CHAPTER FIVE

FAMILY WELFARE PROGRAMMES

After independence, India witnessed steady progress in all fields due to five year plans. India also decided our population policy aimed to control population. The advancement of public health programmes and improved availability of medicines and drugs, considerably reduced our infant mortality, maternal mortality and general mortality rates. In order to solve the population problem in India, Family Welfare Programme was introduced. In 1952 with the objective of reducing the birth rate to stabilise the population at a level consistent with the requirement of the national economy\(^1\). The programme was launched during the First plan period (1951-1955) centrally sponsored scheme, India is the first country to launch this programme as an official programme in the whole of the world to tackle the problem of over population\(^2\).

**Direction and Administration**

The National Family Welfare programme is implemented in the entire country through the general health services as a package of primary health care. The Central Government virtually bears the entire cost of the programme and control polices, planning, implementation, monitoring and financial management of NFWP\(^3\). At the State level, State Governments are responsible for the effective implementation and

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administration of the programme. A State Family Welfare Bureau in the State Directorate of Health and Family Welfare is the nodal agency for this purpose\(^4\). It is headed by a Director of Family Welfare who is a selection Grade IAS Officer.

At the district level, a District Family Welfare Bureau functions for implementation and administration of the NFWP through its three divisions administrative, mass education, and media and evaluation. These are headed by a District Family welfare officer, District mass Media and Education officer and a Statistical officer respectively\(^5\). The over all responsibility to co-ordinate family welfare and other developmental activities for ensuring the delivery of effective services lies with the District Collector\(^6\). At the peripheral level in the rural areas, the programme is implemented through Rural Family welfare centres attached to Government PHCs\(^7\). The PHC is responsible for the implementation of the programme where there is no rural Family Welfare Centres. In the Urban areas, Family welfare services are provided through the Urban Family welfare Centres and Urban Health Posts\(^8\). At the HSC level, the health workers are the key functionaries of the programme. At the village level, the village Health Guides are responsible for spreading knowledge and information to the eligible couples about family planning and supply of nirodh and oral contraceptive pills. Besides these centres, approved

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\(^5\) Ibid., p.48.
\(^8\) Ibid., p.44.
private nursing homes and voluntary organizations are also providing family welfare services.

Tamil Nadu is a pioneer State in the implementation of Family Welfare programme. It is implemented since 1956 purely on voluntary basis⁹ as a people’s programme involving active co-operation of many sectors and participation of the community at large. The aim of the programme at the early stage was to reduce births by fixing contraceptive targets only¹⁰. But it has been changed to bring down fertility through improving maternity and child health care. During 1995-1996, Target Free Approach has been adopted to implement Family Welfare programme in Tamil Nadu¹¹. The approach envisages replacement of the system of setting contraceptive targets from the top by a system of decentralized participatory planning at the grass roots level. This decentralized planning looked after the needs of the community.

**District Family Welfare Bureau**

The District Family Welfare Bureau in Kanyakumari District was established in 1969, under the supervision of Deputy Director of Medical Rural Health and Family Welfare, functioning at Nagercoil¹². He is a civil surgeon and is assisted by one mass Education and Information Officer, Administrative Officer, Statistical Assistant and other staff. He is implementing the Family welfare programmes in the district under the over all guidance of the District Collector. The programme is

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¹⁰ Ibid., p.134.
¹¹ GO. Ms. No. 353, Health and Family Welfare Department, 30 May 1995.
implemented through 9 rural family welfare centres, 1 Urban Family welfare centre, 3
urban health post and 4 Post Partum Centres, PHCs and approved nursing homes in
Kanyakumari District. The Publicity unit carries out publicity work and mass media
activities. The supply in respect of contraceptives such as nirodh, oral pills, copper
tube is made through this bureau. Certain drugs are also redistributed through this
bureau, to the Rural Family welfare centres, Post partum centres and Medical
Termination of Pregnancy centres\textsuperscript{13}.

District Family Welfare Bureau submits each month’s family welfare
performance report to the Collector. The monthly performances of the Bureau are;
organizing sterilization camps in the district; conducting the NSV (Non Scalpal
Vasectomy) camps; distribution of materials for Family welfare camps received from
Directorate; distribution of IUD, oral pills, condoms, E.Pills to PHCs, Government
Hospitals and private Nursing homes; implementing population policy of the
Government in the district; accreditation of private Nursing Homes in the district for
sterilization and Medical Termination of Pregnancy; quality assurance sterilization
and IEC (Information, Education and Communication) activities in Sterilization and
NSV in the area\textsuperscript{14}.

