5.3 Distribution of family Planning Commodities (Public sector) (2020-21 to 2024-25)

Period	Number of Combined Oral Pill cycles distributed	Number of Condom pieces distributed	Number of Centchroman (weekly) pill strips distributed	Number of Emergency Contraceptive Pills (ECP) given
2020-21	3492	28624	537	627
2021-22	5917	53523	314	557
2022-23	4586	103699	98	230
2023-24	3968	92057	362	149
2024-25	4980	103311	679	427

**Source: HMIS*

5.6 Delivery

Private sector deliveries consistently outnumber those in the public sector, though both have shown a declining trend. Home deliveries have decreased sharply, from 77 in 2020–21 to 24 in 2024–25, reflecting improved institutional delivery coverage. Overall, the trend highlights a shift toward institutional deliveries, with the private sector playing a major role.

Table 5.6.1 Trend in total deliveries (2020-21 to 2024 -2025)

Period	Wayanad			
	Public	Private	Home Deliveries	All
2020-21	5235	7808	77	13120
2021-22	5075	7861	49	12985
2022-23	3947	8102	42	12091
2023-24	3422	7104	42	10568
2024-25	3410	6509	24	9943

Source: HMIS

Table 5.6.2 Trend in Institutional and home deliveries

Period	Wayanad	
	Institutional delivery	Home delivery
2020-21	13043	77
2021-22	12936	49
2022-23	12049	42
2023-24	10526	42
2024-25	9919	24

Source: HMIS

5.7 Caesarean section deliveries

Throughout the period, private institutions consistently accounted for a higher share of C- section deliveries (around 41–45%) compared to public facilities (around 27–30%).

The combined average for all institutions remained relatively stable, between 36% and 39%, indicating consistent institutional delivery coverage.

Table 5.7.1 C-section rate in Public and Private sector

Period	Public	Private	All
2020-21	28.84	43.37	37.54
2021-22	29.97	41.09	36.73
2022-23	27.57	44.85	39.19
2023-24	29.16	43.85	39.07
2024-25	28.68	42.10	37.48

**Source: HMIS*

5.8 Maternal Deaths

The data on maternal deaths in Wayanad from 2014–15 to 2024–25 show a declining trend over the decade. Maternal deaths reduced from 11 in 2014–15 to just 1 in 2024–25, indicating significant improvement in maternal health care and institutional delivery services. Although slight fluctuations occurred in some years (notably 9 deaths in 2018–19 and 7 in 2019–20), the overall trend reflects better antenatal, intra-partum, and postnatal care, as well as improved access to emergency obstetric services in the district.

Table 5.8.1 Trends of Maternal deaths 2014 – 2015 to 2024-2025

District	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
WYD	11	4	4	4	9	7	2	6	5	5	1

**Source: HMIS*

5.9 Child birth

The data indicate a gradual decline in total childbirths in Wayanad from 13,907 in 2014–15 to 9,981 in 2024–25. Both male and female births have shown a similar downward trend over the decade. While the numbers remain fairly balanced between the sexes, the overall reduction reflects a decreasing fertility rate and possibly improved family planning practices, education, and health awareness in the district.

Table 5.9.1 Trend of live birth by gender (2014-2015 to 2024-2025)

Period	Wayanad		
	Male	Female	Total
2014-15	7.151	6.756	13.907
2015-16	6.917	6.526	13.443
2016-17	5	4.906	9.906
2017-18	7.513	7.437	14.95
2018-19	7.496	7.322	14.818
2019-20	7.483	7.168	14.651
2020-21	6.63	6.53	13.16
2021-22	6.501	6.523	13.024
2022-23	6.184	5.961	12.145
2023-24	5.429	5.216	10.645
2024-25	5.062	4.919	9.981

**Source: HMIS*

5.10 Infant mortality

Neonatal deaths in Wayanad have shown a consistent decline from 95 in 2014–15 to 43 in 2024–25.

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

District	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Wayanad	95	93	69	77	68	71	64	58	61	42	43

**Source: District Report*

The number of infant deaths in Wayanad has shown a declining trend over the decade, decreasing from 128 in 2014–15 to 74 in 2024–25. Although minor fluctuations occurred in some years, the overall reduction reflects improved child health services, enhanced immunization coverage, better nutrition, and strengthened primary healthcare interventions in the district.

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

District	2014-15	2015-16	206-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Wayanad	128	137	110	126	110	100	91	95	97	75	74

**Source: District Report*

Child deaths in Wayanad show minor fluctuations over the four year period, with 107 reported in 2021–22, peaking at 108 in 2022–23, dropping to 85 in 2023–24, and slightly rising to 93 in 2024–25. The trend reflects moderate improvements in new-born care and institutional delivery services, though further efforts are needed to achieve a consistent reduction in neonatal mortality.

Table 5.10.3: Number of Child Deaths (Under 5) Reported (2021-22 to 2024-25)

District	2021-22	2022-23	2023-24	2024-25
Wayanad	107	108	85	93

**Source: District Report*

The IMR in Wayanad has remained largely stable at 7–8 per 1,000 live births, while the NMR has fluctuated slightly between 4 and 5 per 1,000 live births over the six-year period. These low and stable rates indicate effective maternal and child health interventions, high institutional delivery coverage, and improved neonatal care in the district.

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

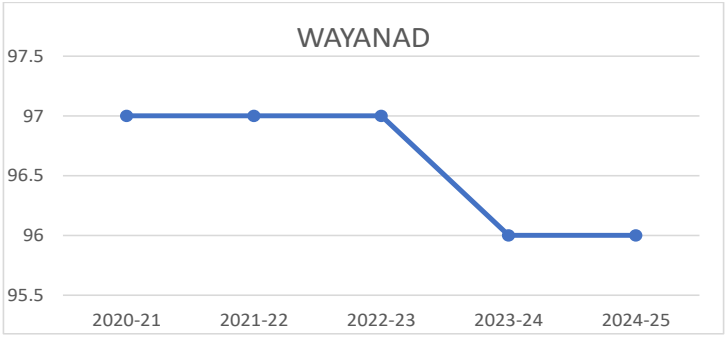
	2019-20		2020-21		2021-22		2022-23		2023-24		2024-25	
District	IMR	NMR	IMR	NMR	IMR	NMR	IMR	NMR	IMR	NMR	IMR	NMR
WYD	7	5	7	5	7	4	8	5	7	4	7	4

**Source: District Report*

5.11 Child Immunization

The immunization remained steady at around 97% from 2020-21 to 2022-23 period. But, a notable decline is observed from 2023-24, where the percentage dropped to 96% and remained nearly the same in 2024-25.

Figure 5.11.1: Trend in Percentage of Children Fully Immunized



**Source: HMIS*

The immunization coverage in Wayanad district demonstrates high uptake across all vaccines. Key highlights include BCG at 100%, OPV0 and Hepatitis B0 at 99%, and full immunization coverage at 96%. Coverage for multi-dose vaccines like OPV, PENTA, Rota, IPV, and PCV ranges between 97–98%, while the second doses of MR and PCV show slightly lower coverage (MR2 – 95%, PCV2 – 96%). The slightly lower coverage for PCV booster (93%) indicates a need for follow-up. Overall, the data reflect strong routine immunization services and high vaccine uptake in the district.

Table 5.11.1. Antigen-wise Immunization Coverage

Vaccine	Coverage (%)
BCG	100
OPV0	99
HEP B0	99
OPV1	98
OPV2	97
OPV3	97
MR1	97
Full immunization	96
PENTA1	98
PENTA2	97
PENTA3	97
Rota1	98
Rota2	97

Rota3	97
IPV1	97
IPV2	97
PCV1	98
PCV2	96
PCV booster	93
MR2	95

**Source: RCH Data*

CHAPTER 6

COMMUNICABLE AND NON-COMMUNICABLE DISEASES

6.1 Disease Burden Overview: Common Communicable Diseases

The major communicable disease leading to death in the district is leptospirosis followed by dengue. Over the past four years, the number of reported dengue cases has been higher than that of leptospirosis.

6.1.1 Communicable Diseases – Cases Reported

Table 6.1.1 Number of Reported Cases of Communicable Diseases in the District (2020-24)

Sl No	Name of Diseases	2024	2023	2022	2021	2020
1	Dengue Fever: Confirmed	72	120	88	32	49
3	Malaria	10	4	5	8	6
4	Chikungunya	1	0	0	0	0
5	Acute Encephalitis Syndrome	15	0	1	0	1
6	Japanese Encephalitis (JE)	0	1	0	0	0
7	Leptospirosis : Confirmed	129	210	424	111	158
9	Hepatitis - A : Confirmed	45	20	3	9	15
11	Hepatitis – B	12	14	28	9	7
12	Hepatitis – C	1	3	2	3	0
13	Hepatitis – E	1	0	0	0	0
14	Cholera	10	0	0	0	0
16	Typhoid	1	0	0	3	0

17	Acute Diarrheal Disease	22546	23170	18996	7987	10259
19	Shigella	1	6	0	12	0
20	Scrub Typhus	12	17	27	20	27
21	Kala Azar	0	0	0	0	0
22	Kysanur Forest Disease	0	0	1	4	29
23	Influenza (H1N1, H3N2, Infl A, Infl B)	77	19	4	0	0
24	Rabies : Confirmed	0	0	0	0	2
26	Zika	0	0	0	0	0
27	West Nile	0	0	0	0	0
30	Nipah	0	0	0	0	0
33	Chicken Pox	896	1034	477	215	981

** Source: IDSP data*

The data indicates notable variations in the incidence of major communicable diseases over the five-year period from 2020 to 2024.

- Acute Diarrheal Disease (ADD) continues to be the most frequently reported illness, with consistently high case numbers each year. Although the number slightly decreased from 23,170 in 2023 to 22,546 in 2024, it remains a major public health concern.
- Leptospirosis showed fluctuating trends, peaking at 424 confirmed cases in 2022 and then declining to 129 in 2024.
- Dengue Fever cases dropped sharply from 120 in 2023 to 72 in 2024,following fluctuating figures in previous years.

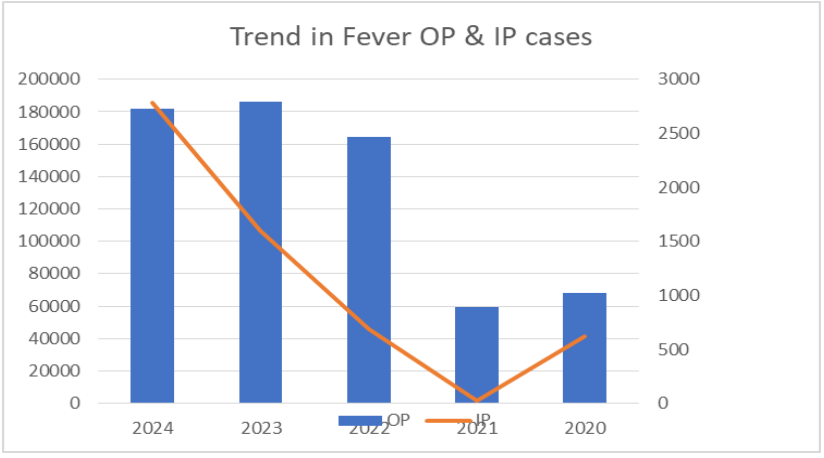
- Influenza (H1N1, H3N2, Infl A, Infl B) showed a notable increase in 2024 with 77 cases compared to only 19 in 2023, indicating a possible resurgence.
- Chicken Pox also remained common, although cases declined from 1,034 in 2023 to 896 in 2024.
- Hepatitis infections (A, B, C, and E) were reported sporadically, with Hepatitis A showing a rise from 20 in 2023 to 45 in 2024.
- Other diseases such as Malaria, Scrub Typhus, and Acute Encephalitis Syndrome (AES) recorded relatively lower but notable case numbers.
- No confirmed cases were recorded for Zika, West Nile, Nipah, or Kala Azar in the five-year period.

Overall, while vector-borne and water-borne diseases remain prevalent, some like Dengue and Leptospirosis have shown declining trends in 2024. Continuous surveillance, public health awareness, and preventive measures remain essential to control outbreaks and reduce disease burden.

6.1.2 Trend in fever outpatient and inpatient cases

Fever OP and IP shows increase from 2021 onwards, which can be due to increased reporting from the institution and changes in health behaviour post covid.

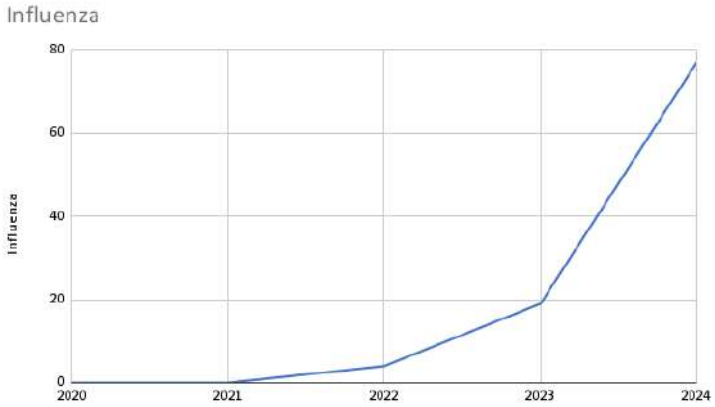
Figure 6.1.2 Trend in fever OP and IP cases.



Source: IDSP data

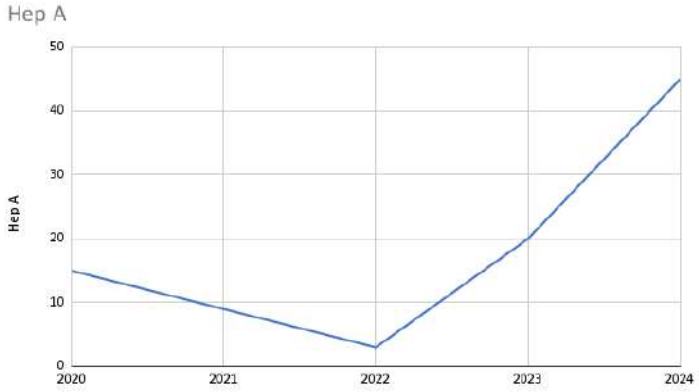
6.1.3 Trend in top 5 communicable disease in the district

Figure 6.1.3.1 Trend of influenza



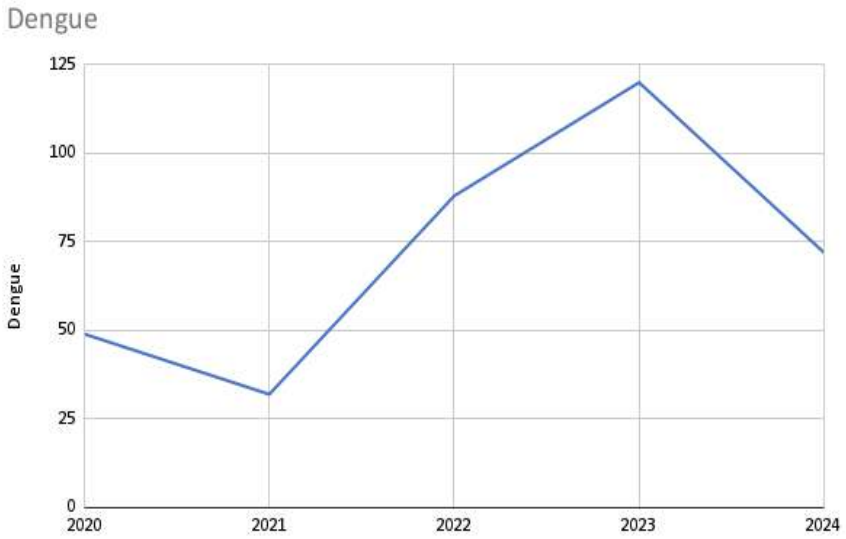
Influenza shows a gradual rising trend from 2022 onwards. It can be due to more reporting after covid.

