CHAPTER XVI

MEDICAL AND PUBLIC HEALTH SERVICES

Indigenous System of Medicine

Prior to the introduction of allopathic system of medicine, people of this area relied upon the *ayurvedic* and *unani* systems. Both the systems were popular among the masses during the middle of nineteenth century as these were cheap and readily available. The *ayurvedic* system was practised by Hindu *vaids* who generally belonged to priestly class of Brahmans and the *unani* system was practised by the Muslim *hakims*. The *vaids* were kept mostly at the charitable and religious institutions supported by the rich persons. However, there were other Dadu Panthi *Vaids* of Narnaul who did not run regular dispensaries but they generally examined the patients at their homes. Likewise the Muslim *hakims* were also available either at the mosque or at their homes.

The rulers of Patiala and Nabha States also encouraged these indigenous systems. They occasionally donated to the religious and medical institutions which kept these systems alive. The following extract of an old gazetteer proves the existence of *Unani* system in the Bawal *nizamat* :—

> "Formerly the state possessed no hospitals but state *hakims* were entertained and they used to treat the sick, medicines being given gratis from the State *lassi-khana*, if they were not obtainable from the *bazars*. In 1880, Unani dispensaries were established at the Capital and the headquarters of each *nizamat*, each having a *hakim*, an *attar* or compounder and a *Jarrah* or blood-letter. Medicines were given free and patients were sometimes given food also[1] ."

With their superstitious habits the people patronized the village *siyanas* for various remedial measures and cure of diseases. They visited deities for cure of their illness. The magicians were called to recite mantras to remove the spirits. Certain diseases like small-pox were considered to be done to the wrath of god/goddess. The temple of Bhaironji at Basduda in Rewari tahsil drew a large gathering of persons with a faith of having remedy for their various diseases and problems. Some villages were known all over the area for their masseurs or massagists and bone-setters for successful curing the dislocation and fracture of bones.

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1. *Phulkian States Gazetteer-Patiala, Jind and Nabha*—1904, p. 381.

These indigenous systems of medicine which were cheap and easily available in rural area were patronized by the people. The allopathic system of medicine was introduced during the British rule. This system was based on scientific lines and vast research conducted in the western countries. The British patronized this system and the rulers of erstwhile princely States followed suit. Towards the close of 19th century Allopathic dispensaries were opened at Narnaul, Rewari[1], Mahendragarh, Bawal, Kanti and Kanina. The dispensaries at Narnaul and Rewari were under Assistant Surgeons whereas the Hospital Assistant looked after other dispensaries.

The medical facilities were extended to the rural areas also. Dispensaries were opened at the following places :—

S.No.	Dispensaries	Year
1.	Dharuhera	September 14, 1922
2.	Jatusana	April 22, 1923
3.	Meerpur	May 12, 1923
4.	Khole	December 1, 1925
5.	Gurawada	January 13, 1928

There was a modernised and well-equipped hospital at Rewari which was started by Sir Shadi Lal, the first Indian Chief Judge of the Lahore High Court, in 1941. The main object in opening this hospital was to give medical aid to women. It was, however, taken over by the government in about 1950-51.

After Independence, the national government was much concerned about extending medical and health services to the people. Medical institutions on modern lines were opened and provided with necessary equipment and other facilities.

The government realised that the indigenous systems of medicine were favoured by the people, particularly the rural people. Keeping this in view, the Punjab Government in 1953-54 started a programme of opening *ayurvedic* dispensaries in the district. These dispensaries were opened on the recommendations of the district authorities. Such institutions at first were housed in the accommodation provided by the village panchayats. The Directorate of Ayurveda was established in November, 1956 and thereby the government encouraged the indigenous system of medicine by affording facilities for its promotion and propagation.

1. In February, 1903, the S.P.G. Mission opened a hospital for women at Rewari but it had to be closed in 1908 owing to the death of the lady doctor.

Due to the re-organisation of the district in 1972, 11 medical institutions, viz. 3 hospitals (Civil Hospital, Sir Shadi Lal Maternity Hospital and Railway Hospital, Rewari); 3 Primary health centres (at Bawal, Guraora and Khole) and 5 dispensaries (at Jatusana, Dharuhera, Meerpur, Dahina, Zainabad and E.S.I. Dispensary, Rewari), were included in the Mahendragarh district.

In 1978, there were 31 Allopathic institutions, 23 *ayurvedic* dispensaries and 2 *unani* dispensaries located in various parts of the district. With the increasing medical aid and availability of life-saving drugs most of the fatal diseases now no longer remain sources of fear. Consequently, mortality has decreased considerably. The hospitals with the number of beds and doctors are given in Table XII. of Appendix.

