tables for the twenty years 1874–1894 printed in the Manual. While these high prices must add considerably to the wealth of the large farmers, their effect on the labouring classes, notwithstanding the increase in wages in recent years, and on the lower middle classes, must have been disastrous.

CHAPTER V.

PUBLIC HEALTH.

Climate and health.

Pages 79 *to* 109.—*For* these pages, *substitute* :—The climate of South Kanara, as well as of the West Coast generally, is characterised by excessive humidity during the greater part of the year, as the south-west monsoon lasts from June to October. Before the onset of the monsoon the air is sultry and oppressive and dense cloud masses accumulate and are driven inland before the strong westerly winds. There is some rain variable in amount, but usually light in April ; but the burst of the monsoon subsequent to which the rain falls in almost incessant torrents, rarely occurs before the last week of May. Throughout the following months—June, July and August—the rainfall is very heavy, but it abates during the remaining months ; occasionally there are breaks or comparatively rainless intervals, at which times the heated atmosphere becomes charged with the vapour arising from the saturated soil. Water stagnates everywhere producing conditions favourable to the production of Malaria. From November to February the climate is cool, the temperature in the shade ranging from 68° to 84°. At this period also strong easterly winds blow during the night and morning, the wind throughout the rest of the day being from the west or north-west. Towards March the heat begins sensibly to increase, the temperature ranging from 80° to 92°. The usual sea breeze blows during the day, but the nights are hot, still and oppressive. The climate of the west-coast has a relaxing and debilitating effect on Europeans, especially women and children, who become pale and anaemic after prolonged residence. This is due, not only to the depressing nature of the climate, but also to the inability to indulge in active exercise, as the humidity of the atmosphere quickly induces fatigue and lassitude, while free perspiration follows on comparatively slight exertion. Digestive and cutaneous disorders are the commonest forms of minor ailments, gradual deterioration of health being the rule and acute illness the exception. Those whose occupations are sedentary are more prone to ill-health, and on the other hand, persons of active habits and whose duties necessitate much travelling and out-door work generally preserve good health.

The Tulu-speaking natives of the district and the lower caste Christians are strong and robust, but the educated classes—Brahmans and higher caste Christians—who enter Government employ and fill the clerical posts in public offices, though often of good physique, lack vigour and strength and are rarely long-lived.

Public Health Administration.

Since April 1923 the administration of public health in rural areas is under the control of a district health officer who is assisted by eight health inspectors in charge of the whole or portions of a taluk and a large number of vaccinators. In the town of Mangalore, public health is under a municipal health officer from June 1925. Infantile vaccination has been compulsory in the district since 1918. There has been a steady progress in vaccination in recent years and the number of deaths from small-pox has considerably diminished. Table XXVIII at page 146 of this volume gives the total number of persons successfully vaccinated in the three years ending 1932–33 and the average number of successful vaccinations on children under one year during these three years.

Vital statistics.

In the rural tracts of South Kanara births and deaths are registered by village headmen, while in the municipal town of Mangalore, this task is performed by a special agency under the municipal health officer. Registration of births and deaths by village headmen in rural tracts is checked by the revenue authorities and the district health staff. During the four hot months of April to July, when the vaccination work is kept in abeyance, the registration of births and deaths is thoroughly checked by the health staff in many villages. These vital statistics though more reliable now than they were, are still far from what they should be, notwithstanding ample powers under legal enactments for securing efficient registration. The Public Health Department has still to contend with certain vagaries in the compilation of these statistics. Not only in the registration of births, but in regard to the classification of diseases that caused the deaths, very peculiar results are brought about. An ordinary village headman cannot, it is true, differentiate between various kinds of fever and will bring most of the deaths under the general term fever. The figures are no longer consolidated in the Collector's office as before, but the work has been taken up by the Director of Public Health. A large proportion of deaths and births continue to be unreported and the district health staffs in the province detected no less than 62,000 unregistered births and 70,000 unregistered deaths during the year 1930. Omissions from the record and the habit of village officers filling up their registers at the end of the month just before sending their return naturally diminish the value of statistics based on them. The statistics so far available can thus only be