Figure 6.1.3.2 Trend of Hepatitis A



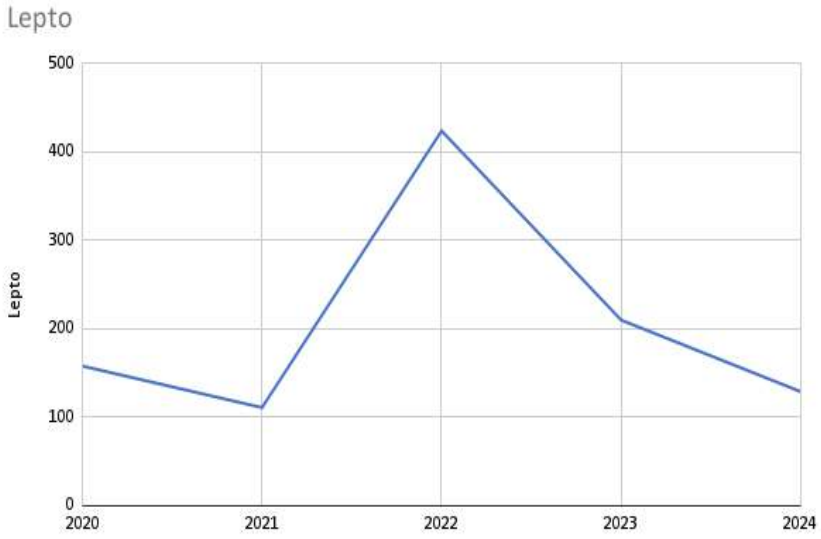
Hep A shows a gradual rising trend from 2022 onwards

Figure 6.1.3.3 Trend of Dengue



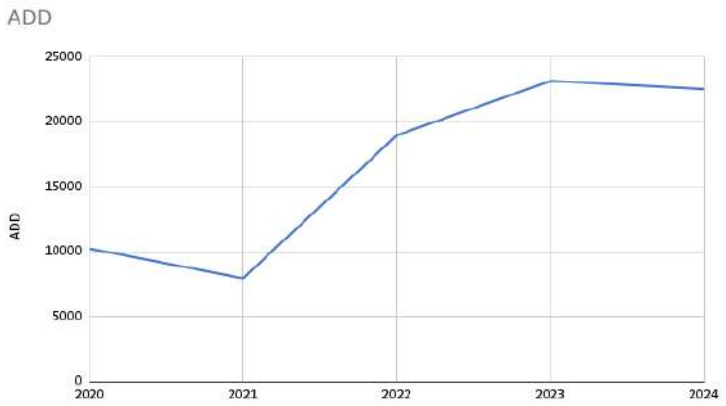
Dengue shows a declining trend from 2023 and continues the same in 2024.

Figure 6.1.3.4 Trend of Leptospirosis



Lepto cases peaked during 2022

Figure 6.1.3.5 Trend of ADD



ADD cases gradually increased from 2021 and there is a slight decline from 2023.

6.1.4 Disease wise deaths due to Communicable Disease in the District

Table 6.1.4.1 Disease wise deaths due to Communicable Disease in the District

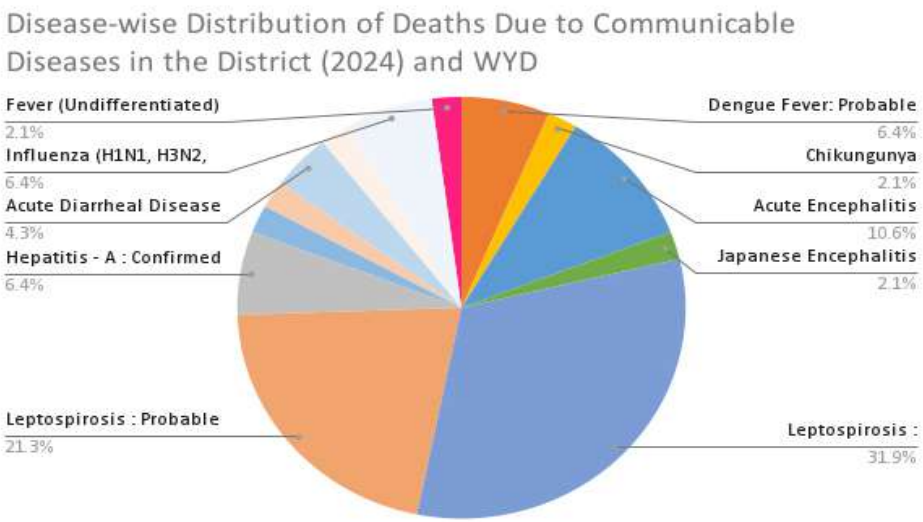
Name of Diseases	WYD
Dengue Fever: Confirmed	0
Dengue Fever: Probable	3
Malaria	0
Chikungunya	1
Acute Encephalitis Syndrome	5
Japanese Encephalitis (JE)	1
Leptospirosis : Confirmed	15
Leptospirosis : Probable	10
Hepatitis - A : Confirmed	3

Hepatitis - A : Probable	0
Hepatitis - B	1
Hepatitis - C	0
Hepatitis - E	0
Cholera	1
Diphtheria	0
Typhoid	0
Acute Diarrheal Disease	2
Food Poisoning	0
Shigella	0
Scrub Typhus	1
Kala Azar	0
Kysanur Forest Disease	0
Influenza (H1N1, H3N2, Infl A, Infl B)	3
Rabies : Confirmed	0
Rabies : Probable	0
Zika	0
West Nile	0
Prob West Nile	0
M Pox	0

Nipah		0
Amoebic Meningoencephalitis		0
Prob Amoebic Meningoencephalitis		0
Chicken Pox		0
Fever (Undifferentiated)	OP	1
	IP	

**Source: District Report*

Figure 6.1.4.1 Disease-wise distribution of deaths due to Communicable disease (2024)



** Source: District Data*

The analysis of communicable disease-related deaths in Wayanad district during 2024 shows that leptospirosis remains the major cause of mortality, accounting for over half (53.2%) of the total deaths (31.9% confirmed and 21.3% probable). Acute encephalitis contributed 10.6%, while hepatitis A, influenza (H1N1, H3N2), and dengue fever each

accounted for about 6.4%. Deaths due to acute diarrheal disease formed 4.3%, and chikungunya, Japanese encephalitis, and undifferentiated fever each made up 2.1%.

Overall, the data highlights the predominance of leptospirosis and vector-borne infections as leading causes of communicable disease mortality in the district, emphasizing the need for strengthened surveillance, early diagnosis, vector control, and public health interventions.

6.2 Burden of Non communicable disease in the district

Table 6.2.1 Burden of non communicable diseases

NCD	2024-25
Diabetes	262096
Hypertension	432652
Stroke (Paralysis)	8923
Cardiovascular Disease	36213
Mental illness	32787
Epilepsy	2535
Ophthalmic Related	112657
Dental	85400
ENT	109020
Asthma	17954
Oral Cancer	2188
Breast Cancer	3719
Cervical Cancer	256

Other Cancers	9301
COPD	29046
CKD (Chronic Kidney Disease)	11212
Patients undergoing refraction	52139
Tuberculosis	2847
Leprosy Cases	17
Leprosy with GradeII disability	0
Geriatric(age>=60yrs)	576894
Chronic Liver Disease	1214
Palliative Care	44964

**Source:District data*

During 2024–25, a total of NCD cases across various categories were reported under the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) in Wayanad district.

Hypertension (4,32,652 cases) and Diabetes (2,62,096 cases) formed the largest burden, indicating a high prevalence of lifestyle-related diseases. Significant numbers were also recorded under ophthalmic (1,12,657), ENT (1,09,020), and dental (85,400) conditions, showing a strong demand for routine screening and outpatient care services.

Among chronic conditions, cardiovascular diseases (36,213), chronic respiratory diseases such as COPD (29,046), and chronic kidney disease (11,212) contributed notably to morbidity. Mental illness (32,787) and palliative care patients (44,964) highlight the growing need for integrated mental health and long-term care services.

Cancer cases, though fewer in comparison, included oral cancer (2,188), breast cancer (3,719), cervical cancer (256), and other cancers (9,301), requiring continued emphasis on early detection and treatment. Additionally, geriatrics (5,76,894) accounted for a

substantial portion of the population seeking care, underscoring the aging demographic and the need for elderly-focused health interventions.

6.3 District-specific Outbreaks and Health Concerns

Wayanad is one of the few districts in Kerala where Kyasanur Forest Disease (KFD), a tick-borne viral hemorrhagic fever, has been reported in recurring outbreaks. The forested and tribal-inhabited areas of Wayanad provide a conducive environment for the disease's transmission cycle, which involves ticks, monkeys, and humans. Outbreaks have occurred intermittently since 2014, with increasing frequency in recent years due to forest fragmentation and rising human-animal contact. The most recent case was reported in 2022. Intersectoral training was conducted on Nov 29, 2024 incorporating officials from LSGD, Forest officials and health workers.

CHAPTER 7

CRITICAL OBSERVATIONS IN THE NFHS 5 DATA AND APPROPRIATE

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

Indicators	NFHS-5 (2019-20)	NFHS-4 (2015-16)
Population and Household Profile	**Total**	**Total**
1. Female population aged 6 years and above who ever attended school (%)	88.2	88.9
2. Population below age 15 years (%)	21.2	21.9
3. Sex ratio of the total population (females per 1,000 males)	1,019	1,065
4. Sex ratio at birth for children born in the last five years (females per 1,000 males)	1,003	1,241
5. Children under age 5 years whose birth was registered with the civil authority (%)	96.8	95.2
6. Deaths in the last 3 years registered with the civil authority (%)	97.1	na
7. Population living in households with electricity (%)	97	96.1
8. Population living in households with an improved drinking-water source (%)	94.1	93.3
9. Population living in households that use an improved sanitation facility (%)	97.6	95.2
10. Households using clean fuel for cooking (%)	55.7	33.2
11. Households using iodized salt (%)	99	96.9

12. Households with any usual member covered under a health insurance/financing scheme (%)	64.8	61.8
13. Children aged 5 years who attended pre-primary school during the school year 2019-20 (%)	33.6	na
Characteristics of Women (age 15-49 years)		
14. Women who are literate (%)	93.7	na
15. Women with 10 or more years of schooling (%)	68	61.3
Marriage and Fertility		
16. Women aged 20-24 years married before age 18 years (%)	8.4	13.8
17. Births in the 5 years preceding the survey that are third or higher order (%)	0.5	0
18. Women aged 15-19 years who were already mothers or pregnant at the time of the survey (%)	2.6	2.1
19. Women aged 15-24 years who use hygienic methods of protection during their menstrual period (%)	84.9	81.9
Current Use of Family Planning Methods (currently married women age 15–49 years)		
20. Any method (%)	78.9	57.8
21. Any modern method (%)	69.5	52.2
22. Female sterilization (%)	64.8	46.3
23. Male sterilization (%)	0.2	0.5
24. IUD/PPIUD (%)	2.7	2.8
25. Pill (%)	0.2	0.2

26. Condom (%)	1.1	2.3
27. Injectables (%)	0	0
Unmet Need for Family Planning (currently married women age 15–49 years)		
28. Total unmet need (%)	5.6	11.2
29. Unmet need for spacing (%)	4	7.5
Quality of Family Planning Services		
30. Health workers ever talked to female non-users about family planning (%)	11.8	20.5
31. Current users ever been told about side effects of current method (%)	68.5	50.2
Indicators	**NFHS-5 (2019-20)**	**NFHS-4 (2015-16)**
Maternal and Child Health	**Total**	**Total**
Maternity Care (for the last birth in the 5 years before the survey)		
32. Mothers who had an antenatal check-up in the first trimester (%)	97.6	94.8
33. Mothers who had at least 4 antenatal care visits (%)	94.2	91.7
34. Mothers whose last birth was protected against neonatal tetanus (%)	99.4	94.9
35. Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	94.9	72.2
36. Mothers who consumed iron folic acid for 180 days or more when they were pregnant (%)	75.3	57.2

37. Registered pregnancies for which the mother received a Mother and Child Protection (MCP) card (%)	97.7	88.7
38. Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)		
	95.9	83.2
39. Average out-of-pocket expenditure per delivery in a public health facility (Rs.)	7,967	4,232
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 (%)		
	97.2	na
Delivery Care (for births in the 5 years before the survey)		
42. Institutional births (%)	100	99.6
43. Institutional births in public facility (%)	37.6	47.2
44. Home births that were conducted by skilled health personnel[10] (%)	0	0
45. Births attended by skilled health personnel[10] (%)	100	99.6
46. Births delivered by caesarean section (%)	25.7	22.8
47. Births in a private health facility that were delivered by caesarean section (%)	30.2	21.9
48. Births in a public health facility that were delivered by caesarean section (%)	18.4	23.9
Child Vaccinations and Vitamin A Supplementation		

49. Children aged 12-23 months fully vaccinated based on information from either vaccination card or mother's recall[11] (%)	86.4	72.8
50. Children aged 12-23 months fully vaccinated based on information from vaccination card only (%)	88.4	85.9
51. Children aged 12-23 months who have received BCG (%)	97.7	100
52. Children aged 12-23 months who have received 3 doses of polio vaccine (%)	88.8	79.2
53. Children aged 12-23 months who have received 3 doses of Penta or DPT vaccine (%)	86.4	83.6
54. Children aged 12-23 months who have received the first dose of measles-containing vaccine (MCV) (%)	90.8	83.5
55. Children aged 24-35 months who have received a second dose of measles-containing vaccine (MCV) (%)	25.6	na
56. Children aged 12-23 months who have received 3 doses of rotavirus vaccine (%)	0	na
57. Children aged 12-23 months who have received 3 doses of penta or hepatitis B vaccine (%)	81.9	71.3
58. Children aged 9-35 months who received a vitamin A dose in the last 6 months (%)	78.1	76.6
59. Children aged 12-23 months who received most of their vaccinations in a public health facility (%)	93.2	87.4
60. Children aged 12-23 months who received most of their vaccinations in a private health facility (%)	6.8	12.6
Treatment of Childhood Diseases (children under age 5 years)		