MEDICAL AND HEALTH SERVICES

Previously medical services were divided into two wings, viz. medical and health. The District Medical Officer was responsible for the functioning of hospitals and dispensaries in a district. The District Medical and Health Officer was in charge of the health wing and was responsible for sanitation, disease prevention and health promotion services in the district. In April, 1964, these two wings were merged and the Chief Medical Officer was made in charge of both the medical and health services. In 1978, he was assisted by two Deputy Chief Medical Officers, District Family Welfare Officer, District Malaria Officer and District Tuberculosis Officer. At block level, Block Medical Officers look after various health services and primary health centres. The civil hospitals at Narnaul and Rewari are under Senior Medical Officers whereas other hospitals and dispensaries function under Medical Officers. Likewise, each Ayurvedic and Unani dispensary is under a *Vaid* or *Hakim*. All Medical Officers and *Vaids* or *Hakims* work under overall supervision of the Chief Medical Officer. Medical service is essentially a hospital organisation for medical relief to the public. This organisation embraces all Allopathic, Ayurvedic and Unani institutions. The important institutions are described below :—

Civil Hospital, Narnaul.—It was a dispensary in 1904 under the charge of an Assistant Surgeon. A female ward was added to it in 1930. It was converted into a 42-bed hospital in 1955 and was later upgraded to a 100-bed hospital.

It has departments of medicine, surgery, ophthalmology, ENT, dentistry and provides facilities of radiology and clinical laboratory.

In 1978, it had 8 doctors and 25 members of auxiliary staff. The number of indoor patients and outdoor patients was 42,667 and 1,52,409 respectively.

Civil Hospital, Mahendragarh.—It was started as a dispensary under the charge of Hospital Assistant towards the close of 18th century. In 1973, this hospital and Smt. Jai Devi Modi Female Hospital were combined and the bed strength was increased from 8 to 25 (13 for male and 12 for female). It provides facilities of x-ray and clinical laboratory. In 1978, there were 2 doctors and 8 members of auxiliary staff. The number of indoor and outdoor patients was 8,069 and 85,367 respectively.

Civil Hospital, Rewari.—Started as a dispensary in 1874-75, it was converted into a hospital in 1924. A maternity hospital viz. Sir Shadilal Maternity Hospital, started in 1941 was merged with the hospital in 1974.

The hospital has the departments of medicine, surgery, gynaecology and dentistry. It is 50 bedded (35 for male and 15 for female) hospital with x-ray and laboratory facilities.

In 1978, there were 4 doctors and other members of auxiliary staff. The number of indoor and outdoor patients was 15,992 and 1,16,616, respectively.

Railway Hospital, Rewari.—It was started by Railways in 1924. It is 20 bedded (8 for male and 12 for female) hospital and provides facilities of x-ray and clinical laboratory. It is controlled by Divisional Medical Officer, Railways, Bikaner. The hospital is manned by 5 doctors and other members of auxiliary staff.

In 1978, 1,18,433 outdoor and 658 indoor patients were treated at the hospital.

T.B. Clinic, Narnaul.—The clinic was set-up in 1959. It remained a part of the Civil Hospital, Narnaul upto 1962, when it was shifted to its own building. It is a 16 bedded (10 for male and 6 for female) clinic and provides facilities of x-ray and clinical laboratory. In 1978, it had 2 doctors and other members of auxiliary staff. The number of indoor and outdoor patients was 314 and 3,130 respectively.

Diseases Common to the District

The common diseases which occur in the district are gastro-enteric and typhoid group of fevers, chest-infection, tuberculosis, malaria and worm infection. Epidemic diseases, viz. cholera, plague and small-pox are three notifiable diseases under the Epidemic Diseases Act, 1897. Of these plague and small-pox were eradicated. The incidence of cholera is dependent largely on the chance of importation of infection and laxity of preventive measures to check them. However, the cholera cases are negligible. Only one case of cholera was reported in 1972 and during 1974, 370 cases of cholera were

detected and out of them ten deaths were reported. However, the disease is under control due to improvement in the sanitation, provision of safe drinking water, strict vigilance and anti-cholera measures at the time of fairs.