regarded as approximate, and with an increasing tendency to accuracy ; and we can draw conclusions from them which may not be far from truth. After an exhaustive investigation, the true birth-rate has been fixed at 42·5 per mille per annum, and the true death-rate 30 per mille per annum. From Table VI at page 106, it can be seen that the birth-rate in the different taluks during the eight years ending 1933 varies from 31·99 in Mangalore taluk in 1933 to 49·08 in Udipi in that year, the earlier years showing a decidedly lower figure ranging from 33 to 40. The latter taluk shows the largest birth-rate, though during the years 1921–25, Coondapoor taluk held the first place with 40·2. The high figures in the more recent years in birth-rates, and the comparatively low figures in regard to deaths must be due to greater care in the compilation of the statistics. The death-rates ranged from 14·75 to 39·7, Kárkal taluk returning the highest rate (39·7) in 1926 and Mangalore taluk the lowest rate (14·75) in 1933. In the Mangalore municipality the mean birth and death-rates for the eight years ending 1933 were 34·9 and 19·5. Registration of births and deaths is compulsory in the municipality and in the villages and areas which have been notified by Government.

Registration is best done in the case of Hindus who had for the five years 1921–25 a mean birth-rate of 37·3 per mille and a death-rate of 23·5 per mille. For Mussalmans, the rates are 37·2 and 19·6. In the case of Christians, the registration of births is very good as is evidenced by the mean birth-rate of 39·3 for the same period, while the death-rate for this community is only 16·8 per mille.

Birth-rate.

The birth-rate showed a small decline in 1918 and a violent drop in 1919. Since that year, the birth-rate has been gradually increasing to 40·3 per mille in 1924. In 1925, there was a violent drop again to 32·9 per mille, which is probably due to the high prices of foodstuffs as a result of the district being successively visited with two disastrous floods during 1923 and 1924, which caused widespread havoc. From 1925 the birth-rate gradually increased till 1931 when the rate was 43·3 per mille. There was then a gradual decline year after year and the rate in 1934 was 37·4. The undermentioned table gives the yearly birth-rate among the three important communities and the district as a whole from 1927 to 1934 :—

Year.	Hindus.	Muhammadans.	Christians.	Total.
1927	36·1	43·3	39·0	37·5
1928	38·4	43·6	44·0	37·0
1929	40·4	45·9	43·0	39·4
1930	46·0	48·5	48·3	42·06
1931	42·5	48·1	44·9	43·3
1932	39·4	37·4	39·3	39·61
1933	38·3	38·9	38·5	38·4
1934	37·3	37·9	39·3	37·41

Births as usual in several other districts are most numerous from March to June, while their number is smallest during October and November. There are on an average 104 boys born to every 100 girls.

Death-rate.

In the ten years 1916–25, the death-rate varied from 21·2 per mille in the first year of the series to 35·1 and 34·3 in 1918 and 1919. There was a violent drop in the death-rate in 1920 and 1921 when it was only 20·0 and 19·1, respectively. Since that year, it has been gradually increasing till 1925, when the death-rate was 27·0 per mille. The high rates in 1918 and 1919 are due to the pandemic of influenza and the epidemics of cholera and small-pox which visited the district during these years. The gradual increase in the years 1921–25 is due to better registration as a result of introduction of the district health scheme. The rate of mortality is lowest in March, April and May and highest in July, December and January. Nearly 26·2 per cent of the total number of deaths occur among infants under one year of age, but high as this proportion is, there can be no doubt that many of the deaths of infants escape registration, for the registered deaths for the last five years give an infant mortality of 193·4 per mille, while the actual rate is much more. The death-rates during the years 1927 to 1934 were 27·5, 28·2, 24·1, 22·1, 21·0, 20·2, 24·6 and 21.

Causes of death.