61. Prevalence of diarrhoea in the 2 weeks preceding the survey (%)	1.4	4
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 were taken to a health facility or health provider (%)	*	*
65. Prevalence of symptoms of acute respiratory infection (ARI) in the 2 weeks preceding the survey (%)	1.4	1.6
66. Children with fever or symptoms of ARI in the 2 weeks preceding the survey, taken to a health facility or health provider (%)	95.5	92.8
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 (%)	60	62.9
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 diet (%)	14.8	22.4
71. Non-breastfeeding children age 6-23 months receiving an adequate diet (%)	*	*

72. Total children age 6-23 months receiving an adequate diet (%)	14.1	23.5
73. Children under 5 years who are stunted (height-for-age) (%)	31.3	27.7
74. Children under 5 years who are wasted (weight-for-height) (%)	16.1	23.9
75. Children under 5 years who are severely wasted (weight-for-height) (%)	5.3	10.7
76. Children under 5 years who are underweight (weight-for-age) (%)	22.5	27.2
77. Children under 5 years who are overweight (weight-for-height) (%)	6.5	1.6
Nutritional Status of Women (age 15-49 years)		
78. Women whose Body Mass Index (BMI) is below normal (BMI <18.5 kg/m^2) (%)	14	12.2
79. Women who are overweight or obese (BMI ≥25.0 kg/m^2) (%)	26.7	24.4
80. Women who have high risk waist-to-hip ratio (≥0.85) (%)	73.9	na
Anaemia among Children and Women		
81. Children aged 6-59 months who are anaemic (<11.0 g/dl) (%)	39.4	45.6
82. Non-pregnant women aged 15-49 years who are anaemic (<12.0 g/dl) (%)	27	32.9
83. Pregnant women aged 15-49 years who are anaemic (<11.0 g/ dl) (%)	*	12.2
84. All women aged 15-49 years who are anaemic (%)	26.9	32.3
85. All women aged 15-19 years who are anaemic(%)	27.7	36
Blood Sugar Level among Adults (age 15 years and above)		

Women		
86. Blood sugar level - high (141-160 mg/dl) (%)	7.5	na
87. Blood sugar level - very high (>160 mg/dl) (%)	8.4	na
88. Blood sugar level - high or very high (>140 mg/dl) or taking medicine to control blood sugar level (%)	18.3	na
Men		
89. Blood sugar level - high (141-160 mg/dl) (%)	8.2	na
90. Blood sugar level - very high (>160 mg/dl) (%)	7.9	na
91. Blood sugar level - high or very high (>140 mg/dl) or taking medicine to control blood sugar level (%)	17.9	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) (%)	15.1	na
93. Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100mm of Hg) (%)	7.2	na
94. Elevated blood pressure (Systolic ≥140 mm of Hg and/or Diastolic ≥90 mm of Hg) or taking medicine to control blood pressure (%)	28.8	na
Men		
95. Mildly elevated blood pressure (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	17.7	na
96. Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100mm of Hg) (%)	7.4	na

97. Elevated blood pressure (Systolic ≥140 mm of Hg and/or Diastolic ≥90 mm of Hg) or taking medicine to control blood pressure (%)	28.3	na
Screening for Cancer among Women (age 30-49 years)		
98. Ever undergone a screening test for cervical cancer (%)	1.5	na
99. Ever undergone a breast examination for breast cancer (%)	1.2	na
100. Ever undergone an oral cavity examination for oral cancer (%)	0.2	na
Tobacco Use and Alcohol Consumption among Adults (age 15 years and above)		
101. Women aged 15 years and above who use any kind of tobacco (%)	10.6	na
102. Men aged 15 years and above who use any kind of tobacco (%)	26	na
103. Women aged 15 years and above who consume alcohol (%)	1.2	na
104. Men aged 15 years and above who consume alcohol (%)	23.2	na

**NFHS 4 data not available from 86 to 104*

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

Women aged 15-49 years reveal encouraging trends in literacy and education levels. A significant majority, 93.7%, of women in this age group are literate, indicating widespread access to basic reading and writing skills. Furthermore, a substantial portion of these women, 68%, have completed 10 or more years of schooling, reflecting a strong commitment to extended education. This figure, while high, is slightly above a comparative rate of 61.3%, suggesting regional or demographic variations in educational attainment. Overall, these statistics highlight positive progress in women's education, which is a crucial factor for empowerment, improved health outcomes, and greater socio-economic participation.

The data on marriage and fertility among women highlights several important trends. Among women aged 20-24 years, 8.4% were married before the age of 18, which is notably lower than the comparative figure of 13.8%, indicating progress in delaying early marriage. The proportion of births that are third order or higher in the five years preceding the survey is very low, at just 0.5%, suggesting a trend towards smaller family sizes. Additionally, only 2.6% of women aged 15-19 were already mothers or pregnant at the time of the survey, a figure slightly higher than the comparative 2.1%, but still relatively low, reflecting improved reproductive health and family planning among younger women. Furthermore, menstrual hygiene practices are relatively high, with 84.9% of women aged 15-24 using hygienic methods of protection during their menstrual periods, slightly above the comparative rate of 81.9%. Together, these statistics indicate positive developments in delaying marriage, reducing high-order births, improving reproductive health, and promoting menstrual hygiene among young women.

Overall, 78.9% of women reported using any method of family planning, which is substantially higher than the comparative rate of 57.8%. When focusing on modern methods, 69.5% of women are using them, again significantly exceeding the comparative figure of 52.2%. Female sterilization emerges as the most commonly used method, with 64.8% of women opting for it, compared to 46.3% in the comparative group, highlighting its dominance as a permanent contraceptive option. Male sterilization is very rare, with only 0.2% uptake, slightly lower than the 0.5% comparative rate. Usage of intrauterine devices (IUD/PPIUD) is fairly similar between the two groups, at around 2.7% and 2.8% respectively. The use of pills remains minimal at 0.2% in both groups, while condom use is relatively low but somewhat higher in the comparative group (2.3%) compared to 1.1%. No women reported using injectables in either group. These figures indicate strong family planning adoption overall, with a particular preference for female sterilization and a higher uptake of modern contraceptive methods compared to the comparative data.

The data on unmet need for family planning among currently married women aged 15–49 years reveals encouraging trends in meeting contraceptive demands. The total unmet need for family planning stands at 5.6%, which is notably lower than the comparative figure of 11.2%, indicating better access to or use of family planning services. Specifically, the unmet need for spacing births is 4%, also significantly less than the comparative 7.5%, reflecting improved ability among women to plan the timing of their pregnancies.

However, when it comes to the quality of family planning services, there are some mixed signals. Only 11.8% of female non-users reported that a health worker had ever talked to them about family planning, which is considerably lower than the 20.5% in the comparative group, suggesting room for improvement in outreach and counselling efforts. On a more positive note, 68.5% of current family planning users were informed about the potential side effects of their method, surpassing the comparative figure of 50.2%, indicating better communication and counselling for those already using contraception. Overall, while unmet need is relatively low, strengthening health worker engagement with non-users could further improve family planning uptake and satisfaction.

The maternal and child health indicators show strong performance in key areas related to maternity care for the last birth in the five years preceding the survey. A very high percentage of mothers 97.6% received antenatal check-ups in the first trimester, slightly higher than the comparative rate of 94.8%. Similarly, 94.2% of mothers had at least four antenatal care visits, surpassing the comparative figure of 91.7%, indicating good adherence to recommended prenatal care schedules. Protection against neonatal tetanus for the last birth is almost universal at 99.4%, significantly better than the comparative rate of 94.9%.

Nutritional support during pregnancy is also notable, with 94.9% of mothers consuming iron folic acid for 100 days or more, much higher than the comparative 72.2%. Even more impressive is that 75.3% of mothers consumed iron folic acid for 180 days or more, compared to 57.2% in the comparison group, reflecting a strong focus on maternal nutrition. Pregnancy registration with receipt of a Mother and Child Protection (MCP) card is nearly universal at 97.7%, again higher than the comparative 88.7%.

Postnatal care within two days of delivery shows similar positive trends, with 95.9% of mothers and 97.2% of children receiving care from qualified health personnel, both exceeding the comparative 83.2% for mothers. This indicates strong follow-up care in the critical postnatal period. However, average out-of-pocket expenditure per delivery in public health facilities shows a stark difference. Overall, these statistics suggest robust maternal and child health services with high coverage of antenatal, nutritional, and postnatal care, alongside effective financial support, all of which contribute to better health outcomes for mothers and newborns.

The delivery care data for births in the five years before the survey reflects excellent access to skilled childbirth services. Institutional births are nearly universal, with 100% of births taking place in health facilities, slightly higher than the comparative rate of 99.6%. However, the distribution between public and private facilities differs: 37.6% of births occurred in public health facilities, which is lower than the comparative figure of 47.2%, indicating a higher reliance on private institutions for delivery care.

Births attended by skilled health personnel also reached 100%, marginally higher than the comparative 99.6%, ensuring professional care during delivery. Caesarean section rates are somewhat elevated, with 25.7% of births delivered via C-section compared to 22.8% in the comparative data. This difference is more pronounced in private health facilities, where 30.2% of births were by C-section, considerably higher than the 21.9% reported in the comparison group. Conversely, public health facilities reported a lower C-section rate at 18.4%, compared to 23.9% in the comparative data. These findings suggest strong institutional delivery coverage and skilled attendance.

The data on child vaccinations and vitamin A supplementation highlight strong immunization coverage among children aged 12-23 months. Fully vaccinated children based on vaccination cards or mother's recall stand at 86.4%, notably higher than the comparative 72.8%. Coverage for key vaccines is also high, with 97.7% receiving BCG, 88.8% receiving three doses of polio vaccine, and 86.4% receiving three doses of Penta or DPT vaccine, all surpassing comparative rates. The first dose of the measles-containing vaccine (MCV) was administered to 90.8% of children, again higher than 83.5% comparatively. Vitamin A supplementation in the last six months reached 78.1%, slightly above the comparative 76.6%. Most vaccinations occurred in public health facilities (93.2%), with a smaller proportion taking place in private facilities (6.8%). Overall, these figures reflect robust immunization efforts and effective public health delivery systems.

The treatment data for childhood diseases among children under five shows a low prevalence of common illnesses. Only 1.4% of children experienced diarrhoea, significantly lower than the comparative 4%. Similarly, symptoms of acute respiratory infection (ARI) were reported in 1.4% of children, closely aligned with the comparative 1.6%. Among children with fever or ARI symptoms, a high percentage 95.5% were taken to a health facility or provider, slightly better than the comparative 92.8%. Although specific data on the use of oral rehydration salts (ORS) and zinc for diarrhoea treatment

is unavailable, the overall figures indicate effective care-seeking behaviour and low incidence of these common childhood illnesses.

The data on child feeding practices and nutritional status reveal mixed outcomes. About 60% of children under age 3 were breastfed within one hour of birth. Nutritional status shows that 31.3% of children under five are stunted, higher than the comparative 27.7%, while wasting affects 16.1%, which is lower than the comparative 23.9%. Severe wasting stands at 5.3%, less than half the comparative rate of 10.7%. Underweight children constitute 22.5%, somewhat better than the comparative 27.2%. Interestingly, overweight prevalence is higher at 6.5%, compared to 1.6% in the comparative group, signalling emerging concerns around overnutrition. Overall, while acute malnutrition indicators show improvement.

The nutritional status of women aged 15-49 years shows that 14% have a body mass index (BMI) below the normal range (<18.5 kg/m^2), which is slightly higher than the comparative figure of 12.2%, indicating some prevalence of under nutrition. On the other hand, 26.7% of women are overweight or obese (BMI ≥25.0 kg/m^2), marginally exceeding the comparative rate of 24.4%, reflecting rising concerns about overweight and obesity. Additionally, a high-risk waist-to-hip ratio (≥0.85), which is linked to increased risk of metabolic diseases, affects a significant 73.9% of women, highlighting a potential public health concern related to central obesity. Overall, these figures suggest a dual burden of malnutrition among women, with notable levels of both under nutrition and overweight/obesity.

The data on anaemia among children and women indicate a relatively lower prevalence compared to the comparative figures. Among children aged 6-59 months, 39.4% are anaemic, which is notably less than the comparative rate of 45.6%. Non-pregnant women aged 15-49 years show 27% anaemia prevalence, again lower than the comparative 32.9%. Overall, 26.9% of all women aged 15-49 are anaemic, compared to 32.3% in the comparative group. Anaemia among adolescent girls (age 15-19) stands at 27.7%, significantly lower than the comparative 36%. These figures suggest progress in reducing anaemia.

The data on blood sugar levels among adults aged 15 years and above reveals a notable prevalence of elevated blood glucose. Among women, 7.5% have high blood sugar levels

(141-160 mg/dl), and 8.4% have very high levels (>160 mg/dl), with a combined 18.3% either having high or very high blood sugar or taking medication to control it. Similarly, among men, 8.2% have high blood sugar, 7.9% have very high levels, and 17.9% fall into the category of high or very high blood sugar or are on treatment. These figures indicate a significant burden of hyperglycaemia among both men and women, highlighting the need for continued screening, prevention, and management efforts for diabetes and related conditions.

The data on hypertension among adults aged 15 years and above shows prevalence of elevated blood pressure in both women and men. Among women, 15.1% have mildly elevated blood pressure (systolic 140-159 mm Hg and/or diastolic 90-99 mm Hg), and 7.2% have moderately or severely elevated levels (systolic ≥160 mm Hg and/or diastolic ≥100 mm Hg). Overall, 28.8% of women either have elevated blood pressure or are taking medication to control it. Similarly, among men, 17.7% have mildly elevated blood pressure, 7.4% have moderately or severely elevated levels, and 28.3% have elevated blood pressure or are on treatment. These figures indicate a substantial burden of hypertension in the adult population.

Only 1.5% of women have ever undergone a screening test for cervical cancer, 1.2% had a breast examination for breast cancer, and a mere 0.2% have received an oral cavity examination for oral cancer. Cancer screening among women aged 30-49 years indicates low levels of preventive health checks, which need awareness.

The data on tobacco use and alcohol consumption among adults aged 15 years and above reveals significant gender differences. Tobacco use is reported by 10.6% of women, while a much higher 26% of men use some form of tobacco. Alcohol consumption is relatively low among women, with only 1.2% reporting use, compared to 23.2% of men. These figures highlight the higher prevalence of both tobacco and alcohol use among men, underscoring the need for targeted public health interventions to address substance use, particularly among men.

CHAPTER 8

DISTRICT MENTAL HEALTH PROGRAMME

8.1 District Mental Health Programme

The District Mental Health Programme (DMHP) Wayanad started in 2007 with the support of NIMHANS. In April 2017, this programme was undertaken by DHS. It aims at integrating mental health components at different levels of health program delivery and providing comprehensive care and support to patients with mental health issues and their relatives. Training, mental health care, IEC and Rehabilitation are the major components of DMHP.