\textbf{Infrastructure Facilities}

The family welfare services in Kanyakumari District are extended through a
vast network of 36 PHCs and 267 HSCs in the rural areas. In the Urban areas, family
Welfare services are provided through the Urban Family Welfare Centre and Urban

\textsuperscript{13} Ibid., p.2.

\textsuperscript{14} Monthly Performance Report September 2009, Department of Family Welfare, District
Health posts. There are one Urban Family Welfare Centre at the Kanyakumari Government Hospital and 3 Urban Health Posts at Vattavilai, Vadiveeswaram and Krishnankoil in Nagercoil, to disseminate the knowledge of family welfare among the public. The programme is implemented in the rural areas through the rural family welfare centres attached to Government PHCs. There are 9 rural family welfare centres in the district. They are Government PHCs at Agastheeswaram, Thovalai, Melpuram, Thiruvattar, Rajakkamangalam, Kurunthancode, Munchirai, Killiyoor and Thuckalai. Besides 4 Post Partum Centres functioning in the District of different types where family welfare services are extended. They are Government District Hospital, Nagercoil, Government Hospital, Colachel, Government Hospital, Kuzhithurai and Government Headquarters Hospital Padmanabhapuram.

Moreover, 4 voluntary organizations both in rural and urban areas actively, extending family welfare and maternal child health services. The rural institutions, CSI Hospital, Neyyoor and Sri.Mukambka College of Medical sciences and Hospital, Kulasekaram and in the Urban, CSI Hospital, Marthandam and Catherine Booth Hospital, Putheri play vital role in the successful implementation of family welfare programme in the district. In addition, the Tamil Nadu Government approved 40 private hospitals in the rural areas and 59 private hospitals in the urban areas to

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16 Ibid., 5.
perform the operations under family welfare programme\(^{19}\). Besides, there are 9 unapproved private hospitals in rural areas and 18 unapproved private hospitals in urban areas extending Family welfare services in the district.

The following table mentions the infrastructure facilities of Family Welfare programme available in Kanyakumari District.

<table>
<thead>
<tr>
<th>Sl. NO.</th>
<th>Name of the Institutions</th>
<th>Total No.</th>
<th>Controlling Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PHCs</td>
<td>36</td>
<td>Government</td>
</tr>
<tr>
<td>2</td>
<td>HSCs</td>
<td>267</td>
<td>Government</td>
</tr>
<tr>
<td>3</td>
<td>Government Hospitals</td>
<td>10</td>
<td>Government</td>
</tr>
<tr>
<td>4</td>
<td>Post partum centres</td>
<td>4</td>
<td>Government</td>
</tr>
<tr>
<td>5</td>
<td>Rural Family Welfare Centres</td>
<td>9</td>
<td>Government</td>
</tr>
<tr>
<td>6</td>
<td>Urban Family welfare centre</td>
<td>1</td>
<td>Government</td>
</tr>
<tr>
<td>7</td>
<td>Urban Health post</td>
<td>3</td>
<td>Local Body</td>
</tr>
<tr>
<td>8</td>
<td>Voluntary service organisations</td>
<td>4</td>
<td>Private</td>
</tr>
<tr>
<td>9</td>
<td>Approved Nursing Homes (Rural)</td>
<td>40</td>
<td>Private</td>
</tr>
<tr>
<td>10</td>
<td>Unapproved Nursing Homes (Rural)</td>
<td>9</td>
<td>Private</td>
</tr>
<tr>
<td>11</td>
<td>Approved Nursing Homes (Urban)</td>
<td>59</td>
<td>Private</td>
</tr>
<tr>
<td>12</td>
<td>Unapproved Nursing Homes (Urban)</td>
<td>18</td>
<td>Private</td>
</tr>
</tbody>
</table>

\(^{19}\) Ibid., pp.2-3 and 5-6.
Family Planning programme

Family planning is a deliberate attempt on the part of married couple to space the births of their children and to plan the size of the family in accordance with their social, economic and health conditions, so as to ensure that the family is happy both physically and mentally. The aim of family planning is to prevent unwanted pregnancies. For this, Vasectomy, Tubectomy, Intra Uterine Devices and Contraceptive services are available in all the Government hospitals including PHCs, voluntary organizations and approved nursing homes. Vasectomy and tubectomy are being performed in the taluk and non taluk hospitals and PHCs, which have operation theatre facilities. The PHCs at Agastheeswaram, CR. Pudur, Thadikaramkonam, Edaicode, Arudesam, Kothanallur, Kuttakuzhi are having operation theatres. Adoption of temporary methods such as intra uterine device, distribution of oral pills and condoms are also available in the district.