The marginal statement based on the Vital Statistics for the five years 1921–25 and for the eight years 1927-34 shows the principal causes of death. The returns on which it is based are unfortunately defective, for 45 per cent of the deaths are shown under the indefinite heading of "all other causes." Of the specified diseases, "fevers" is the most fatal. Next in frequency come bowel affections, then diseases of the respiratory organs, rheumatism and skin diseases, specially ring-worm and itch. Venereal diseases are rife specially in the more populous towns and villages, the town of Udipi enjoying an unenviable pre-eminence in this respect, but the same fact is noticeable wherever there are temples attracting numbers of people to their annua *jatras*. Intestinal worms (the *Ascaris lumbricoides* being the commonest form) infest individuals of all ages, while hookworm attacks nearly 90 to 95 per cent of the population. The deaths

Causes of death.	Average number of deaths.		Percentage in 1927—1934.
	1921—25.	1927—34.	
Cholera	40	86	·29
Small-pox	472	127	·43
Plague	26	1	·01
Fevers	10,378	10,365	35·58
Dysentery ... ... Diarrhoea	2,585	2,548	8·75
Respiratory diseases.	1,488	2,048	7·03
Suicide ... ... Wounds and accidents.	354	453	1·55
All other causes ...	12,843	13,501	46·34
Total ...	28,186	29,129	100·00

from suicide are 60 per million; in England and Wales the rate is about 80 per million. In that country the tendency to suicide is much greater among males than among females, and the same feature is observed in South Kanara, although in most other districts of the Presidency the reverse is the case.

Malarial and other fevers.

Malarious fevers besides constituting the commonest form of disease, also contribute most largely to mortality and suffering. They occur at all periods, but are exceptionally prevalent at certain seasons and in certain localities. The forest-clothed country stretching away from the foot of the ghats is naturally the most unhealthy and there the most and worst virulent fevers prevail. The population in the most unhealthy parts is either stationary or diminishing and many adults and children are permanently enfeebled by the sequelae of such fevers, e.g., anaemia, dropsy, enlarged spleen. Several fertile localities have been abandoned both from their unhealthiness and from the decrease of population by deaths and the departure of survivors. The diversion of a large labour supply to the neighbouring coffee planting taluks of Mysore and Coorg, may, however, account to some extent for the reduced area under cultivation observed in particular places. The portion of the district bordering on the coast is comparatively healthy, the lowlands being highly cultivated, while the uplands are dry, arid and free from jungle, conditions adverse to the development of malaria. Some of the low-lying hill-enclosed village sites in this area are, however, hardly less unhealthy than more inland parts as from their situation, their drainage is defective and the level of the ground water in them is necessarily high.

The unhealthy season commences prior to the onset and during the early portion of the south-west monsoon. With the rains which fall in April and which are sometimes heavy near the ghats, the number of fever cases and the resultant mortality gradually increase as then there is generally increased stagnation of water, condition favourable to the breeding of mosquitoes. The six months, from October to March are generally healthier than the other half of the year, but in January the fever mortality is usually higher than either the preceding or subsequent month. In the town of Mangalore and in some of the important towns of the district many cases of enteric fever, with a high death-rate occur during this season, the incidence of the disease being chiefly limited to low badly drained parts of the towns with a contaminated water-supply. Bowel complaints come next in order of frequency and fatality to fevers, the mortality from them being about one-fourth of that from the latter. The high mortality from these diseases is chiefly due to the extremely unsatisfactory condition of water-supply in the district which is mainly

derived from shallow wells or ponds which are liable to be contaminated by surface drainage.

Cholera.

South Kanara suffers less than any other district in the Madras Presidency from cholera in an epidemic form; indeed few parts of India enjoy such immunity from the ravages of this disease. Local conditions and modes of living are adverse to the spread of cholera, as almost all villages consist of comparatively few houses relatively to the area over which they are dispersed, and hence are without a common source of water-supply from the specific contamination of which the disease could be propagated. When, therefore, cholera makes its appearance in a village, it is not infrequently limited to the inmates of the infected house, or to those dwelling in the immediate vicinity, or to persons who have visited affected individuals, while those residing at some distance, protected by their isolation, as well as by the possession of a separate water-supply, escape.

Influenza of 1918.

Influenza which prevailed in India in 1918 was prevalent throughout the district in the years 1918 and 1919 and the increased rate of mortality in these years can be directly traced to this as well as to the epidemics of cholera and small-pox which visited the district during these years.

Small-pox.