Table 8.1.1 HR position DMHP

DMHP	
Nodal Officer	1
Psychiatrist(Working Arrangement)	1
Medical Officer	1
Clinical Psychologist	0
Psychiatric Social Worker	1
NMHP Counsellors	2
Staff Nurse	1
Clerk cum DEO	1
Attender	1
CMHP	
SMHP Project Officer	1
Project Officer	1
Staff Nurse	1

Source: district data

Table 8.1.2 DMHP Clinics (year 2024-2025)

MONTH	NO.OF CLINICS	TOTAL	NO.OF NEW CASES	FOLLOW UP	Counseling Given	Psycho Education given	CASES REFFERED
APRIL	21	1424	41	1383	345	153	8
MAY	21	1382	37	1345	86	92	2
JUNE	21	1380	40	1340	148	129	4
JULY	21	1359	33	1326	132	71	0
AUGUST	21	1337	49	1288	29	13	0
SEPTEMBER	21	1370	52	1318	185	0	3
OCTOBER	21	1376	41	1335	137	26	1
NOVEMBER	21	1401	59	1342	132	62	1
DECEMBER	21	1363	52	1311	117	102	0
JANUARY	21	1346	50	1295	75	91	0
FEBRUARY	21	1381	58	1323	52	67	0
MARCH	21	1360	52	1308	76	12	0
TOTAL	252	16479	564	15914	1514	818	19

**Source: district data*

8.2 Post-Flood Activities & Training Programs

Post-flood activities and training programs were done to provide support to the individuals and families affected by flood-related issues. Through 32 training sessions, 1183 health workers/volunteers were trained to provide supportive services. They visited 17,397 houses. Also, Psychosocial interventions were provided to 7562 individuals.

8.3 Landslide activities

The District Mental Health Programme team visited the first relief camp at Meppadi GHSS on the day the landslide occurred. A psychosocial support task force was created, including psychiatrists and qualified counsellors from the district Mental Health Programme and National Health Mission, ICDS, later counsellors from the Police department, Kudumbashree, Social Justice department and volunteers from Wayanad and other districts of Kerala were integrated into the task force. These team members, after being given training for psychosocial interventions for disaster management, were posted to all the relief camps. The main purpose was to provide reassurance and support to all the inhabitants of the camp and to identify people in distress.

The counsellors were present round the clock in all the camps, and if any person needed higher-level intervention specialist services were made available. A twenty-four hour

mobile psychiatry unit was started to ensure speciality services in the camps and also to provide house visits if needed. Tele consultation facilities using two toll-free numbers and Telemanas toll-free number provided twenty-four hour on-call psychiatric counselling services.

High-risk populations, including children less than 18 years, elderly people more than 60 years, pregnant and lactating women, people with a history of mental illness, people with psychoactive substance use, and migrant workers, were identified, and special attention was given to them. Follow-up screening and support were ensured by making the same set of counsellors available to interact with the same people, which helped in establishing a good rapport and observing day-to-day changes.

Daily data reporting was done to the concerned higher authorities, which helped in the proper evaluation and monitoring of the progress of the ground-level activities. IEC/ training has been given to ASHAs of the Vythiri block for screening all the residents. Field monitoring of the people impacted by the landslide started from the very next day after the relief camps closed.

Based on the data from the district administration and the camps, 2706 people were seen in the field. Following this, a list was prepared for weekly, by weekly, monthly follow-up visits by counsellors and psychiatrists, which is being followed meticulously. The mobile psychiatry unit is active in the field and Teleconsultation facilities are still live.

A separate follow-up team is also there for the second round follow-up visits of all the affected people

8.3.1 Current Activities related to Landslide

The total number of people who were affected by the landslide was calculated based on the data given by the administration and data from the relief camps. Based on the assessments done, people who require repeated follow-ups were identified. Out of the total number of people, 682 people were found to require repeated follow-ups.

Currently, two sets of Counsellors are in the field doing house visits. One set of counsellors reviews the people who require repeated follow-ups, and the other set of counsellors sees the rest of the people. For the people who require repeated follow-ups, each counsellor is assigned around 60 people so that the same counsellor is available for

counselling all the time. The mobile psychiatry unit is still active, with a psychiatrist consultation as and when needed at their doorstep.

8.4 DMHP Targeted Interventions

DMHP contains Nodal Officer, Medical Officer, Psychiatrist, Clinical Psychologist, Psychiatric Social Worker, Staff Nurse, Clerk cum DEO and attender. SMA(Sampoorna Manasika Arogyam), Amma Manass, ASWASAM(Depression Clinic), SMHP(School Mental Health Programme), CMHP(Community Mental Health Programme, Day Care Centre, Thariyode) are the projects that are functioning under DMHP. Special programs undertaken by the District Mental Health Authority (DMHA) are the following.

Sampoorna Manasika Aarogyam (SMA)

SMA was implemented in 2018 to ensure the psychiatry service at the primary level. Major activities conducted as part of the program are

(1) developing a panel of resource persons to give awareness classes to health professionals including ASHA workers

(2) Conducting training at FHC level and

(3) Conducting camps identifying patients by DMHP for care.

Table 8.4.1 Beneficiaries of SMA

MONTH	NO.OF CLINICS	TOTAL	NO.OF NEW CASES	FOLLOW UP	Counseling Given	Psycho Education given	CASES REFFERED
APRIL	21	1424	41	1383	345	153	8
MAY	21	1382	37	1345	86	92	2
JUNE	21	1380	40	1340	148	129	4
JULY	21	1359	33	1326	132	71	0
AUGUST	21	1337	49	1288	29	13	0
SEPTEMBER	21	1370	52	1318	185	0	3
OCTOBER	21	1376	41	1335	137	26	1
NOVEMBER	21	1401	59	1342	132	62	1
DECEMBER	21	1363	52	1311	117	102	0
JANUARY	21	1346	50	1295	75	91	0
FEBRUARY	21	1381	58	1323	52	67	0
MARCH	21	1360	52	1308	76	12	0
TOTAL	252	16479	564	15914	1514	818	19

**Source: district data*

AmmaManas

Amma Manass was focussed on pre- and postnatal mental health to include maternal mental health at the primary level. Block-wise Trainings were conducted for ASHA workers and health workers.

Table 8.4.2 Beneficiaries of AMMA MANAS (2024-2025)

MONTH	NO.OF CLINICS	TOTAL	NO.OF NEW CASES	FOLLOW UP	Counseling Given	Psycho Education given	CASES REFFERED
APRIL	21	1424	41	1383	345	153	8
MAY	21	1382	37	1345	86	92	2
JUNE	21	1380	40	1340	148	129	4
JULY	21	1359	33	1326	132	71	0
AUGUST	21	1337	49	1288	29	13	0
SEPTEMBER	21	1370	52	1318	185	0	3
OCTOBER	21	1376	41	1335	137	26	1
NOVEMBER	21	1401	59	1342	132	62	1
DECEMBER	21	1363	52	1311	117	102	0
JANUARY	21	1346	50	1295	75	91	0
FEBRUARY	21	1381	58	1323	52	67	0
MARCH	21	1360	52	1308	76	12	0
TOTAL	252	16479	564	15914	1514	818	19

**Source: district data*

Aswasam Clinic

Aswasam clinic is a project run in Family Health Centres under the supervision of DMHP, which is for patients with mood disorders, mainly Depression. Trained staff (doctor and a staff nurse) from FHC used to conduct the clinic every month and to send the report to DMHP.

Table 8.4.3 Beneficiaries of ASWASAM CLINIC (2024-2025)

MONTH	FHCs conducting Clinics	Total no.of clinics	Cases screened	Screened positives	Cases started on pharmacotherapy	Cases started on psycho social intervention	Cases referred to DMHP
APRIL	24	96	2281	57	19	51	31
MAY	24	102	2577	57	32	55	36
JUNE	24	96	2576	49	29	37	25
JULY	24	96	2435	24	22	22	12
AUGUST	24	100	2803	40	30	43	36
SEPTEMBER	24	96	2946	31	31	48	13
OCTOBER	24	99	3242	45	29	42	31
NOVEMBER	24	97	2993	199	24	49	37
DECEMBER	24	96	2831	46	25	31	22
JANUARY	24	90	3302	41	30	41	17
FEBRUARY	24	96	2881	43	16	40	18
MARCH	24	96	3083	28	20	26	22
TOTAL	288	1160	33950	660	307	485	300

**Source: district data*

SMHP (School Mental Health Programme)

SMHP is a programme under DMHP. SMHP also promotes the mental health of the entire school community including students, parents and teachers. SMHP trains health nurses, DEIC, Adolescent counsellors of NHM and school counsellors of ICDS. It acts as a link between schools and school mental health teams. SMHP is run by a Project Officer.

CMHP (Community Mental Health Programme, Pakalveedu, Thariyod)

Pakalveedu was started on 04/11/2014 under NHM. Presently, it's working under DMHP Wayanad. Strength of this institution is 16. Staff pattern of this institution is 3(1 Project Officer, 1 Staff Nurse and 1 cleaning staff). Pakalveedu initiates different rehabilitation programs, such as vegetable farming, gardening, paper pen making, soap making, hand wash making and umbrella making.

Table 8.4.4 Beneficiaries of Pakal veedu (2024-2025)

MONTH	NUMBER OF INMATES(Monthly)
APRIL	307
MAY	343

JUNE	308
JULY	297
AUGUST	301
SEPTEMBER	268
OCTOBER	312
NOVEMBER	291
DECEMBER	298
JANUARY	325
FEBRUARY	280
MARCH	314
TOTAL	**3644**

**Source: district data*

Awareness Programmes and other Activities

DMHP conducts awareness programmes for police, health workers, Teachers, Students, Psychiatric patients and their family members. Every year on October 10 we celebrate World Mental Health Day. DMHP published patients & manuscripts to encourage their creativity. Conducted different competitions for school children and the public to know the importance of mental health.

Covid-19 Activities

DMHP started Covid 19 related activities from February 2020 under the guidance of Dr Hareesh Krishnan, Nodal Officer, DMHP. The SMHP Project Officer is the Co-ordinator and reporting officer of the District Rapid Response Team (Wayanad).

Rapid response team includes the whole DMHP Staff, AH Counsellors (under NHM), DEIC Psychologist, ICDS counsellors and NHM Counsellors. 65 counsellors from various

departments co-ordinately works under DMHP, providing psychosocial support to Covid patients and quarantine.

81503 Reassurance calls were given to quarantine. 9115 Reassurance calls were given to Covid positive patients. During the initial phase of Covid, psychosocial support and medicines were given for additional cases. Psychosocial support was provided for aged, Health workers and also for differently abled children during COVID-19.

CHAPTER 9

TRIBAL HEALTH PROGRAMME

9.1 Tribal Health Program

The tribal population, which constitutes 18 percent (1,72,000) of Wayanad's population, is scattered across different parts of the district. 36 percent of tribal groups in the state are in Wayanad district. There are 3,313 colonies in the district. The Health Department provides various services to the tribal community.

9.1.1 Nalloornad Cancer Care Centre

This government hospital is pioneering a major change in cancer treatment. The Nalloornad Tribal Specialty Hospital was handed over to the Health Department by the Scheduled Tribes Development Department in 2007. The only cancer care centre in the district was started at the tribal hospital in 2013 under the National Cancer Control Programme.

In the first phase, there was a general OP facility. The Digital X-ray system is working here with NHM funds. It now has facilities for chemotherapy and radiotherapy for cancer patients. Previously, patients requiring radiation treatment had to go to Kozhikode Medical College and Thalassery Malabar Cancer Centre. With the introduction of a radiation system in Nalloornad hospital, the travel difficulties of patients have been largely resolved.

A radiation machine has been installed in the cancer care unit by spending Rs.2.99/- crore included in backward region grant fund. In 2018, former health minister KK Shailaja inaugurated the telecobalt machine for radiotherapy. At present, along with the Govt. Tribal Hospital, the District Cancer Centre is fully functioning here. General OP, Dental Unit, Dialysis Centre (with 6 units), Secondary Palliative Care including home visits, Physiotherapy and Day Care Chemotherapy Unit with 12 beds are also operational. Radiotherapy is also provided.

A mammogram facility is available in the institution, and a cancer patient rehabilitation unit is functioning. The total OP in 2024 was 44,164 of which cancer OP was 13,911 and total chemo drugs were 8,305 and total radiation was 1,980. A new building is currently

under construction to enhance the infrastructure, funded by the 5-crore prize money received from NITI Aayog.

Many patients from other districts and from the states of Karnataka and Tamil Nadu seek treatment here.

9.1.2 OORUM UYIRUM Project

'Oorum Uyirum' project, aimed at promoting holistic health among the tribal communities of Wayanad, was launched at Ponkuzhi Paniya Colony in Noolpuzha Panchayat. This initiative is jointly implemented by the District Administration, Scheduled Tribe Development Department, National Health Mission, Health Department, Women and Child Development Department and UNICEF. The project includes health screening and distribution of medicines to address issues such as for problems like anemia, stunting, underweight, and infant mortality.

In the first phase, activities are being carried out in eight colonies in Wayanad. In the second phase, the scheme will be expanded to 100 backward colonies.

PUKA ILLA' Campaign

'PUKA ILLA' campaign is being implemented to make Wayanad tobacco-free with special emphasis on tribal areas. In the first phase, Kappikkunnu Colony in Meenangadi Grama Panchayat was declared smoke-free.

In the second phase, Manalvayal Colony in Edavaka Panchayat was declared a smoke free colony by District Collector Dr. Renu Raj IAS. As part of the campaign, various awareness activities including workshops are being conducted.

CHAPTER 10

FINANCIAL ALLOCATION AND UTILIZATION

10.1 Financial allocation and utilization for the last four years (Rs)

For 2025–26 (up to September), utilization is 50.6%, which is reasonable for a half-year period, suggesting spending is on track, provided the current pace continues.

Table 10.1.1 financial allocation and utilization for the last four years (Rs)

YEAR	Budget allowed (in Lakhs)	Expense (in Lakhs)
2021-2022	3164.65	2779.82
2022-2023	3768.28	3073.21
2023-2024	3359.83	2546.21
2024-2025	4465.9	3408.62
2025- 2026(upto September)	4753.03	2404.91

Source: district data

In Wayanad district nearly 99.9% of funds have been utilized under various heads including RCH, NDCP, NCD, HSS (Health System Strengthening) (NUHM). The NHM programme in Wayanad for 2024–25 shows strong financial performance, with almost full budget utilization when committed expenses are considered. The major spending driver was the Health System Strengthening (HSS) component.

The total NHM budget for 2024–25 was Rs.4465.9/- lakhs, of which Rs.3351.11/- lakhs (75%) has been spent. When committed expenditure is included, the utilization rises to 99.91%, indicating near-complete financial commitment. The HSS component accounted for the largest share of the budget (₹3274.6 lakhs) and achieved over 112% utilization including commitments. RCH and NCD demonstrated moderate utilization (83% and 77% respectively when commitments included).

Table 10.1.2 Expenditure of funds under various programmes

TOTAL BUDGET OF NHM (Rs. IN LAKH) 2024-25				Actual+Committed Expenditure	
Activity Head	**Budget Allotted (Amount in lakhs)**	**Expenditure (Amount in lakhs)**	**Expenditure Percentage up to March (%)**	**Committed expenditure**	**Percentage if add Committed expenditure**
RCH	514.83	319.64	62.09	107.56	82.98
NDCP	178.51	78.02	43.71	0.82	44.17
NCD	152.68	78.71	51.55	38.28	76.62
HSS(NUHM)	345.28	142.04	41.14	17.22	46.13
HSS	3274.6	2732.70	83.45	946.7	112.36
TOTAL	4465.9	3351.11	75.04	1110.59	99.91

Source: district data

10.2 Financial Allocation - DMO

The District Medical Office, Wayanad, demonstrates efficient fund utilization across major health programmes. Priority areas such as mental health, palliative care, communicable disease control, and nursing service strengthening received substantial attention. Overall, the financial performance reflects strong budget management and program implementation capacity.