A new method of sterilization called laparoscopic sterilization has also been introduced in the district. About 70 percent of women prefer this new method. Laparoscopic camps are arranged every month in the Government hospitals and PHC’s in the district. A mobile medical unit is also available for family welfare programmes in Kanyakumari District. Village health nurses are given training in IUD insertions and Oral Pill administration. Tamil Nadu Government has ordered to conduct IUD camp in every month in all the Government institutions to achieve stable population in TamilNadu. In Kanyakumari District every Wednesday is observed as a

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21 Personal Interview with Mr. Selva Raj, Statistical Assistant, District Family Welfare Bureau, Nagercoil, 28th December 2009.
IUD Insertion day in all Government Hospitals and PHCs\textsuperscript{22}. Apart from that, four camps are planned and conducted in every month to cover the eligible Mothers.

The District Collector organised the family welfare campaigns periodically in the district. In each camp, large number of sterilizations is done. Government has sanctioned special temporary advances for the purpose of conducting such camps. Motivation is done by the family welfare field staff and public health department staff. Target is fixed to each officer of the department and there is also the practice of giving special incentive to officers, who exceed the target\textsuperscript{23}.

Family welfare achievements in the month of March 2010 in Kanyakumari District submitted by the District Family Welfare Bureau to the District Collector is given below\textsuperscript{24}.

<table>
<thead>
<tr>
<th>Sl.No</th>
<th>Methods</th>
<th>Monthly Target</th>
<th>Achievement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sterilization</td>
<td>917</td>
<td>1171</td>
<td>127.1</td>
</tr>
<tr>
<td>2</td>
<td>IUD</td>
<td>833</td>
<td>631</td>
<td>75.7</td>
</tr>
<tr>
<td>3</td>
<td>Condom</td>
<td>51000</td>
<td>31514</td>
<td>61.8</td>
</tr>
<tr>
<td>4</td>
<td>Oral Pills</td>
<td>4333</td>
<td>1916</td>
<td>44.2</td>
</tr>
<tr>
<td>5</td>
<td>Medical Termination of Pregnancy</td>
<td>292</td>
<td>67</td>
<td>36.7</td>
</tr>
</tbody>
</table>

\textsuperscript{22} Report from the Department of Public Health, Nagercoil, 2010, p.5.
\textsuperscript{23} Personal Interview with Mrs. Sahajini, Health Visitor, PHC, Agastheeswaram, 3 December 2009.
Post Partum Programme

It is a maternity centred hospital approach of family welfare programme started in 1969\(^25\). The objective of the programme is to provide ante-natal and post-natal services to expectant Mothers and also to provide family planning services. Ideally antenated care should begin soon after conception and continue throughout the pregnancy. Care of the Mother and the new born after delivery is post-natal care. Broadly this care falls in to two areas. Firstly, the care of the Mother which is primarily the responsibility of the obstetrician, secondly, the care of the new bore, which is the combined responsibility of the obstetrician and Paediatrician. This combined responsibility is also known as perinatology\(^26\).

In Kanyakumari District, four post partum centres are functioning at Government Headquarters Hospital, Padmanabhapuram, Government Hospital Colachel, District Headquarters Hospital, Nagercoil and Government Hospital, Kuzhithurai. These Post Partum institutions are performing the following services under the MCH supplemental programme\(^27\): Ante-natal and post – natal care including prevention against anaemia by multi – vitamin therapy and protection against tetanus through regular immunization programme; Children are protected against diphtheria, tetanus and whooping cough by regular immunization and prophylaxis against


\(^{26}\) Park, K., *op.cit.* , p.454.

anaemia and night blindness is achieved through regular administration of Iron and Folic Acid and Vitamin A concentrate.

With a view to provide maternal and child health and family welfare services in rural and semi urban areas as well as to bring an over all improvement in the health status of Mothers and infants, the post partum programme was extended during the sixth Five year plan period (1980-1985). After 1 April 2002, the Government of India transferred the Post Partum Programme under State head.

Medical Termination of Pregnancy Programme

Medical Termination of Pregnancy (MTP) is a health care measure which helps to reduce maternal morbidity and mortality resulting from illegal abortions. Though this is mainly a health care measure, it can supplement family welfare, as a large percentage of women undergoing MTP are wedded to the acceptance of small family norm and will therefore accept family welfare procedure. Unsafe abortion is one of the major causes for maternal mortality. In order to prevent those health hazards to women, the Medical Termination of Pregnancy Act was passed in 1971 and the Medical Termination of Pregnancy programme was launched all over India on 1 April 1972. Through this programme, abortions are conducted by trained doctors in well equipped approved medical institutions. Under this Act, termination of pregnancy can

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be done up to 20 weeks, if pregnancy is likely to result in birth of congenitally malformed child or continuation of pregnancy is likely to harm the Mother in the existing circumstances and in case of rape and contraceptive failures\textsuperscript{32}.