No case of plague was reported in the district after 1956. However, small-pox which was most contagious and dreadful disease used to occur in an epidemic form in the district and many people were disfigured, lost their eyes and other organs or even lost their life. In the beginning of the 20th century, the vaccination which is the only check for control and prevention of the disease, was not compulsory. In 1962, a Small-Pox Eradication Programme was launched and thereafter all new born babies were vaccinated and 80 per cent of the total population of the district was revaccinated. The target of primary vaccination was raised to 100 per cent in 1965 and this brought down the incidence of disease. Under the National Small Pox Eradication Programme, supervisors and vaccinators were posted in all municipalities and primary health centres. These special measures eradicated the disease and no case of small-pox was reported in the district after 1974.

Malaria.—Malaria in the past was responsible for a very heavy toll of life. As the village reporting agencies were not qualified to distinguish between malaria or other fevers, no reliable figures of death due to malaria are available. In 1953, National Malaria Control Programme was initiated, later in 1958, it was redesignated as the National Malaria Eradication Programme. The object originally was to curb malaria menace to such an extent that it may not cause any set back in economic and social development of the country. The insecticidal spray on mass basis in the first phase, known as attack phase, gave encouraging results and the incidence was controlled to the desired level. In 1958, the scope of the campaign was enlarged to ensure eradication of the disease from the community. Besides the insecticidal spray in every house, the fever cases were screened by basic health workers during fortnightly house to house visits. The positive cases of malaria were given radical treatment for five days. As a result of these intensive activities, malaria was effectively controlled and curbed by 1963.

A Malaria Unit was established in 1959 to look after the control of malaria in Mahendragarh, Gurgaon and Hisar districts. However, in 1972, the entire area of the district was taken as an independent unit.

Of late, however, the mosquitoes responsible for transmission of malaria have developed resistance against insecticides, and there has been a recurrence of malaria cases. The yearwise incidence of malaria during 1975

to 1978 is given below :—

Year	Malaria Cases Detected
1975	28,752
1976	40,936
1977	27,294
1978	20,093

From 1977, the Government of India launched a modified plan and operation for the control of malaria which included a spray, drug distribution through panchayats , establishment of malaria clinics in all civil hospitals and primary health centres and strengthening of organisational set-up of Malaria Eradication Programme. At the block level, the responsibility for the implementation of malaria programme has been entrusted to the Block Medical Officer.

Tuberculosis.—This is common in the district and poses a major health problem. It has been persisting due to spread of infection and less resistance among the people. Since the cure of tuberculosis requires a sufficiently long time, domiciliary treatment is carried on in the district. After diagnosis, medicines are prescribed and necessary precautions are explained to them so that they may continue their treatment while staying at home.

The National Tuberculosis Control Programme was started in 1951. T.B. Clinic sanctioned in 1959 was the part of the Civil Hospital, Narnaul but later in 1962 the T.B. clinic was shifted in its own building with all the facilities. Besides diagnosis and treatment facilities have been provided in each primary health centre. A B.C.G. vaccination team was deputed in the district in 1965 and it is functioning effectively and all persons below 20 years of age are given B.C.G. vaccination.

The surveys to determine the incidence of tuberculosis in the district were carried out in Kutubpur, Jatwas villages in 1975 and Harijan bastis of Narnaul in 1977. The population of 7,703 was covered under the survey and 213 cases were referred for X-ray and sputum examination and 13 cases of tuberculosis were found.

Trachoma.—It is a common eye disease in the district, specially amongst children under 10 years of age. Untreated trachoma, sometimes leads to serious disability of the eye and even leads to blindness. The National Trachoma Eradication Programme was started in the district and free medicines are supplied to the persons suffering from it.

Gastro-enteric Diseases.—The most common infectious diseases are typhoid and enteric group of fevers, dysentery, diarrhoea and diseases of 5 F's–flies, fingers, faeces, fomites and food. These diseases are kept under control by organised preventive measures, i.e. supply of safe drinking water, regular disinfection of drinking water and general sanitation measures.

Vital Statistics

Due to concerted efforts of the Health Department, incidence of diseases has been lessened. The diseases like plague, cholera and smallpox have been almost eradicated. The following table shows births and deaths during the period from 1974 to 1977 :—

Year	Births			Deaths		
	Males	Females	Total	Males	Females	Total
1974	14,091	11,647	25,738	4,966	4,513	9,479
1975	13,637	11,299	24,936	4,387	3,618	8,005
1976	13,064	10,350	23,414	4,352	3,568	7,920
1977	13,266	10,523	23,789	5,379	4,346	9,725

The number of births in the district decreased from 25,738 in 1974 to 23,414 in 1976 which again slightly increased to 23,789 in 1977. It is significant that the number of birth of females during the period under review has always been lower as compared to the males. Similarly, the number of deaths decreased from 9,479 in 1974 to 7,920 in 1976 and it again increased to 9,725 in 1977.