Table 10.2.1 Details of fund expenditure

Total Number of Schemes	17
Total Allocated Amount	125.39 Lakhs (approximately)
Total Released Amount	125.39 lakhs (full allocation released)
Total Expenditure	121.56 lakhs (approx.)
Overall Utilization Rate	97%

Source: District Data

Most schemes show near 100% fund utilization, reflecting effective financial management.

Highest allocations were under:

- District Mental Health Programme (₹25.89 lakhs)
- Control of Communicable Diseases (₹24.59 lakhs)
- Pain, Palliative and Elderly Health Care Centres (₹19.58 lakhs)
- Comprehensive Mental Health Programme (₹17.08 lakhs)

Table 10.2.2 financial allocation under various scheme by DMOH

Si:No	Officer Name	Scheme Code	Scheme Name	Head Of Account	Total Amount allocated (in Lakhs)	Released Amount (in Lakhs)	Financial Expenditure(in Lakhs)
1	District Medical Officer,Health,Wayanad	MPS 019	Health Transport	XVIII-2210-01-200-91	5.29000	5.29000	5.28119
2	District Medical Officer,Health,Wayanad	MPS 028	Pain, Palliative and Elderly Health Care Centers	XVIII-2210-01-110-52	19.57500	19.57500	19.56252
3	District Medical Officer,Health,Wayanad	MPS 048	Control of Communicable diseases	XVIII-2210-06-101-49	24.59518	24.59518	23.48779
4	District Medical Officer,Health,Wayanad	MPS 165	District Mental Health Programme	XVIII-2210-01-110-40	25.88570	25.88570	23.16064
5	District Medical Officer,Health,Wayanad	MPS 166	Prevention of Non Communicable Diseases	XVIII-2210-06-101-45	3.72000	3.72000	3.35270
6	District Medical Officer,Health,Wayanad	MPS 222	Cancer Care Programme	XVIII-2210-06-101-41	0.75000	0.75000	0.74999
7	District Medical Officer,Health,Wayanad	MPS 271	Strengthening of Medical Record Libraries	XVIII-2210-06-001-98	1.02400	1.02400	1.02360
8	District Medical Officer,Health,Wayanad	MPS 322	Nursing Schools	XVIII-2210-05-105-89	2.49685	2.49685	2.49670
9	District Medical Officer,Health,Wayanad	MPS 356	Strengthening of Dental units in Health services Department(Improvemnt of Dental clinics)	XVIII-2210-01-110-70	3.56000	3.56000	3.46663
10	District Medical Officer,Health,Wayanad	MPS 362	COMPREHENSIVE MENTAL HEALTH PROGRAMME	XVIII-2210-01-110-68	17.07960	17.07960	16.92814
11	District Medical Officer,Health,Wayanad	MPS 466	SETTING UP OF LABORATORIES IN PRIMARY HEALTH CENTRE	XVIII-2210-03-103-89	0.50000	0.50000	0.50000
12	District Medical Officer,Health,Wayanad	MPS 469	STRENGTHENING OF NURSING SERVICE	XVIII-2210-01-001-90	1.33450	1.33450	1.33438
13	District Medical Officer,Health,Wayanad	MPS 524	Modernization of Health Services Department	XVIII-2210-01-001-87	0.50000	0.50000	0.32123
14	District Medical Officer,Health,Wayanad	NUT 017	State Nutritional and Diet Related Intervention Programmes	XVIII-2210-06-200-97	1.66000	1.66000	1.66000
15	District Medical Officer,Health,Wayanad	MPS 542	Implementing code grey protocol in healthcare institutions under DHS	[XVIII]2210-06-003-84	3.00000	3.00000	3.00000
16	District Medical Officer,Health,Wayanad	MPS 541	Research in Health Services	[XVIII]2210-06-112-92	0.90000	0.90000	0.00000
17	District Medical Officer,Health,Wayanad	MPS 540	School Health and Wellness Programme	[XVIII]2210-06-113-94	1.50450	1.50450	1.18095

Source: District Data

CHAPTER 11

NHM ACTIVITIES IN THE DISTRICT

National Health Mission (NHM) seeks to provide equitable, affordable, and quality health care to the rural population, especially vulnerable groups. The program in Wayanad district has led to an overall transformation of a majority of institutions in terms of their structure, facility upgrades, resource availability, manpower, and decentralization of finance management.

All national programmes were implemented under the broader umbrella of NHM, with all DMO level officers being the programme officers in charge.

Empowering of existing health system, and introducing and integrating newer programs such as non-communicable disease control program, palliative care program, sickle cell disease control program and district mental health program have infused new vigour into the health services of the district and give us pride to declare them as successful, widely accepted, and fruitful health interventions carried out with ASHAs.

The National Health Mission has various components and programmes under its supervision. Each programme focuses on various aspects of public health, including mother and child health, immunization, adolescent health, infrastructure, health communication and so on. The following are the major programmes under NHM:

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

The Ministry of Health & Family Welfare, Government of India, under the National Health Mission, launched the Rashtriya Bal Swasthya Karyakram (RBSK), an innovative and ambitious initiative that envisages Child Health Screening and Early Intervention Services - a systematic approach for early identification and linkage to care, support and treatment. This programme subsumes the existing School Health Programme. Child Health Screening and Early Intervention Services primarily refer to the early detection and management of a set of 32 health conditions prevalent among children below 18 years of age.

In Wayanad 40 RBSK Nurses are posted in each CHC and FHC . The primary role is to conduct screenings for children aged 0-18 years through Anganawady, School

Immunization, Outreach RCH programmes and colony visits. There are 5 delivery points in Wayanad. Five Shalabham Nurses are allotted in each Delivery point. The primary roles of Shalabham Nurses include VBD Screening, Pulse Oximetry Screening, OAE Screening, IEM Screening, newborn sickle cell screening and IEM Screening.

Table 11.1.1 Delivery status

Year	Total no of deliveries	Total no of New-borns Screened	No of Conditions identified
2024 - 2025	3407	3437	108

Source: District Data

Table 11.1.2 Screening under RBSK

Indicators	2023-24	2024-25
0-3 years	28520	32693
3-6 years	31256	29486
6 – 18 years	106841	74163

Source: District Data

Table 11.1.3 Services offered under the program at a glance (up to March)

Department Wise Service Details								
	Medical Officer	Pediatrician	Dental Department	Speech Therapist	Physiotherapist	Psychologist	Special Educator	Optometrist
New Cases	428	292	780	760	308	461	496	140

Followup Cases	644	324	646	1100	807	614	1224	204
Followup Sessions			267	2729	1971	1051	2302	449

Source: District Data

Table 11.1.4 District Early Intervention Centre

Client Details	
New Cases	1090
Followup Cases	4706

Source: District Data

11.2 Hridyam:

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

Table 11.2.1 Hridyam programme: case registration and surgery data

Year	Total no. of cases registered	No.of cases surgery intervention done
2024-2025	261	32
2025 till March	1459	332

Source: District Data

11.3 Mobile Intervention Unit (MIU)

MIU works as an outreach facility of DEIC. This facility is helpful for patients from remote areas and Patients who have limited access to reach DEIC Wayanad. Twice a month, 13 Institutions are covered by the team for providing services.

Table 11.3.1 MIU Status

	Special Educator	Physiotherapist
New Case	196	159
Follow up Cases	1132	781
Follow up Sessions	1584	1209

Source: District Data

11.4 Mobile Health Team (MHT)

One Mobile Health Team is approved for Wayanad and is dedicated to enhance health care delivery for 0 - 18 years of age group. Mainly focussed on rural and remote areas by RBSK Nurses in each Panchayath.

MHT Activities

- Thematic Health Screening Camps: - Eye camps, dental camps, adolescent health camps, anaemia detection camps
- Tribal / Remote area screening
- Focused screening and follow-up services in remote/tribal regions
- Health education sessions for children and parents
- Screening of Out-of-School Children / Madrasas / care homes
- Special Screening during Epidemics or Public Health Emergencies

11.5 Nutrition Rehabilitation Centre to address Severe Acute Malnutrition

Nutrition Rehabilitation Centre presently functioning in Taluk Head Quarters Hospital, Sulthan Bathery, and it is a 10-bedded facility for the medical management of Severe Acute Malnutrition Children from the community of Wayanad District. Wayanad is a high prevalence tribal district, so majority of the patients come from the tribal community.

The RBSK Nurse of each health institution conducts anthropometric screening in the community for identifying SAM children. If they identify SAM children, they are referred to NRC Bathery for medical and therapeutic management. The NRC team includes a Medical Officer, Dietitian and Social Worker, conducting field work activities for identifying SAM and MAM categories and also conducting follow-ups in the field. At NRC, all medical and therapeutic management are given as per the NRC guidelines and protocols. In the financial year 2024-2025, 116 patients were admitted and managed.

Table 11.5.1 NRC Staff Details

Medical officer	1
Dietician	1
Social worker	1
Staff nurse	3
Cook/ Attender	1

Source: District Data

11.6 Rashtriya Kishore Swasthya Karyakram (RKSK)

RKSK programme has provided counselling in all five blocks within the district with yearly average of 3571 in 2024 and 3853 in 2025. The average follow-up was 1660 in 2024 and 2358 in 2025. The average total counselling sessions increased by about 7.9% from 2023–24 to 2024–25. Follow-up cases rose significantly — about 42% increase, indicating improved continuity of care and follow-up engagement.

Table 11.6.1 Cases attended by counsellors in different centres

Case Profile	Porunnannoor Block	Thariod Block	Meppadi Block	Meenangadi Block	Pulpally Block
Total Counselling 2023 – 2024	3356	4023	3567	3268	3643
Total Counselling 2024 – 2025	3900	4271	3413	3120	4561
Follow-up cases 2023 – 2024	1250	1899	1980	1950	1221
Follow-up cases 2024 – 2025	2300	2786	2100	2080	2522

Source: District Data

Types of case handled

1. Trauma & Abuse (Childhood sexual abuse Physical abuse)
2. Health-Related Issues, Sleep disorders (insomnia, nightmares, nutritional deficiencies, anaemia, and Juvenile diabetes)
3. Technology-Related Issues (Social media dependency, Exposure to inappropriate online content)
4. Motivation and Goal-Setting Issues (Lack of direction or ambition, Difficulty setting and achieving goals, Procrastination, Time management struggles)
5. School-related Issues (Poor academic performance, School refusal or truancy, Exam Test anxiety or performance anxiety, Bullying (victim or perpetrator), Learning difficulties (e.g., ADHD, dyslexia))

6. Emotional & Behavioural Issues (Depression, Anxiety disorders, Anger management, Low self-esteem or self-worth, Grief, and loss).
7. Family & Relationship Problems (Parental conflict or divorce, Sibling rivalry, Attachment issues, Communication breakdown with parents).
8. Peer & Social Issues (Peer pressure, Friendship problems, Social anxiety or isolation).
9. Risky or Harmful Behaviours (Substance use or experimentation, Self-harm (cutting, burning, etc.), Suicidal thoughts or behaviours, Porn addiction, Internet or gaming addiction)
10. Gender-Specific Challenges, Menstrual health-related anxiety or stigma (for girls), Pressure to conform to masculine/feminine norms, Male adolescent aggression or suppression of emotion.
11. Romantic Relationship Issues, Breakup distress or heartbreak.
12. Neglect of Self-Care (Poor hygiene due to neglect, Malnutrition)

11.7 Peer Educators Programme -SDC (Student Doctor Cadet)

The Major Objectives of SDC:

- Nurture the scientific understanding of health
- Increase the awareness of various health issues
- Improving the mental health of children

Table 11.7.1 SDC Status

Year	Total Peer Educators selected	Trained
2024 - 2025	600	600

Source: District Data

11.8 National Sickle Cell Anaemia Elimination Mission

Sickle cell project was initiated in the district in 2006. Initially, it covered 1.34 lakh screenings. After that, from 2023, it became a national programme, and the entire target of the state was given to Wayanad district for the year 2023-2024, which was 7,40,000.

As part of the National Sickle Cell Anaemia Elimination Mission project, sickle cell activities are going well in the district. The main objectives of this project are to detect sickle cell disease in the district, provide nutrition to the detected sickle cell patients and conduct screening of 2 lakh people. During the financial year 2023-2024, 120000 POC kits were distributed to all health facilities, and extensive testing was carried out. At present, 70000 POC kits have been received in financial Year 2024-2025, currently 47092 screenings are underway, and the remaining screenings are in progress. Mananthavady Medical College has the most modern and accurate HPLC testing facility for sickle cell diagnosis. The SS and AS samples obtained from POC testing were sent for HPLC confirmation testing.

There are 9 Electrophoresis testing centers in the district

1. MCH Mananthavadi
2. CHC Panamaram
3. FHC Noolpuzha
4. CHC Pulpalli
5. THQH Sultan Bathery
6. CHC Meenangadi
7. General Hospital Kalpetta
8. FHC Meppadi
9. THQH Vythiri

A special unit for treating sickle cell patients was inaugurated by Hon. Health Minister Smt. Veena George on 22/03/2025 at Mananthavady Medical College in the district.

Staffs in Sickle Cell Anemia unit

- Doctor
- Staff Nurse
- Physiotherapist
- Lab Technician

- Social worker
- Data entry operator

Currently, through the District Panchayat's scheme, Sickle Cell patients are provided nutritional kits every month. Along with this, hydroxyurea is also given to patients through health institutions for free.

As on 09/05/2025

Total Screening : 1, 54,751

Sickle cell disease confirmed : 1351

Sickle Cell Carriers : 4827

Sickle Cell Negative : 146501

Camps are being organised at health institutions in the district using vehicles received through CSR fund for sickle cell anaemia activities. SBI has provided a Bolero vehicle for the CSR activities.

11.9 Family Planning

Table 11.9.1 FP Status

Year	No. of Lapro Cases	No. of NSV Cases	CC	OP	IUCD
2024-25	139	13	102921	4966	1113
2023-24	171	43	92057	3968	922
2022-23	209	48	103699	4586	1405
2021-22	205	36	53523	5917	1136

Source: District Data

11.10 Biomedical Equipment Maintenance Program (BEMP)

Table 11.10.1 BEMP Status

Description	Total Call Registered	Total Call rectified	Pending calls	Percentage of rectified calls
2024-2025	2420	2383	9	98.47%

Source: District Data

Compliance to the norms of AERB for equipment under Radiology department

- Total 8 institutions registered under AERB.
- All radiology equipment have AERB approval except the X-ray at FHC Vellamunda (Centre TB Supply)

Procurement of Equipment at State level through KMSCL – NHM

Table 11.10.2 Procurement details

Year	Details	Sanctioned Amount (Rs)	Status
2024-25	Maternal Health	5152915	Not supplied
	SNCU/NBSU	223517	Not supplied
	Others	3642122	Not supplied
	BB/BS	293331	Not supplied

Source: District Data

11.11 Janani Suraksha Yojana (JSY)

It is a government sponsored scheme aimed at reducing maternal and infant mortality by promoting institutional deliveries among pregnant women. It provides financial assistance to eligible pregnant women for delivering in a government or accredited private healthcare facility.