Small-pox, relatively to the population, is comparatively low in incidence and mortality in this district. It caused 7,277 deaths in the ten years 1916–1925, an average of 0·6 per mille per annum but the death rate from this cause for the years 1924 and 1925 was only 0·5 and 0·2 per mille respectively. The appearance of this disease in any locality can be generally traced to the arrival of an infected individual from Mysore or Coorg. Its failure to spread extensively is due to the better vaccinal state of the people owing to the fact that infantile vaccination is compulsory in the district since 1918, and to the mode of life adopted in rural parts.

Plague.

Plague first broke out in Mangalore in 1902, when it was imported from Bombay. In about six months of that year 836 deaths occurred in the town. Since then it continued more or less severe till 1918 when there were 94 deaths in Mangalore town. Finally about 1926 the disease completely disappeared from Mangalore. It spread, however, only rarely to other parts of the district. This is due to the fact that the extension of plague epidemics is generally due to the movements of grain from an infected area to a non-infected area. Grain is generally imported to Mangalore from other parts of the district, and not *vice versa*. Even in the town of Mangalore it must be said that the disease, though it existed almost every year from 1902 to 1927 seldom caused such havoc as in other plague infected towns in the Presidency. This is due to

the almost universal custom prevalent among the inhabitants of Mangalore, in common with natives of other parts of the district, of periodically exposing to the sun's rays the bedding, clothing and general contents of houses. This measure not only disturbs the rats but also kills the rat fleas which are the important 'carrier' agents in the development and perpetuation of plague epidemics. It is just possible that plague-carrying fleas that were introduced in 1902 and which multiplied rapidly decreased and ultimately died out in 1927. Experiments to find out why the rats in Mangalore town are immune have been carried out in Parel and the results are awaited.

Other diseases.

The infective diseases of infancy and childhood—measles, chicken-pox and whooping cough—make their appearance frequently in Mangalore and the larger villages. Two other diseases may be particularly referred to under the category of rare diseases—leprosy and elephantiasis. The latter disease is infrequently met with and is chiefly confined to the dwellers of the coast. Lepers are generally met with near the coast, less often in the interior. There is one leper asylum in the town of Mangalore maintained by the Jesuits. There are on the average 40 to 50 lepers as inmates of this institution and amongst them may be witnessed subjects in every stage of the disease. Most of the lepers gave a history of leprosy having existed in their families, a circumstance which confirms the views entertained regarding the contagious nature of the disease; a similar belief is also held by the inhabitants of the district. Among rare diseases, the almost entire absence of stone in the bladder, so common in some parts of India, is noteworthy. Cases of guinea-worm are already met with. Tuberculosis is on the increase. The heavy rainfall and humidity favour its growth, and coupled with the present economic depression, early marriages, congestion in towns and increased motor traffic, there has been a noticeably rapid expansion of this disease in the more populous areas of this district.

Village hygiene.

Of the three essential desiderata of village hygiene, viz., provision of pure drinking water, drainage and a simple conservancy system, attention to the first alone is mainly called for in South Kanara (outside the few large towns). The fact that dwelling houses are scattered about necessarily mitigates or prevents the evils inseparable from the neglect of drainage and conservancy in the more compact and populous villages of other districts. Most houses have one or two wells on the premises, but in regard to the poorer class the absence of good wells sunk to a sufficient depth and protected against pollution by surface drainage induces them to obtain water from shallow wells or pits which dry up in the hot season or from ponds or streams which irrigate paddy fields and must therefore contain much organic matter suspended and in solution and must also

be full of micro-organisms. The continued use of such water must give rise to enteric fever and bowel complaints. There is thus a great necessity for providing good public wells in all the large villages for the use of the poorer classes. The vaccinators attend to the systematic vaccination of all infants in their areas and the health inspector checks the results and in the case of any large festivals in the district, the district health staff make proper arrangements for the sanitation of the villages and the health of the crowds by providing good drinking water, latrines, airy sheds for their accommodation and even inoculating them against cholera. The important festivals and fairs are the *Pariyáya* (once in two years) at Udipi, the cattle fair at Kulgunda, the Shashti at Subramanya and the Lakshadípam at Dharmasthala. In these and in other but less important festivals in other places also elaborate precautions are taken by the health staff and the local temples or mutts. They thus prevent the outbreaks of any epidemic in the localities themselves and also the spreading of the infection into the surrounding country.

Infirmities.