General Standard of Health.—Because of the dry climate, outdoor habits of the people and the absence of congestion in towns, the district generally remains free from epidemics. So the standard of health in general is good.

Preventive Measures to Promote Public Health

The modern concept of good health lays greater emphasis on prevention of diseases and this necessitates various kinds of measures. The younger generation must be given health education which is perhaps the most important activity for effective preventive measures. Health education is equally necessary for older persons. Likewise, family welfare and maternity welfare require greatest attention if the problem of overpopulation has to be solved. It is equally important to take suitable

measures to prevent adulteration of food, promote desirable knowledge and practice of nutritive articles of food, make supply of clean and safe drinking water possible even for those living in rural areas and to take other such steps as will improve environmental hygiene.

School health services.—Before 1962, school health services in the district were practically non-existent. An urban school health clinic was started at Narnaul in 1962, on the recommendations of School Health Committee, constituted by the Government of India in 1960. A Medical Officer attended to this work.

School health services were re-organised in 1967 after the formation of Haryana. A post of District School Medical Officer was created in 1967. His job was to organise effective health services in both rural and urban areas of the district.

The school health services in the urban areas are provided by the District School Medical Officer while in the rural areas, this work is looked after by primary health centres. Under the School Health Services Programme, periodic examination of the students are arranged in the school itself. Cases requiring specialised treatment are referred to hospitals. The school teachers are also trained in first-aid for treatment of minor ailments of the school children on the spot. Special arrangements are made for giving immunization to the children against small-pox, B.C.G., diptheria, tetanus and whooping cough. Health education is imparted to school children regarding personal hygiene and environmental sanitation. The District School Medical Officer/Block Medical Officers/Public Health Nurse visit the schools from time to time.

The following table shows the work done under the School Health Programme since 1971 :—

Sr.No.	Type of work done	Year						
		1971	1972	1973	1974	1975	1976	1977
1.	Number of schools visited by District School Medical Officer/ Medical Officers	148	212	322	306	122	144	—

	1971	1972	1973	1974	1975	1976	1977
2. Number of children who attended school health clinics	2,607	2,696	5,279	7,985	13,890	1,299	849
3. Number of children given detailed physical examination	1,629	2,280	4,102	7,492	12,511	6,763	11,314
4. Number of children referred after medical check-up	63	402	188	127	57	—	—
5. Number of teachers trained in school health work	70	49	18	—	—	30	—

General Health Education.—The aim of health education programme is to provide integrated curative and preventive health services for betterment of the health of the people in general. Proper health education is the main pre-requisite for the success of all health programmes. The health education work is carried out by the medical and para-medical staff of the Health Department by holding group meetings.

At the block level, the Block Extension Educator under the guidance and supervision of Block Medical Officer and District Mass Education and Information Officer organises mass education work in the block. He is assisted in this work by the para-medical staff of the primary health centres.

For successful implementation of the health education programmes, three dimensional approaches, viz. the mass approach, the group approach and the individual approach are followed. To create awareness among the people in this regard, modern mass communication media are employed. These include film shows, dramas and cultural programmes. In addition to the above, *bhajan* parties, puppet shows and visual publicity through wall paintings, bus boards, cinema slides, banners, mass meetings and declamation contests, etc. are employed.

Family Welfare.—The Family Welfare Programme earlier known as Family Planning Programme is being implemented in the district to control population. During the first two Five-Year Plans, i.e. between 1951—61, the approach was essentially clinical. It was expected that people would come for family planning advice and services to the clinics opened under the programme. Although facilities for voluntary sterilization were introduced during the Second Five-Year Plan, yet stress was laid on the distribution of conventional contraceptives. An urban family planning clinic was set up at Civil Hospital, Narnaul, in 1961-62. Mass vasectomy camps were organised but the movement was not sufficient to arrest the unwanted population growth.

During the Third Five-Year Plan, the programme was placed on a war footing and clinical approach was replaced by extension approach. The (IUCD) device, popularly known as loop was introduced in 1965. The facilities for IUCD insertions and sterilizations were provided not only free but acceptors were given incentives. The mass education programme was also intensified. During the Fourth and Fifth Five-Year Plans the highest priority was given to the programme and it was made an integral part of health services in the state.