Benefits of JSY:

1. Cash assistance
2. Reduced risk of complications
3. Improved access to care

11.12 Janani Shishu Suraksha Karyakram (JSSK)

This is another initiative implemented by the government that aims to provide free and cashless service to pregnant women and sick new-borns accessing public health institutions.

Benefits of JSSK:

1. Free and cashless delivery
2. Free drugs and consumables
3. Free diagnostics
4. Free diet during their stay in the health institution
5. Exemption from user charges
6. Free transport from home to the health institution and between facilities in case of referral.

11.13 Quality Assurance

LaQshya

LaQshya was launched with the objective of reduction in maternal and new-born mortality and morbidity due to occurrence of complications during and immediately after delivery, to improve quality of care during the delivery and immediate postpartum 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. DH Manathavady is the first institution in Wayanad to achieve LaQshya standard achieve LaQshya standard with 92% for MOT

and Labour Room. Gap Analysis and gap filling of THQH Bathery, THQH Vythiri and GH Kalpetta are in progress for achieving the LAQSHYA standards

MusQan

Quality Improvement in health care is a systematic approach that monitors, assesses, and improves the standard of quality care. MusQan is designed to ensure provision of quality child friendly services from birth to children upto 12 years of age. MusQan aims to ensure provision of quality child friendly services in public health facilities to reduce preventable newborn and child morbidity and mortality. It encompasses all the pivotal aspects of child growth and development, including the child's physical, mental, and social development. In addition, MusQan initiative intends to achieve an explicit improvement in the quality of childcare services in public facilities of India. DH Manathavady is the first institution in Wayanad and first institution in Kerala under DHS to achieve MusQan Accreditation.

Under MusQan, a multi-pronged strategy has been adopted to address the gaps in the SNCUs, NBSUs, Postnatal wards, Paediatric OPD and Nutritional Rehabilitation Centre against the quality standards traversed within the shortest possible time and visible in quality care services. DH Manathavady is the first institution in Wayanad and first institution in Kerala under DHS to achieve MusQan Accreditation. Assessment was conducted for SNCU and pediatric ward on 28th and 29th February 2024 and the institution was accredited with 95%. THQH Bathery, THQH Vythiri and GH Kalpetta are also selected for achieving MusQan Standards.

Kayakalp & Swachh Swasth Sarvatra

A clean environment improves healing and fastens recovery, besides enhancing patient's experience at health facilities. The Union Health and Family Welfare Minister Shri J P Nadda has launched 'Kayakalp Award Scheme' on May 15, 2015 as an extension of 'Swachh Bharat Mission'. The initiative which aims to improve and promote the cleanliness, hygiene, waste management and infection control practices in public health care facilities and incentivize the exemplary performing facilities. The scheme is intended to encourage and incentivize Public Health Facilities (PHFs) in the country to demonstrate their commitment for cleanliness, hygiene and infection control practices.

Initiated from District hospitals in 2015, the scheme expanded to PHC level (2016) and then covered all Urban Health Facilities by 2017.

The objectives of the award scheme are:

- To inculcate a culture of ongoing assessment and peer review of performance related to hygiene, sanitation and infection control.
- To incentivize and recognize public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness, infection control and sanitation.
- To create and share sustainable practices related to improve cleanliness in public health facilities which lead to positive health outcomes.

Every year Kayakalp internal assessment, peer assessments and state assessments are conducted in all institutions including AAM SC's. Through the Peer assessments, best 3 PHC/FHC and AAM SC with Top percentage is selected and incentivised. CHCs, THQHs, GH and DH with or more than 70% are selected for state assessments. In 2023-24, CHC Meenangady was selected for the commendation. The results of 2024-25 assessments are yet to be declared.

Patient Safety- "SaQushal"

Patient Safety is the key component of quality and an integral part of the health care systems. It means avoidance, prevention, and amelioration of adverse events and injuries arising from or during the processes of health care. In developed countries, 1 in 10 patients experiences adverse events and harm in hospitalized care settings. Available evidence reflects that 15% of hospital expenditure takes place in addressing the issue related to safety failures.

NHSRC has developed the patient safety tool SaQushal Checklist.This is a self assessment tool. The assessment tool 'SaQushal' aims to enhance the visibility and implementation of patient safety practices in health care facilities. The initiative provides a framework through which a health facility can assess its status in terms of patient safety and take action to deliver safer patient care. This checklist is run in all major institutions every year. Patient safety pledge is taken in all institutions every year during the patient safety week.

Trainings- NQAS/LaQshya/MusQan/Kayakalp

Every year district level training, institutional level training, orientation cum refresher training and workshops are conducted to make a competent team and to provide quality services to the public. District level TOTs and Aspirational Block level ToTs are formed to enhance the functionality. Rather than the physical training, online training is also ongoing.

Visit Of Quality Consultant From NHSRC

As per the information from the state Quality Division, Dr. Abhay Dahiya, Quality Consultant, Quality and Patient Safety Division, NHSRC, New Delhi visited the health institutions (CHC Panamaram, FHC Poothady, UPHC Munderi, JAK 12th Bridge) of Wayanad district on 16.11.2023. Wayanad is the only aspirational district in Kerala where all the blocks namely, Panamaram, Mananthavady , Sulthan Bathery and Kalpetta are under the aspirational block. Since the percentage of NQAS certified facilities in each block is an indicator of the aspirational district, the main agenda of the visit was to monitor the quality assurance activities in the aspirational blocks. Selection of the institutions was based on the NQAS certified facilities and institutions aspiring for NQAS.

11.14 Accredited Social Health Activist (ASHA)

1. Completed Palliative Grid Training
2. Completed FP-LMIS Training
3. ASHA workers Conducted Poshan Abhiyan training at Field Level

ASHA Training

Figure 11.14.1 ASHA training

11.15 AYUSH Integration and Training

The Department of AYUSH in Kerala (both ISM & Homeo) has upgraded their dispensaries as AYUSH Health and Wellness Centers. In Wayanad district 195 ASHA were selected and trained in the AYUSH programme and posted to the upgraded centres. The AYUSH department also gives them an incentive of Rs 1000 per month.

11.16 State Health App Initiative for Lifestyle Intervention (SHAILI)

An android-based mobile application "SHAILI" is launched by e-Health Kerala for the ASHA workers to carry out a population-based risk factor assessment for common NCDs like hypertension, diabetes, oral cancer, cervical cancer, breast cancer. It aimed at diagnosing and controlling lifestyle diseases among the people in the state of Kerala.

11.17 District ASHA Review

District ASHA review meetings are conducted in every quarter with the participation of one ASHA from each health facility.

Fig 11.17.1 ASHA reports

അവർ അജ്ഞാതരല്ല, ബന്ധുക്കളെന്ന് ഷൈജ

നൂറോളം മൃതശരീരങ്ങൾ തിരിച്ചറിഞ്ഞത് ആശാവർക്കർ

വിജിത

ഷൈജ

ചങ്ക് തകരുന്നുണ്ട്; ചെയ്തേ തീരൂ...

ASHA Shaija of Meppadi FHC received Kerala Sri Award for her impeccable service in Mundakai landslide where she was the person to identify over hundreds of bodies during Mundakai landslides.

11.18 National Programme for Palliative Care (NPPC)

Palliative care is also known as supportive care which is required in the terminal cases of Cancer, AIDS etc. and can be provided relatively simply and inexpensively. Effective palliative care requires a broad multidisciplinary approach that includes the family and

makes use of available community resources. It can be provided in tertiary care facilities, in Community Health Centers and even in patient's homes. It improves the quality of life of patients and families who face life-threatening illnesses, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement.

11.19 Karunya Arogya Suraksha Padhathi (KASP)

Ayushman Bharat PM-JAY is the largest health care scheme in the world which aims at providing a health cover of Rs. 5 lakhs per family per year. PM-JAY is fully funded by the Government and cost of implementation is shared between the Central and State Governments. State of Kerala signed an agreement with NHA on 31st October 2018 and constituted State Health Agency (SHA) for implementing the scheme in the State as Karunya Arogya Suraksha Padhathi (KASP).

Karunya Arogya Suraksha Padhathi (KASP) is the health care scheme which aims at providing a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization to over 42 Lakhs poor and vulnerable families (approximately 64 lakhs beneficiaries) that form the bottom 40% of the Kerala population. State of Kerala decided to converge all the Government sponsored health care schemes namely RSBY (Central and State Government combined scheme, where the premium is shared in the ratio 60:40), Comprehensive Health Insurance Scheme-CHIS (Kerala government fully sponsored scheme i.e. full premium paid by the State), and Karunya Benevolent Fund-KBF (Trust model implemented through lottery department) along with Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY) and formulated Karunya Arogya Suraksha Padhathi (KASP). KASP's district implementation unit, Wayanad, is functioning in the National Health Mission office (DPMSU). As part of this scheme 7 Government hospitals and 17 private hospitals have been empanelled.

Table 11.19.1 List of AB PMJAY /KASP Empanelled Hospitals

Sl No	Name Of Hospital	Type
1.	GH Kalpetta	Public Hospitals
2.	District Hospital Mananthavady	

3.	Govt. Tribal Hospital Nalloornad	
4.	THQH Vythiri	
5.	THQH S.Bathery	
6.	CHC Meenangadi	
7.	CHC Panamaram	
8.	DM WIMS	Private Hospitals
9.	Thanal Dialysis Kakkavayal	
10.	St.Martin Hospital Ambalavayal	
11.	Karuna Hospital Bathery	
12.	KMH MES Hospital Bathery	
13.	Appukkuttan Memorial Hospital	
14.	Bathery Health Care & Research Foundation	
15.	Iqraa Hospital Sulthan Bathery	
16.	Al Karama Dialysis Centre	
17.	Santhi Free Subsidised Dialysis Unit	
18.	Jyothi Thanal Dialysis Meppadi	
19.	Shri Sharada Eye & ENT Clinic	
20.	St Joseph Mission Hospital	
21.	Arogya Hospital	
22.	Ahalia Foundation Eye Hospital, Kalpetta	

23.	Stars Dialysis Unit Kalpetta	
24.	Wayanad Dialysis Center Pulpally	

Source: District Data

CHAPTER 12

NATIONAL URBAN HEALTH MISSION (NUHM)

12.1 National Urban Health Mission (NUHM)

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

Table 12.1.1 Community Process Details

Community process	Approved	In position
No. of Mahila Arogya Samithi (MAS) constituted	30	24
No. of MAS Accounts opened	24	24
No. of MAS trainings/ orientations held	nil	nil
No. of ASHAs	18	18
No. of UHNDs held in 2024-25 with frequency (Weekly, Monthly, Quarterly)	216	240
Population and households assigned per ASHA	One Ward One ASHA	One Ward One ASHA
Population and households assigned per JPHN	Total population covered = 26918. Per each JPHN around 4487 population assigned	
NGO Support in Community process, if any	SMSB (Swasth Mahila Swasth Bharath)	

Source: District Data

12.1.1 Institutional Level Activities

There are 2 UPHCS

- Average OP (Per Day): 150
- Average Lab (Per Day): 50

Table 12.1.2 Institutional Level Activities

Items	2024-25	
	UPHC Munderi	**UPHC Vengoor**
Total OP	33734	25888
Total NCD	6340	5079
Total Lab	16660	12472

Source: District Data

CHAPTER 13

NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME

13.1 National Tuberculosis Elimination Programme (NTEP)

It is no longer known as the Revised National TB Control Programme (RNTCP), and has been renamed as the National Tuberculosis Elimination Programme (NTEP). The change aligns with the larger goal of eliminating the disease by 2025, five years ahead of the Sustainable Development Goals target.

Wayanad is a rural district in Kerala, characterised by hilly terrain and dense forests and with the largest population of tribal people, who are the most vulnerable category among the social fabric. More than 50% of the TB cases are among the tribes in Wayanad who are socially weak and clinically high-risk, living in the interiors of forest and mountain ranges very difficult to reach.

The government has developed aggressive strategies to reduce TB burden in the district by 2030 in line with the Global “End TB" targets and sustainable development goals (SDG) to attain the vision of "TB free Wayanad".

13.2 Components of NTEP

The information from notification to treatment completion of TB patients shall be communicated in a timely manner to the authorities through 'Nikshay' software. The Health Worker visits the houses of the newly identified patients and makes necessary arrangements to examine those who closely interact with the patient. Then commences treatment under direct observation of the Health Worker. Measures to disburse financial assistance as per the entitlement of the patient through the bank account are also initiated.

- The patient gets cured through short–term treatment under direct observation of the Health Worker.
- As treatment commences, drugs are provided to the patient under the direct observation of the Health Worker at a location convenient to the patient.
- Treatment after examination is made available to the patient in all government hospitals and the selected private hospitals and clinics.

- NTEP activities are effectively implemented under the supervision of district health authorities.

13.3 Programme Implementation

The NTEP activities are reviewed in the district by the District Medical Officer and Programme Officers. The District TB Officer and the Medical Officer – Tuberculosis provide leadership for the activities at the district and the treatment unit levels. The Senior Treatment Supervisor, the Senior TB Lab Supervisor, DRTB Supervisor, TB Health Visitor and Treatment Organiser conduct fieldwork and tuberculosis awareness activities at the district level. Medical Officers, Health Inspectors, Junior Health Inspectors, Junior Public Health Nurses, ASHAs and other community volunteers are important links in the NTEP activities in the district. The DOTS process in the district has effectively been implemented through the 'Treatment Supporter'.

13.4 Progress in the Tuberculosis Eradication in the District

Wayanad district has recently bagged the gold medal in the Sub National Certification of the Union Ministry of Health and Family Welfare and the NTEP for achieving 68% reduction in TB cases in the district. However, 50% of the TB cases were reported among the tribal population in the district. Difficult access, poor health seeking behaviour, undernutrition, indoor air pollution, tobacco consumption and alcoholism are all contributing to the high burden of TB among the tribal population.

The district has achieved 100% notification of new TB cases this year. Employees of all private health institutions, clinics, private practitioners, and medical shops have been given special training to notify all tuberculosis patients through 'Nikshay'. All patients have been provided financial assistance through DBT (Direct Benefit Transfer) during the treatment period. For the TB patients from tribal category, nutritional kits have been provided with the support of CSR Fund. In 2023, Fujifilm and in 2024, Cochin Shipyard provided nutrition kits to all TB patients in the district. In addition to the CBNAAT testing facility, 6 TRUENAAT testing facilities were started in the district, located at DTC Mananthavady, THQH Bathery, GH Kalpetta, THQH Vythiri, CHC Panamaram, and CHC Porunnannur.