The Act stipulates that no termination of pregnancy shall be made at any place other than a hospital established or maintained by the Government or a place approved for this purpose by the Act of Government\textsuperscript{33}. It also provides that no pregnancy shall be terminated except with the consent of the pregnant women. The written consent of the guardian is necessary before performing abortion in women under 18 years of age, and in lunatics even if they are above 18 years\textsuperscript{34}. Abortion services are provided in hospitals in strict confidence. The name of the abortion seeker is kept confidential, since abortion has been treated statutorily as a personal matter.

To supplement the small family norm, the medical termination of pregnancy is legally approved and this has been performed by all the government hospitals, PHCs and approved nursing homes. In Kanyakumari District, Government hospitals, 36 PHCs, 40 rural approved nursing homes and 59 Urban approved nursing homes have facilities to perform MTP\textsuperscript{35}. The untrained doctors from various institutions in the district are being trained to perform MTP and other family welfare surgeries at the teaching institutions for 15 days.

\textsuperscript{32} Dr. Veena Shatugna, \textit{Women and Health}, Tiruchi, 1983, p.43.
\textsuperscript{33} Park, K., \textit{op.cit.}, p.435.
\textsuperscript{35} Report from the Department of Medical Health and Rural Health Services, Nagercoil 2010, p.9.
Pre-natal Diagnostic Techniques Act, 1994

The Pre-natal Techniques like amniocentesis and sonography are useful for the detection of genetic or chromosomal disorders or congenital malformations or sex linked disorder\(^{36}\). However, this technology is misused on a large scale for sex determination of the foetus. If the foetus is pronounced as female, this prompts termination of the pregnancy and it brings to an end an unborn child.

In order to check female foeticide, the Pre-natal Diagnostic Techniques (prohibition of sex selection) Act, 1994 was enacted and brought into operation from 1 January 1996\(^{37}\). The Act prohibits determination and disclosure of the sex of the foetus. It also prohibits any advertisements of facilities relating to pre-natal determination of sex. Punishments are prescribed for contravention of any of its provisions. The person who contravences the provisions of this Act is punishable with imprisonment up to 5 years and fine up to Rs. 1,00,000\(^{38}\) apart from cancelation of the registration and license.

Under the Act, facility of pre-natal diagnostic techniques and genetic counselling is to be provided only at clinics registered under this Act. The Act seeks to permit diagnostic techniques on a woman only in certain specified circumstances

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and in registered institutions\textsuperscript{39}. Under this act, the District Maternal and Child Health officer and Community Health Nurses visit the scan centres periodically and collect address, list of pregnant Mother who have undergone scan and hand over the list to the Village Health Nurses. The Village Health Nurses visit the household and interview the individual and family members and ascertain the reasons whether the mothers undergone MTP after scan test. If the Mothers have undergone MTP immediately after a scan test, the scan centres will be put under surveillance. These scan centres would be brought to book by sending decoy patients in co-ordination with police\textsuperscript{40}. Audit of scan centres in the districts is conducted by the Deputy Director of Medical and Rural Health Services and Family Welfare or Joint Director of Health Services, District Maternal and Child Health officer, Community Health nurses and Block Health statisticians to ascertain the misuse of sex determination scan centres by violation of Pre-natal Diagnostic Technique Act\textsuperscript{41}.

In Kanyakumari District, under this Act, 127 registered scan centres are functioning\textsuperscript{42}. All registered scan centres are submitting their performance report to the office of Joint Director of Medical and Rural Health Services every month and all registered scan centres are following the instructions of Pre-natal Diagnostic Techniques Act, 1994. Scan centre audit will be conducted with the help of field staff headed by District Maternal and Child Health Officer in Kanyakumari District. In


\textsuperscript{40} Year Book 2005-2006, Family Welfare Programme in Tamil Nadu, State Family Welfare Bureau, Madras, p.10-11.

\textsuperscript{41} G.O.(2D) No.20, Health and Family Welfare, 24 February 2006.