The family Welfare Programme in the district is looked after by the Chief Medical Officer who is assisted by a District Family Welfare Officer. At block level, rural family welfare units have been attached with all primary centres and these units comprise an Extension Educator, Family Planning Field Workers, Lady Health Visitor, Auxiliary Nurse Mid-wives and trained *dais*. At village level, family welfare services are provided by sub-centres, field workers and rural dispensaries. In 1976, multipurpose field workers scheme was introduced and all family welfare workers were converted into multi-purpose health workers and family welfare services henceforward were provided by these workers.

The family welfare practices include sterilizations of males and females, insertion of IUCD (intra-uterine contraceptive device) and other conventional contraceptives (condoms, diaphragm, jelly, foam tablets and oral pills). Oral pills are available at Civil Hospital, Narnaul whereas the other contraceptives are distributed through primary health centres, sub-centres, contraceptive depots and rural post offices.

Services under the Medical Termination of Pregnancy Act, 1971, are available in the district at civil hospitals at Narnaul, Rewari and Mahendragarh and primary health centre at Bawal. In 1978, there were 1,38,880 eligible couples but there were only 430 sterilization cases, and 2,454 IUCD cases and 14,267 used other conventional contraceptives. The success of the programme

depends on the way these couples and other couples adopt family welfare methods. User and non-user couples are visited by multi-purpose workers at regular intervals to educate and motivate them to adopt some method of family planning. Group meetings and other mass media approach are also adopted. Over the years, the family welfare programme has gained momentum. Although the message of spacing and limitation has reached every corner of the district, yet the problem of population explosion is still acute and requires constant efforts.

Maternity Services.—Many women lost their lives as a consequence of child-birth; many more who survived suffered from ill-health. It was a problem because people were conservative and illiterate. So the work pertaining to maternity and child health was taken up.

Maternity and child health services form an integral part of general health care in the district. The maternity and child health services have been integrated with family welfare services and these services are provided through primary health centres and sub-centres, maternity and child health centres, family planning clinics and civil hospitals.

The District Red Cross Society has been running two maternity and child health centres since 1957 in the Rewari tahsil. A lady health visitor and a trained *dai* have been provided in each of the maternity and child health centres for providing maternity and child health services. Besides, 5 *dai* centres at villages Khori, Mundi, Bhudpur, Rampura and Balaha Kalan have been opened by the District Red Cross Society. Trained *dais* are also available in Ayurvedic dispensaries, rural dispensaries and civil dispensaries. They provide midwifery service to the rural population.

Primary Health Centres.—These institutions are rendering a valuable service in the rural areas. The primary health centres at Nargal Chaudhry, Kanina, Ateli, Bawal, Khole, Gurawada were established between 1955 and 1959. The primary health centres at Shelong and Dochana were established during 1960 and 1963 respectively.

The main function of these centres is to provide both preventive and curative services to the people. These include treatment of outdoor and indoor patients, maternity and child health services, family welfare services, environmental sanitation, nutrition, school health services and immunization programme.

Prevention of food adulteration.—Adulteration in food stuffs is checked under the Prevention of Food Adulteration Act, 1954. Besides Food Inspector specially appointed under the provisions of the Act, the Chief Medical Officer, Deputy Chief Medical Officer (Health), all Senior Medical Officers, Medical Officers and tahsil Sanitary Inspectors have been invested with the powers of Food Inspector.

Nutrition

The Applied Nutrition Programme aided by UNICEF has been introduced in Ateli, Kanina and Mahendragarh blocks. Under this programme, powder milk, eggs, *gur*, groundnut, groundnut oil and fruit are distributed to the babies and pregnant women. The programme aims at educating people in taking a balanced and nutritive diet from amongst the available food items.

WATER SUPPLY

Water Supply (Rural).—Village ponds and percolation wells were the only sources of water supply in the past. The percolation wells were mostly located by the side of ponds. Since the rainfall was scanty, the continuous drought condition dried up ponds and wells. Thus the human beings and cattle were exposed to great hardship. In order to ameliorate the miserable plight of the people, the work under the National Water Supply and Sanitation Programme was taken up in 1954. By 1966 only 5 villages were covered, but the scheme progressed thereafter and by 1978, 181 villages of the district were covered under the programme and water supply was made available to many villages. As individual and domestic connections were not given in rural areas, public stand posts were provided at focal points.

Water Supply (Urban).—By 1978, all the 6 towns of the district were covered with piped water supply.

Sewerage.—There is no underground sewerage facilities in the rural area. Skeleton sewerage facilities existed in Rewari and Narnaul towns.