Current Status of TB in Wayanad

TB cases and deaths have been declining nationally, and are likely continuing to decrease in Wayanad through an ongoing elimination programme. Efforts are focused on patient support systems, including specific programs for vulnerable populations like the tribal communities, to address risk factors such as substance abuse. As part of the national programme, Wayanad continues to participate in TB elimination activities aimed at reducing cases and deaths.

In 2024-25, 492 cases were notified in the district. Among these, 50% belong to tribal communities. The case status for 2024–25 is given below.

Table 13.4.1 TB status in Wayanad

Particulars	Number of Cases	Remarks
Male	269	
Female	223	
Total notified cases	492	
Successfully Treated	401	
Success Rate	81.50	31 cases are continuing on treatment
Pulmonary TB Cases	341	69.31%
Extra Pulmonary cases	135	
Pediatric TB Cases	27	5.49%
HIV Co infected case	1	
TB Diabetic Co morbid patients	84	
TB Death	43	
Death Rate per total notified cases	8.74	

Source: District Data

Table 13.4.2 Annual TB notification rate

Annual TB Notification Rate					
Year	**TB Notification**			**Population**	**Annual TB Notification Rate per Lakh**
	Public sector	**Private Sector**	**Total**		
2020	392	92	484	853112	56.73
2021	396	59	455	857130	53.08
2022	462	77	539	861167	62.59
2023	445	74	519	865223	59.98
2024	387	116	503	869299	57.86
2025	280	84	364	876414	55.38

Source: district data

Table 13.4.3 TB death rate

TB Death Rate				
Year	**Total TB Notification**	**Population**	**Total Death**	**Death Rate/ Lakh**
2020	484	853112	41	4.81
2021	455	857130	49	5.72
2022	539	861167	48	5.57
2023	519	865223	55	6.36

2024	503	869299	49	5.64
2025	364	876414	28	4.26

Source: district data

13.5 Major achievements in 2024-25

13.5.1.100% upfront NAAT Test

Six NAAT sites are functioning in the district with nine NAAT machines (3 CBNAAT & 6 TRUENAAT) located at District TB Centre, Mananthavady, GH Kalpetta, THQH Bathery, THQH Vythiri, CHC Panamaram and CHC Porunnannur. These facilities significantly increase early and accurate diagnosis of TB cases, leading to timely treatment and reduced transmission. It also helps to improve case detection, reducing diagnostic delays and enhancing treatment outcomes.

Table 13.5.1 Presumptive TB status 2024-25

PRESUMPTIVE TB TEST STATUS in 2024-25					
Basis of Diagnosis	Q12024-25	Q22024-25	Q32024-25	Q42024-25	Total
CBNAAT	893	1773	2021	2558	7245
TRUENAT	2325	2297	3736	5196	13554
Microscopy	1054	920	658	118	2750
Total	4272	4990	6415	7872	23549
Percentage of NAAT Test	75.33	81.56	89.74	98.50	88.32

Source: district data

13.5.2. TB Champions/Survivors Meeting

TB champions/survivors meeting was conducted at CHC Panamaram where 40 TB Champions/Survivors participated and shared their treatment experiences. TB champions meetings are held to leverage the experiences of TB survivors in the fight against the disease. These meetings aim to empower TB survivors, providing them with

training and a platform to advocate for TB elimination, reduce stigma, and improve community engagement with the NTEP programme. The primary objectives of TB Champions meetings are to equip individuals affected by TB to actively participate in TB prevention and control efforts, ultimately contributing to TB elimination. These meetings focus on capacity building, advocacy, and community engagement, fostering a network of informed and motivated TB Champions.

13.5.3. Sputum Transportation Mechanism

A well-coordinated sputum transportation streamlines the diagnostic process, ensuring that samples are handled efficiently from collection to testing. ASHAs and Tribal promoters collected the samples from the field level and transported them to the nearest NAAT site. Training was provided to all ASHA workers and Tribal promoters. Timely and safe transportation ensures that sputum samples reach diagnostic laboratories quickly and in optimal condition, enabling accurate testing and prompt initiation of appropriate treatment. Accurate diagnosis through timely testing allows for the rapid initiation of appropriate anti-TB treatment, reducing the duration of illness and preventing further transmission.

13.5.4. Nutrition Support to the TB Patients

Nutritional support is crucial for tuberculosis (TB) patients as it significantly impacts treatment outcomes, recovery, and overall health. Adequate nutrition helps strengthen the immune system, improves treatment adherence, reduces the risk of relapse and ultimately decreases mortality rates. Cochin Shipyard Ltd. Supported 280 patients per month for five months. In addition to the support provided by Cochin Shipyard Ltd., the Pradhan Mantri TB Mukt Bharat Abhiyaan enables individuals and organizations to register online to adopt TB patients and provide them with nutritional, diagnostic, or vocational support. This initiative aims to increase community engagement in ending TB. 24 new Nikshay Mitras (Individuals & NGOs) registered in the district and they provided nutrition support to 75 patients for 6 months.

13.5.5. TB Mukt Panchayath

The TB Mukt Panchayath initiative was launched by the Hon'ble Prime Minister on 24th March 2023. This initiative is in collaboration with the Ministry of Panchayati Raj. The objective of “TB Mukt Panchayats” is to empower the Panchayati Raj Institutions to

realize the extent and magnitude of the problems associated with Tuberculosis, take necessary actions towards solving them and create healthy competition amongst panchayats and to appreciate their contribution. There are 6 indicators for submission of claims and the same indicators will be verified by the District Verification Team for TB Mukt Panchayat. In 2023, 23% of LSGDs were declared as TB-free Panchayats. By providing training to all LSGD members and health staff in the district 62% LSGDs declared as TB free in 2024. 4 LSGDs won Silver medal and 12 won Bronze.

13.5.6 Best Performing District in 100 Day Campaign

On December 7, 2024, India will take a bold step towards eliminating tuberculosis (TB), a disease that continues to affect millions across the nation. This campaign aims to accelerate the fight against TB by improving case detection, reducing diagnostic delays, and enhancing treatment outcomes, particularly for vulnerable populations. Spanning 347 districts across 33 states and union territories, the campaign represents a critical component of India's strategy to eliminate TB and build a TB-free nation. Wayanad district was selected as the best performing district in the state in the 100 Day Campaign activities held from 7th December 2024 to 24th March 2025. Vulnerability based active surveillance was completed in the district during the campaign period. 238835 individuals were screened during the campaign period.

The NTEP is actively implemented in Wayanad district, resulting in significant progress in reducing TB cases. The NTEP in Wayanad is overseen by the District TB Centre, which coordinates all TB elimination activities across the district. A significant focus in Wayanad is on screening high risk groups, particularly its tribal communities. Tribal populations are often socio economically disadvantaged and have specific challenges in accessing health care. Tuberculosis (TB) elimination in Wayanad is challenging due to the district's high concentration of marginalized tribal communities, who face geographical, socioeconomic and cultural barriers.

CHAPTER 14

NATIONAL AIDS CONTROL PROGRAM

14.1 National AIDS Control Program (NACP) implementation in Wayanad

The National AIDS Control Organization (NACO) works towards its vision of 'Paving the way for an AIDS free India' through 'attaining universal coverage of HIV prevention, treatment to care continuum of services that are effective, inclusive, equitable and adapted to needs'. The goal of the program is to achieve zero new infections, zero AIDS-related deaths and zero discrimination.

Under the National AIDS Control Programme (NACP), the following service facilities are operational in Wayanad district (Table 14.1.1).

Table 14.1.1 HIV services

Name of HIV service centres	No. of HIV Service centres
Targeted interventions	2 [Female sex workers 1, Migrant 1]
Integrated counselling and testing centres	3
Designated STI & RTI clinic	1
ART Centre	0
Link ART	1
Blood Banks (Government)	2 [Mananthavady, Bathery]
Blood Banks (Private)	2 [Kalpetta, Meppady]

Source: District Data

14.2 Targeted Interventions

Table 14.2.1 Targeted Intervention Projects by High-Risk Group (FSW & Migrants)

Indicator	FSW	Migrant
Total No. of TI Projects	1	1

CHAPTER 15

OTHER INTERVENTIONS

15.1 Aspirational Programmes Driving Change

The Government of India launched the Aspirational Districts Programme in 2018, identifying 112 districts across the country that required targeted development interventions. Wayanad emerged as the only district from Kerala to be included in this list. Building on this initiative, in 2023, the Aspirational Block Programme was introduced, under which all four development blocks of the district-Kalpetta, Sultan Bathery, Panamaram, and Mananthavady-, were selected. This recognition has brought renewed hope for Wayanad's comprehensive and sustainable development.

The programme primarily focuses on enhancing the quality of life in underdeveloped regions by implementing people-centric projects and aligning them with Sustainable Development Goals. Among its priority areas, healthcare has been given special emphasis.

Health Priorities

Key health objectives include:

- Ensuring timely antenatal care for all pregnant women
- Achieving 100% institutional deliveries
- Securing appropriate birth weight for newborns
- Universal immunization coverage for children
- Providing complete treatment for all tuberculosis patients
- Upgrading public health centres to National Quality Assurance Standards (NQAS)
- Preventing and controlling lifestyle diseases such as hypertension and diabetes

These goals are being pursued through clearly defined action plans, and the district's performance shows that most targets are within reach. At the same time, the rising incidence of lifestyle diseases, mirroring the state-wide trend, calls for community ownership and behavioural change to achieve long-term impact.

Reaching the Unreached: Hamlet ASHA

The Hamlet ASHA initiative was introduced in Wayanad by the State Health Mission with support from the Tribal Department, LSGD, ICDS, and the Excise Department. Tribal women, chosen from their own hamlets, are trained to provide primary health services and emergency support in their settlements, ensuring culturally sensitive communication and immediate response.

Currently, 229 Hamlet ASHAs serve 241 remote tribal hamlets. Their contributions have been transformative:

- Home deliveries reduced from 132 in 2018 to 33 in 2022, all attended by trained ASHAs
- Childhood immunization coverage improved from 79% in the base year to 100% in 2022
- Regular intake of supplementary nutrition and IFA among pregnant women increased from 86% (2018) to 99% (2020–2022)
- Nearly 100% institutional delivery was achieved between 2020 and 2022

Community Convergence: Oorum Uyirum

"Oorum Uyirum" is a flagship convergence initiative of the district administration with the support of the Health Department, Tribal Department, Women & Child Department, LSGD, and UNICEF. It seeks to provide comprehensive healthcare to 1.8 lakh tribal people, with special emphasis on nutrition.

Transformation of PHCs

Recognising that Primary Health Centres are the backbone of rural healthcare, Wayanad initiated a convergence model to upgrade them into integrated Health and Wellness Centres. The pilot at Noolpuzha, a panchayat with the second largest tribal population and a strategic location at the Karnataka–Tamil Nadu border, has become a model for comprehensive services at the village level. Following its success, five more panchayats have begun transforming their PHCs, and the district aims to scale up across all 23 Family Health Centres. The initiative is supported through MPLADS, LSGD funds, CFC grants, CSR contributions, and central and state schemes, embodying the motto: "Where there is a will, there is well-being."

TB Elimination Interventions

Wayanad is a high-burden district for tuberculosis, with 0.6 – 0.8% cases notified annually. Under the National TB Elimination Programme (NTEP), the district partnered with Fujifilm's 'Never Stop Screening' campaign, deploying a mobile van with handheld X-ray units and AI-driven instant interpretation for early detection. The district now maintains a 90% treatment success rate, though co-morbidities prevent achieving 100%. Notably, Wayanad was awarded a Gold Medal by the Ministry of Family Health and Women in March 2022 for achieving a 68% reduction in TB incidence. The vision is to make Wayanad TB-free by 2025.

Anemia Mukt Bharat (AMB) Implementation

Wayanad has effectively implemented the AMB programme through strong inter-departmental convergence. Using the existing network of Health Sub-Centres, Anganwadis, and schools, screenings were conducted with digital hemoglobinometers. Mobile Medical Units ensured access in remote tribal hamlets and forest interiors, while the Oorum Uyirum programme enabled screening of working men during weekends. The intervention has contributed to reducing preterm deliveries, low birth weight, and severe acute malnutrition (SAM/MAM).

Impact on Key Health Indicators

Table 15.1.1 Impact on Key Health Indicators

Indicator	2023-24	2024-25
Maternal Mortality Rate (per 1 lakh live births)	46.9	10.02
Infant Mortality Rate (per 1000 live births)	6.67 (71/10645)	7.4 (74/9980)
Early Antenatal Registration (%)	93.75 (9170/9815)	93.43 (9860/10517)
Institutional Deliveries (%)	99.60	99.75
Immunization Coverage (%)	96.61	*

Source: District Data

Delta Rankings and Recognition

In the monthly Delta Rankings published on the Champions of Change (CoC) Dashboard. Wayanad's consistent improvement highlights its commitment to accountability and excellence.

Major Achievements in Health & Nutrition Rankings:

- Oct 2018 – Rank 12 | Feb 2019 – Rank 11
- Sep 2020 – Rank 15 | Mar 2021 – Rank 05
- Sep 2021 – Rank 02 | Oct 2021 – Rank 11
- Aug 2022 – Rank 05 | Oct 2022 – Rank 02
- Mar 2023 – Rank 07 | Mar 2024 – Rank 04
- Oct 2024 – Rank 07 | Nov 2024 – Rank 04
- Jan 2025 – Rank 02 | Mar 2025 – Rank 03

Ensuring Accountability and Progress

Progress under the Aspirational District and Block Programmes is reviewed every month under the chairpersonship of the District Collector, with continuous monitoring of strengths and gaps. This data-driven, result-oriented approach enables timely corrective measures and ensures that the health sector of Wayanad remains firmly on the path of sustainable growth. By combining focused interventions, community participation, and systematic monitoring, the Aspirational District and Block initiatives are transforming Wayanad into a model of inclusive and resilient development.

15.2 Gothra Sparsam

It is a comprehensive health care scheme for tribal communities. TB and leprosy are diagnosed and treated early. Care, nutrition, and a monthly check-up are provided to pregnant women.

15.3 Pratheeksha - Shelter for tribal pregnant women.

15.4 E-Auto for Tribal, Geriatric, and physiotherapy Patients @ Noolpuzha.

15.5 Smitham

Cervical cancer screening program in women. The target population is Women above 25 years of age, those who are found to be susceptible to the disease during screening are subjected to further treatment.

15.6 Ammayude Taarat

A scheme designed to prevent anemia in tribal communities.

TAARAT – Tribal Anemia Assessment And Treatment.

Target population – 15 to 45-year-old women from tribal communities.

Ammayude Taarat - Activities

- Iron Sucrose Infusion
- Those diagnosed with anemia are taken to the hospital in vehicles
- They are given a welcome drink and fruits
- Then they are examined by a doctor
- Iron sucrose infusion is given
- They are brought back to the colonies with lunch and medicines.

Follow-up

- Those who have been treated and cured of anemia are followed up at regular intervals.
- This ensures that they are completely free from anemia.

15.7 DIPAM Disability In Paediatric Adult Management

It is a complete disability rehabilitation program for children and adults. Services provided as part of the 'DIPAM' scheme are Physiotherapy, Speech therapy, and Counselling.