\textsuperscript{42} Report from the Office of Joint Director of Medical and Rural Health Services and Family Welfare, Nagercoil, 2009, p. 8.
case of any scan centre found to be guilty, the scan centre will be sealed permanently and the prosecuted person. In Kanyakumari District, so far no scan centre is found to be guilty. The powers of registration and renewal which were held by the Joint Director of medical and Rural Health Services is decentralized to the following sub-District Appropriate Authorities. They are Government Headquarters Hospital, Padmanabhapuram, the three Taluk hospitals named Government Hospital, Kanyakumari, Government Hospital BhoothaPandy and Government Hospital, Kuzhithurai. The names and address of 127 registered scan centres functioning in Kanyakumari District are included in the Appendix.

**Insurance Scheme for Mothers who undergo sterilization**

The Government of Tamil Nadu, through National Insurance Company Limited introduced a Unique Scheme of providing insurance coverage for the Mothers who undergo sterilization from February 2001. Under this Scheme, each Mother will be insured at Government paying a risk premium of Rs. 14 per case. In the event of death due to sterilization in any Government hospital, Voluntary organizations and approved Nursing Homes, a compensation of Rs.2 lakhs will be paid to the family of the deceased Mothers. It would be deposited in the name of their children. For death outside the hospital within 30 days of discharge, a compensation

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43 Ibid., pp.8-9.
44 Letter of the Director of Medical and Rural Health services, Chennai-6, R.No. 55520/E7/3/04, 12 March 2005.
of Rs. 25,000 will be paid to the family of the deceased Mothers\textsuperscript{46} and it would be deposited in the name of the children.

On 29 November 2005, the Ministry of Health and Family welfare has launched a Family Planning Insurance Scheme uniformly all over the country, through Oriental Insurance Company. This policy was renewed for a further period from 29 November 2006 to 31 December 2007. Under this Scheme, Rs. 2 Lakhs was to be paid for death due to sterilization in hospitals or within 7 days from the date of discharge from the hospitals\textsuperscript{47}. In the event of death due to sterilization within 8 to 30 days from the date of discharge from the hospital, a compensation of Rs. 50,000 will be paid to the family of deceased Mothers and Rs. 25,000 for failure of sterilisation.

In the present policy, the payment of death claim, would now be available equally to spouse and children of the deceased mother. If the children are minor, the payment would be made as a fixed deposit in a Bank in their names payable on the date of their attaining majority. However, the interest accrued on monthly basis shall be paid to the children through their guardian. In case there are no surviving spouse or children, the claim shall be payable to the legal heir of the deceased acceptor\textsuperscript{48}.

**Maternal and Child Health Programme**

One of the important aspects of the Family Welfare Programme is the promotion of health of Mother and children. The future of any Nation depends upon its roaring healthy new generation. The protection of Motherhood and Childhood has

\textsuperscript{46} Ibid., p.10.
\textsuperscript{47} Year Book 2006-2007, Ibid, p.11.
\textsuperscript{48} Ibid., pp.11-12.
rightly become a primary concern of the modern state\(^{49}\). So the maternity and child welfare service has come to be recognized as a very important branch of public health work. In 1976, WHO defined Maternal and Child Health (MCH) as “the promotive, preventive, curative and rehabilitative care for mothers and children”\(^{50}\). In order to create better awareness, all over the world, WHO on the eve of the world Health day on 7 April 1984, which were celebrated as “CHILDRENS HEALTH–TOMORROW’S WEALTH”\(^{51}\). MCH creates a sense of security in the minds of parents that the children born will live a healthy life which in turn will contribute greatly to the acceptance of small family norm as a way of life\(^{52}\). With this objective in view, the Ministry of Health and Family Welfare sponsored special schemes.

Care for the Mother is care for the unborn child. Mother’s health influences to a great extent the health of the child. So the Mother should be healthy enough to take full care of each child even before conception. This is possible only through full physical maturity of the women, spacing of births and limiting the number of children. These are the basis for better maternal and child health care. The main objective of MCH programme is a healthy Mother – healthy baby\(^{53}\). Reduction of maternal mortality is an important goal because maternal death rate is comparatively high in our country\(^{54}\).

\(^{49}\) Madras Information, (Health), 1952 p.27,  
\(^{53}\) Alka Gupta, M.D., op.cit., p.30  
\(^{54}\) Madras Information (Health), 1952, p.27.
Programmes for maternal and child welfare are implemented to promote the health and social status of the Mother and children. The maternal and child welfare activities are rendered through a network of 36 PHCs, 267 HSCs and Government Hospitals in Kanyakumari District. The MCH programmes are directed towards effective ante-natal care, ensuring safe and aseptic delivery and appropriate post natal care, initiation and maintenance of breast feeding, timely immunization against common infectious diseases, vaccination against tetanus, control of diarrhoea, attention to growth and provision of basic medical care\textsuperscript{55}. MCH services in the rural areas are rendered through PHCs and HSCs. In urban areas concerned, Medical officers of the general hospitals and Municipal Health officer guide and conduct the entire MCH services in their respective areas.