15.8 Radio Mattoli

The 'E-Talks' programme started by the National Health Mission on Radio Mattoli in the era of Covid continues till today for awareness work in tribal areas. Awareness messages are broadcast in tribal language and Malayalam.

CHAPTER 16

MUNDAKAI LANDSLIDE

16.1 Rapid response to landslide crisis: Decisive action by District Medical Office(H) and National Health Mission, under the supervision of Health Department, Government of Kerala.

In response to the devastating landslide that struck the Mundakkai village of Wayanad district on the early morning of 30th July 2024, the District Medical Office(H), in collaboration with the Health and Family Welfare Department (H&FWD) and the National Health Mission (NHM), swiftly implemented a series of critical initiatives to address the emergency. First call activity was initiated by NHM and even the rescue operations were initiated through the health department. Recognizing the urgency of the situation, district-level call centres were promptly established, with additional support from a state-level call centre at the Directorate of Health Services in Thiruvananthapuram. The health minister has camped in the district for four days and was directly involved in coordinating the activities. Principal Secretary of health and Child health secretary was present at the site. ACS conducted daily review meetings to coordinate as well as assess the activities at Mundakai Land Slides.

Given the anticipated high number of casualties, the Family Health Centre Meppady was designated as the primary facility for conducting post-mortem examinations. Initially, these examinations were performed by the available Forensic Surgeon in Wayanad, with additional personnel later provided by the Medical College Hospital Kozhikode. The post-mortem operations extended late into the night, continuing until 4:00 am. on the first day, demonstrating the unwavering commitment of the medical teams involved.

The critical care of the injured survivors was adeptly managed at DM Wayanad Institute of Medical Sciences (WIMS), Meppady. The hospital management promptly arranged all necessary facilities during the initial hours after the landslide at Mundakkai, ensuring thorough engagement in the critical care process. A dedicated team was allocated by the management to handle the emergency, which contributed to effectively managing the situation and guaranteeing proper treatment.

This report outlines the comprehensive measures undertaken by the District Medical

Office(H) along with the support from the state team to manage the aftermath of the landslide, highlighting the coordinated efforts and rapid response that were crucial in mitigating the impact of this natural disaster.

16.2 Immediate Interventions-Day 1

- **Activity 1: Wake -Up Call**

  Immediately after receiving a call from the district administration regarding the landslide catastrophe, the DMO, DPM (NHM), Dy DMO (Administration), and Medical Officer (Meppady FHC) reached Meppady at 6 am. They had a quick meeting to assess the situation and discussed an emergency action plan to manage the recovered deadbodies, provide critical care to the seriously injured, arrange hospitals for critical care, and organize resource pooling and management with ambulances and other requirements.

- **Activity 2: Plan of Action**

  Given the anticipated high number of casualties, the FHC Meppady was designated as the primary facility for conducting post-mortem examinations.

- **Activity 3: Setting Up of Postmortem Centre**

  FHC Meppady was established as the procedure center for conducting postmortems on the first day.

- **Activity 4: Critical Care Management**

  DM WIMS Hospital was immediately arranged as the critical care management center for injured persons. 17 ventilators, consumables and additional resources, including staff nurses, were provided. Public relation officers from the National Health Mission were also deployed for data management and coordination.

- **Activity 5: Dead Body and Critical Care Management Plan**

  Medical camps were set up during the initial hours of the incident. Dead bodies were managed at FHC Meppady, and critically ill patients were transferred to WIMS Hospital. Less injured patients were shifted to General Hospital, Kalpetta and Taluk Hospital, Vythiri. After treatment, these patients were further shifted to relief camps.

- **Activity 6: Relief Camp Management**

  A special team, including doctors and staff nurses, was constituted to manage the relief camps. Health teams regularly visited the relief camps, conducting health check-ups for patients and vulnerable groups. They collected data on pregnant women, breastfeeding children, children who lost their parents, cancer patients, patients with hypertension, persons with disabilities, and those with cardiological issues. Based on this data, a priority list was prepared and ensured continuous medical care at each camp.

- **Activity 7: Emergency Control Room**

  An emergency control room was set up at Meppady FHC to manage operations, review status, and coordinate field-level activities.

- **Activity 8: Vehicle Management**

  An ambulance movement plan was set up to manage the required vehicles and ambulances for transporting patients and shifting deadbodies from the rescue site to FHC Meppady, WIMS hospital, GH Kalpetta and Taluk hospital Vythiri. Directions were given to the vehicle management team to manage ambulance movement according to the dead body and critical care management plan.

- **Activity 9: Logistics Management**

  A team was constituted under the supervision of the store verification officer for the immediate arrangement of necessary equipment, medicines, etc., to the critical care management hospitals, FHC Meppady, and relief camps. Donations from various sources, including medicines, equipment, PPEs, etc., were managed and distributed under the supervision of the team. The protective gear and hygiene products, graciously donated, were systematically catalogued, and transferred to the District Emergency Operation Centre (DEOC) at the Collectorate, reinforcing the comprehensive response to this catastrophic event.

- **Activity 10: Arrangements for Forensic Surgeons**

  Forensic surgeons from various medical colleges were actively involved in postmortem procedures according to the number of bodies received at Meppady FHC. The Indian Medical Association and Kerala Government Medical Officers

Association proactively supported the HR requirement of forensic surgeons as per the request of the DMO.

- **Activity 11: Data Management**

  A team was constituted for data management under the supervision of the district RCH officer. The team regularly updated field-level data on recovered dead bodies, injured patients, patients admitted to critical care management centers, patients shifted from hospitals to camps, body parts received, availability of freezers, ambulances, etc.

16.3 Intervention strategy

The team comprising Director Health Services, State Mission Director, ADHS (Public Health), DMO (H), State Program Manager (NHM), District Program Manager (NHM), and Deputy DMO (Administration), quickly formulated a comprehensive emergency response strategy. The plan prioritized immediate medical attention for the severely injured, who were expediently transported to DM WIMS Hospital in Meppady for critical care.

Foreseeing the grim reality of numerous fatalities, a meticulous action plan was enacted for postmortem proceedings and the dignified management of the deceased. FHC Meppady was designated for the initial handling of the deceased, while DM WIMS Hospital continued to provide urgent medical services.Those with less severe injuries were carefully relocated to the General Hospital in Kalpetta and the Taluk Hospital in Vythiri.

To accommodate the post mortem process, an ample supply of mobile freezers was sourced from both government and private hospitals within and beyond the district. A dedicated task force was established to ensure the seamless provision of these essential facilities, operating like a call centre to coordinate the collection of freezers from various locations across the state. These units were strategically placed in the Grama panchayat community hall, conference hall, and a private auditorium (MSauditorium), with a specialized freezer room setup at the Taluk Hospital in Vythiri for the subsequent transfer of the deceased. DNA sampling and disaster management SOP was made, and it was the first prototype for the state.

The recovery efforts along the Chaliyar River in Nilambur were managed by the District

Hospital in Nilambur. Commencing on the third day post-disaster, the remains and body parts underwent post-mortem and other necessary procedures before being transported to Wayanad. The body parts were stored in the freezers at the Taluk Hospital in Vythiri, while the deceased were moved to the MS auditorium. Upon arrival, each individual and body part was catalogued with a unique identifier. In accordance with the directives of the District Administration, the remains recognized by family members were respectfully released to them, while those unidentified were preserved in the freezers. Following the government's mandate and the district administration's guidance, any unidentified remains held in freezers beyond 72 hours were solemnly committed to community burial.

This exceptional effort by the health department underscores their unwavering commitment to providing compassionate care and upholding the dignity of all affected by this unprecedented natural calamity.

16.4 Other emergency activities initiated.

- **Immediate Postmortems**: Postmortem procedures began on the first day, with doctors from Government hospitals, Wayanad, Beach Hospital, Calicut, and Adoor Medical Colleges performing 94 postmortems in a single day in a CHC.

- **Setting up of doxy corner**: A dedicated "DoxyCorner" was set up with a special medical team near the rescue site to prevent communicable diseases, including dengue and leptospirosis. This initiative aimed to address the risk of spreading communicable diseases among the rescue team and volunteers. Doxycycline was distributed to the rescue team at the base camp and in the search areas at Choorlamala and Mundakkai.

- **Medical Support**: Doctors from 30 hospitals, including private hospitals in Wayanad, and other districts supported the Health Department in dead body management and postmortem procedures upon the District Medical Officer's request.

- **Staff Deployment**: Ministerial staff from the District Medical Office(H) and National Health Mission staff were assigned to the control room at FHC for coordination.

- **Support from other Districts**: A team of doctors from General Hospital Thalassery, Alappuzha, and Kottayam Medical Colleges provided support at Meppady FHC on a rotational basis.

- **Health Expert Teams**: A team of health experts, including super-specialists like cardiologists and nephrologists, as well as specialists in medicine, surgery, paediatrics, and staff nurses,were deployed with ambulances, emergency medicines and equipment to all relief camps.

- **Mobile Medical Unit**: A mobile medical unit sponsored by ESAF and the Rotary Club supported activities in Mundakai and Meppady FHC.

- **Health Camps**: From the second day onwards, health camps were initiated at major landslide locations, including Mundakkai and Chooralmala, under government doctors' supervision and management.

- **Student Engagement**: Students from the 61st batch of Calicut Medical College were actively involved in supporting all relief camps and the body cremation process.

- **Hospital Staff Involvement**: Doctors and nurses from following hospitals were engaged in camp visits, health camps, body cremation, and dead body management.

- **Inter departmental coordination**: TheDistrict Medical Office(H) and the National Health Mission team coordinated closely with the Police Department, Local Self Government Department, Revenue Department, Women and Child Welfare Department, Social Justice Department, and Forest Department to manage the emergency. The combined efforts ensured timely medical care, effective evacuation and rescue operations, transportation support, and the distribution of medicines and equipment. Additionally, dedicated services were provided to vulnerable groups, resulting in a comprehensive and efficient response to the crisis.

A dedicated doxy corner was set up near the rescue site to prevent communicable

diseases including Dengue fever and Leptospirosis. A specialized task force including the esteemed doctors, epidemiologist and public health experts from Medical College Manjeri has been assembled to orchestrate the prevention of the communicable diseases. These experts instantly initiated a comprehensive training programme for Health Inspectors and Junior Health Inspectors, equipping them with the necessary skills to effectively manage the disease prevention measures. This concentrated effort is pivotal in mitigating the spread of communicable disease among the landslide survivors who are at heightened risk due to their vulnerable state.

16.5 Proactive Leadership by the State Mission Director of NHM and the Director of Health Services

Upon receiving news of the calamity in the early hours of July 30, 2024, the Health and Family Welfare Department, guided by the Director, Health Services and State Mission Director (SMD), promptly convened an emergency meeting. This assembly, which was also led by the Director of Health Services (DHS), the state program manager, and other key members from the state mission, was instrumental in launching an emergency management plan. The plan's immediate execution involved a comprehensive review of the situation with the DMO, DPM, and programme officers, ensuring rapid deployment of health teams to the landslide site, relief camps and dead body management centre.

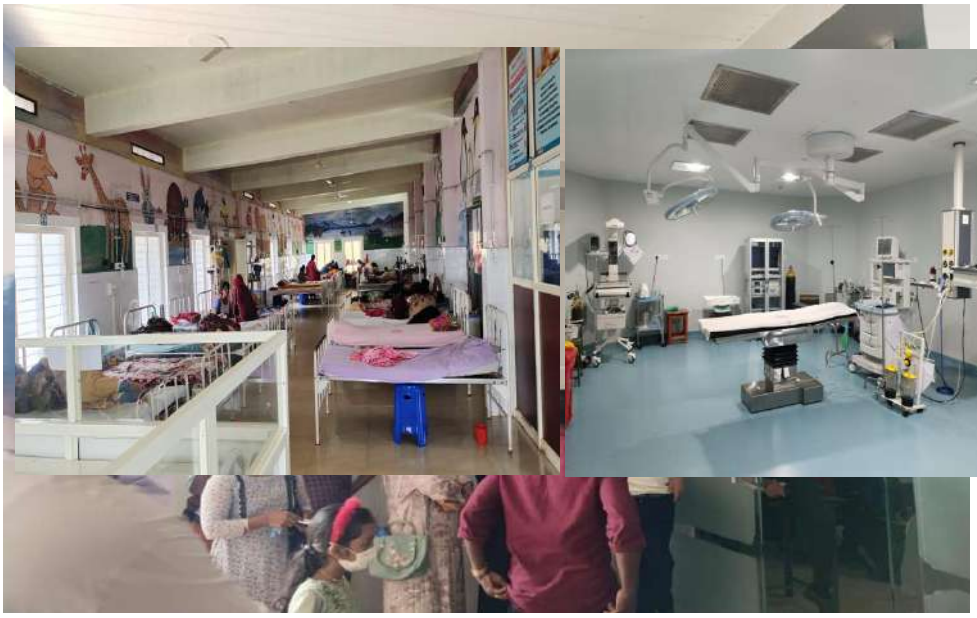
A specialized unit was rapidly formed to provide emergency medical care to the survivors and the injured. Concurrently, facilities for the respectful management of the deceased were arranged, and district-level call centres were set up to coordinate these efforts. In addition, a state-level call centre was established at the Directorate of Health Services in Thiruvananthapuram to manage the wider response. The SMD and DHS were remaining stationed at Meppady until the emergency was fully addressed.

Annexures

ANNEXURE

Inauguration of special unit for treating sickle cell patients at Mananthavady Medical College

LaQshya assurance



MusQan Accreditated DH Mananthavady

Trainings - NQAS/LaQshya/MusQan/Kayakalp

Visit of quality consultant

ASHA training

AYUSH Training

ASHA workers recording data using Shaili app

Smitham: Cervical cancer screening program

AMMA – Ayah Monitoring Maternal Activities.

List of Contributors - District Health Intiative

Name of Officer/Staff	Designation	Office (DMO/ NHM)	Role in Preparation (Data Compilation / Analysis / Drafting / Review / Coordination etc.)	Mobile Number	Email ID
Dr. T Mohandas	DMO	DMO	Review &Monitoring	9496710370	dmowyd.hsd @kerala.gov.in
Dr. Sameeha Saidalavi	DPM	DPMSU	Review &Monitoring	9946105494	Dpmwynd @gmail.com
Dr Dinesh P	DSO	DMO	Review &Monitoring	9847172740	Idspwayanad @gmail.com
Dr Ancy Mary Jacob	Dy DMO	DMO	Review &Monitoring	9846923712	dmowyd.hsd @kerala.gov.in
Dr. Gana Saraswathi	Urban Epidemiologist	DPMSU	Drafting, compiling, analysis	8086278211	Jcmewayanad @gmail.com
Anumol A T	JC MIS	DPMSU	Drafting, Data Preparation	9562463286	Hmiswynd @gmail.com
Nijil	JC IEC	DPMSU	Drafting, Data Preparation	9961603803	Jcwayanad @gmail.com
Jubin Augustin	Urban Data Manager		Drafting, Data Preparation	9947669177	Urbandata Managerwyd @gmail.com
Dr.Liyana	JC M and E	Resigned	Drafting, compiling, analysis