**Oral Rehydration Therapy Programme**

Diarrhoea is one of the leading causes of child mortality. To enhance the child survival by decreasing the morbidity and mortality due to diarrhoeal diseases in children under five, a National Diarrhoeal Disease Control programme was started through promotion of Oral Rehydration Therapy (ORT). ORT programme is centrally sponsored and implemented by Tamil Nadu Government since 1986-87\textsuperscript{56}. It was implemented in Kanyakumari District during 1989-1990. The main components of the programme are health education of the population, training of medical and paramedical workers at all levels, augmentation of supply of oral rehydration salts and


\textsuperscript{56} Tamil Nadu State Administration Report 1989-1990, Madras, p.171.
monitoring and evaluation\textsuperscript{57}. Maternal and child Health officers are over all in charge for guiding the programme.

**Immunization Programme**

Immunization is one of the best tools to save a child’s life. It is a way of protecting the human body against infectious diseases through vaccination\textsuperscript{58}. Every country has its own programme of immunization as a part of the over all health programmes. Immunization programme has had a direct bearing on the country’s infant mortality rate. Immunization was included in the 20 point programme and there was thrust on coverage of infants or new born of to 12 months old\textsuperscript{59}. In Tamil Nadu, a well established system has been developed for successful implementation of immunization programme. Initially the Government of India funded for the vaccination scheme\textsuperscript{60}. Immunization, services are extended through the PHCs and HSCs in the rural areas and through hospitals and maternity and child welfare centres in the urban areas. Immunisation strategies are being suitably planned and implemented to reduce mortality and morbidity due to vaccine preventable diseases such as diptheria, pertussis, tetanus, tuberculosis and measles.


\textsuperscript{58} National Rural health Mission (NRHM), Newsletter, Vol.1, No.3, February to March 2006, New Delhi, p.19.

\textsuperscript{59} Ibid., p.4.

BCG

One of the objectives of the Five year plan is to protect the entire young population of India against the ravages of tuberculosis. For this purpose a mass BCG (Bacillus Calmette Guarine) campaign, the biggest project of its kind, was initiated in India in August 1948 with the help of WHO and UNICEF\(^61\). BCG\(^62\) is the only widely used live bacterial vaccine. It is given to neo-nates or infants, i.e., under one year of age. BCG is given on the left upper arm to maintain uniformity and for helping surveyors in verifying the receipt of the vaccine\(^63\). For all deliveries that take place in a hospital or an institution, the BCG injection is given at birth, or before the baby leaves the hospital. BCG Vaccine Laboratory a subordinate office of the Directorate General of health services was setup in 1948 at Guindy, Madras with the assistance of WHO and UNICEF\(^64\). It produces and supplies BCG vaccine and tuberculin dilutions to all the States and Union Territories of India.

Immunization against Tetanus

This disease results from infection with Clostridium tetanni. It is a commensal in the gut of humans and domestic animals and is found in soil. It is characterized by tonic muscular spasms. If child birth takes place in an unhygienic environment,


\(^62\) Calmette and Guarine, two French scientists began attenuating avirulent strain in 1906, with a view to develop a vaccine against tuberculosis. After 230 subcultures over a period of 13 years, they were able to evolve a strain known as Bacille Calmette. Guarine or BCG which was avirulent for man while retaining its capacity to induce an immune response.


Tetanus neonatorum may result from infection of the umbilical stump, or the mother may develop the disease. Tetanus is still one of major killers of adults, children and neonates. Tetanus has been known since early times. In rural areas, tetanus was a common cause of death particularly in the new born. But the immunization of infants and expectant mothers has reduced the incidence to a large extent. Immunisation is by injection of tetanus anti toxin (TT). Pre-natal Mothers are administered 2 doses of Tetanus toxoid (TT) at an interval of 4 weeks to prevent tetanus among Mothers and neo-nates.

**Immunization against Polio myelites**

Polio myelites is an exclusively human disease caused by polio virus. Live polio vaccine is administered orally and is therefore known as the Oral Polio Vaccine (OPV). It is prepared by growing the attenuated strains in monkey kidney cells. It is used for the eradication of Poliomyelites. Infants in the age group of 6 weeks to 12 months are given 3 doses of oral polio vaccine at the interval of 4 weeks between each dose, 4 booster dose is given at 16 months after 3 dose of primary immunization.

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Immunization against Diptheria, Pertussis and Tetanus (DPT)

The tetanus toxoid is given either alone or along with the Diphtheria toxoid and Pertussis vaccine as Triple vaccine (DPT). Infants from 6 weeks to 12 months of age are given 3 dose of DPT at an interval of 4 weeks between each dose\textsuperscript{70}.

Immunization against measles

Immunization against measles is carried out for infants of 9 to 12 months old. A single dose of the vaccine is given\textsuperscript{71}.

Vitamin A

To prevent blindness due to Vitamin ‘A’ deficiency, doses of Vitamin A solutions are given orally to children up to 5 years of age at intervals of 6 months from 6 months of age to 5 years of age\textsuperscript{72}.

Expanded Programme on Immunization

The Government of India started the Expanded programme on Immunization (EPI) in 1978\textsuperscript{73}. The objective of the programme was to reduce morbidity and mortality due to the childhood diseases like diptheria, whooping cough, tetanus,

\textsuperscript{70} Immunization Hand Book for Medical officers, Ministry of Health and Family Welfare, New Delhi. 2009, p.22.


poliomyelites, childhood tuberculosis by making free vaccination services easily available to all eligible children and expectant Mothers. Tamil Nadu started immunization programme against these six vaccine preventable diseases during 1978. Tetanus Toxoid (TT) immunization for expectant Mothers was introduced in 1975-1976 and it was integrated with EPI in 1978. Immunization against Polio and Typhoid was included in the programme in 1979-1980 and TT for school children was added in 1980-1981. BCG Immunization was brought under EPI in 1981-1982.

**Universal Immunization Programme**

In order to strengthen the immunization programme, Government of India started a special programme called Universal Immunization programme (UIP) in 1985\(^74\). UIP was launched to reduce infant, child and maternal morbidity and mortality by protecting against six vaccine preventable diseases like diphtheria, tuberculosis, pertussis, tetanus, polio and measles. It also aims to protect 100 percent of pregnant women against tetanus and of immunizing 85 percent of eligible infants against six vaccine preventable diseases. It is extended throughout the country. Under this UIP, immunization is done on all Wednesdays and the eligible children and Mothers receive immunization on an outreach basis\(^75\). To strengthen the routine immunization, with the aim to improve the coverage, Government of India as part of NRHM since 2005-2006 introduced AD (Auto Disable) syringes for all immunizations, replacing the existing glass syringes and needles\(^76\).

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\(^{74}\) Tamil Nadu State Administration Report 1988-1989, Madras, p.121.

\(^{75}\) Ibid., 1989-1990, Madras, p.120.

Government of India has decided to introduce Hepatitis B Vaccine for infants under the UIP on a pilot basis. This is being implemented firstly in slum areas. This pilot project is supported by the Global Alliance for Vaccines and Immunization (GAVI). Atal Bihari Vajpayee as the Prime Minister of India introduced the pilot project in New Delhi on 10 June 2003. Being a good performing State, the Government of India selected Tamil Nadu state for the implementation of Hepatitis B vaccination programme in all districts to prevent liver cancer.

**Routine Immunization Strategy**

Routine Immunization is one of most cost effective public health interventions and was first introduced in India in 1978. Government has revised the immunization strategy since May 2008. Under the new strategy all children and Mothers will be immunized under the supervision of Medical Officers of PHCs, Government Hospitals, Medical College Hospitals and Urban Health centres. Mobile Medical Team is sent to remote villages to cover the eligible children. Apart from Wednesday, immunization is also given on Tuesday for the benefit of the community. The routine immunization strategy is depicted in the following table.

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79 Ibid., pp. 178-179.
80 Ibid., p. 179.
<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Places of Immunization</th>
<th>Days of Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>In Rural and Urban areas</td>
<td>All Tuesdays and Wednesdays</td>
</tr>
<tr>
<td>2</td>
<td>Immunization clinics in Taluk and Non-Taluk Hospitals.</td>
<td>Every Wednesday</td>
</tr>
<tr>
<td>3</td>
<td>Immunization Clinics in Medical College Hospitals.</td>
<td>Six days in a week Monday to Saturday.</td>
</tr>
<tr>
<td>4</td>
<td>Immunization Clinics in District headquarter Hospital.</td>
<td>Monday, Wednesday and Friday of every week.</td>
</tr>
</tbody>
</table>

Along with the vaccination every pregnant woman and Mother of the infant will get an immunization card in which the date of immunization is mentioned. It is very important to take the baby for the vaccination at the correct time. The card must be preserved carefully and taken every time the pregnant woman or infant is due for a vaccination\(^{81}\). National Immunization schedule for infants children and Pregnant women is given in the Appendix.

The table given below shows the number of beneficiaries under Immunization programmes in Kanyakumari district since 1983-1984 to 1987-1988\(^{82}\).


\(^{82}\) GopalaKrishnan, M. (Ed.), *op.cit.*, p.1107.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>DTP</td>
<td>33238</td>
<td>38940</td>
<td>41220</td>
<td>20259</td>
<td>41761</td>
</tr>
<tr>
<td>2</td>
<td>Polio</td>
<td>30864</td>
<td>32757</td>
<td>41224</td>
<td>34019</td>
<td>39531</td>
</tr>
<tr>
<td>3</td>
<td>TT (Expectant mothers)</td>
<td>21595</td>
<td>15404</td>
<td>19238</td>
<td>28874</td>
<td>36918</td>
</tr>
<tr>
<td>4</td>
<td>TT (10 years)</td>
<td>2795</td>
<td>15767</td>
<td>95112</td>
<td>27698</td>
<td>25775</td>
</tr>
<tr>
<td>5</td>
<td>TT (16 Years)</td>
<td>1980</td>
<td>16041</td>
<td>13005</td>
<td>27448</td>
<td>18589</td>
</tr>
<tr>
<td>6</td>
<td>Measles</td>
<td>No programme</td>
<td>No programme</td>
<td>Nil</td>
<td>29393</td>
<td>33955</td>
</tr>
<tr>
<td>7</td>
<td>DT</td>
<td>28349</td>
<td>27761</td>
<td>87759</td>
<td>51693</td>
<td>43855</td>
</tr>
</tbody>
</table>

**Mass Education and Media Activities**

Mass Education and Media activities play a vital role in making the Family Welfare programme a people’s movement. These activities are responsible for creating demand for Family Welfare services. The District Family welfare Bureau, Nagercoil gives wide publicity in the district on ‘Small Family Norm’ by which various methods on family planning is explained in detail to the public. In Kanyakumari district, considerable awareness has been created about various permanent as well as temporary methods about the importance of ‘small family norm, that is ONE FAMILY ONE CHILD’ through the sustained efforts of the Information, Education and Communication (IEC) Wing.

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The Family Welfare programme is nothing but Maternal and Child Health on the whole is realized by the public. The IEC activities are being geared up through mass media like Closed Circuit T.V. System, Electronic Display, Wall paintings, Press Advertisements and Activities like Erection of Hoardings, Conducting Seminars, Workshops and Inter-personal Contacts through Mahila Swasthiya Sanghs (Self Help Groups)\textsuperscript{85}. The following subjects regarding child welfare, mother care, female literacy, male and female sterilization are stressed through these messages\textsuperscript{86}; ideal age for marriage of women is 21 years; spacing of birth interval is 3 years; ideal birth weight of child is 3 Kilograms; to make hospitals and Maternity Centres ‘baby friendly’; elimination of vaccine preventable diseases; educate about various methods of contraception; to take steps to engrave the symbol of inverted red triangle on all vehicles; promotion of new technique of “No Scalpel Vasectomy” and female child is also an heir for the family.

Education of masses about Family planning is done through several media such as wall paintings, drama, villupattu, bus boards, exhibitions; cinema slides, All India Radio Broadcasts and Seminars, Orientation Training Camps etc\textsuperscript{87}. Film shows are screened by the mass media authorities even in remote tribal areas like Arukani, Ganapathykkal and Coastal areas like Simoncolony and Melmidalam in Kanyakumari District. More than thousand people witness each show. The cinema unit attached to the Family Welfare Bureau, screened flims which could influence the people to adopt

\textsuperscript{86} Ibid., p.2.
\textsuperscript{87} Annual Plan 1974-1975, Narrative Notes on Plan Programmes, State Planning Commission, Madras, p.146.
family planning. A film on family planning entitled ‘Kudumba Nalam” was produced by the Government and also 1000 Cinema slides on family planning depicting ‘Happiness through family planning and unhappiness due to lack of family planning” were shown in the Cinema theatres in all the district of the State from 18 December 1960 onwards. Dramas, cultural programmes and rural audience programmes are also held by the publicity unit besides wall painting, pasting of wall posters and erection of boards with slogans high lighting family welfare programmes.

Thus, the family welfare programmes introduced by the Government in the district, considerably reduced the maternal death and infant mortality and most of the people in the district are benefited. By adopting the above system of periodical checkup, taking the routine immunization strategy regularly, many of the disabling cases of early childhood may be prevented and enabled the child to begin a healthy life.

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88 G.O. Ms, No. 94, Government of Madras, 10 January 1962.