At each census information is collected as to the number of persons afflicted with insanity, congenital deaf-mutism, blindness and leprosy. The returns are most probably incomplete, but they are useful for comparison of one enumeration with another and of one locality with another. An abstract is given below :—

Infirmity.	Persons afflicted in 1911.	1921.	1931.
Insanity	215	189	389
Deaf-mutism ...	608	168	880
Blindness ...	947	976	1,213
Leprosy	534	371	710

These figures can only be regarded as approximate. They depend upon the capacity of the individual enumerators to observe the people and to classify them correctly ; besides there are also cases of intentional concealment which it is difficult, even for the most efficient census official, to detect. There is not probably so much difficulty in computing the number of people suffering from blindness or deaf-mutism. These people are easily detected and there is no motive to conceal these defects. But in regard to insanity and leprosy the matter is different. No one will be willing to admit he is a leper ; it is a shameful disease and there is a great tendency to suppress the fact. Besides in its earlier stages it is impossible for a layman to detect leprosy. A census enumerator cannot differentiate between various manifestations of mental aberration and the value of their returns is obviously open to question. The figures of 1931 show a large increase over those of the

previous censuses. While the population as a whole increased in this district by 10 per cent over that of 1921, the persons suffering from these four infirmities increased by 205, 524, 124 and 190 per cent respectively. These increases are impressive, but the figures themselves are small and below one thousand in three cases and the proportions are therefore naturally high. With reference to the total population it is seen that in a million of the population these were as follows :—

Infirmity.	1911.	1921.	1931.
Insane	171	152	283
Deaf-mutes ...	508	134	641
Blind	792	782	884
Lepers	446	367	517

The above statement shows that there has been an increase in the infirmity ratio in regard to all these four cases, and that except in the case of blindness (where it does not show great divergence from the ratios in 1911 and 1921), there has been a considerable increase in the case of the other three ailments. Much of this must be attributed to better enumeration and to a weakening of a desire for concealment. The existence of special institutions for the treatment of these diseases and the inclination of the relations of the sufferers to transfer their burden to a leper or lunatic asylum or to the institution for the deaf and dumb people account for the rise recorded at each succeeding census. There were in 1931, 11 Leper asylums, three mental hospitals and 3 blind schools in the Presidency of which one of the first was in Mangalore town and one of the second was in the neighbouring district of Malabar at Calicut.

Insanity and deaf-mutism.

It would appear from an examination of the census figures of the last five censuses that the frequency of blindness grows with age and that its incidence advances steadily with the age-periods. In the case of the others it appears that after a certain age the infirm die off more quickly than the ordinary population. In the case of insanity, the infirmity appears at certain turning points in the person's life, and it is highest in case of males at the age-period 30 to 40, after which there is a sudden drop indicating that they die off after that period. But for women there is a similar appearance at a later age period and they do not die off so abruptly (as the men do) after that period. There are fewer deaf-mutes in South Kanara than in most other districts and the figures indicate that it is congenital and it appears equally in both sexes. Most deaf-mutes are also afflicted with lunacy.

Blindness.

In regard to blindness, the district is again less afflicted than many others. As in most districts, it is more common among

women than among men; and the figures in 1931 were 643 and 570. This excess of women blind is not found in all age-periods, for up to the 35th year there are more blind men than blind women, and there are more blind women in the later age-periods. Women live longer than men and old women being more numerous make a greater contribution to blindness than old men. The reason for greater infection among women is that they spend most of their time in smoky, ill-lit and ill-ventilated houses, especially after they are married and settle down to family life. The less incidence of blindness in South Kanara may perhaps be attributed to its greener and shadier lands free from dust and to its pleasant downs and valleys. The proportion of blind children gets less with each succeeding census which is a welcome feature. Blindness due to cataract comes on with advancing years and is curable, but the chief tragedy lies in the case of blindness among infants due to parental folly and neglect and to improper food and housing. The disease of the parents appears as blindness in their children and if all parents ensured their soundness before begetting children, blindness due to syphillis would disappear. Blindness from small-pox is again due to the parents neglecting to get the child vaccinated at the proper time. In several cases infantile blindness is due to violent irritants like chewed red pepper, tobacco juice, red-hot coals or strong alum solution being put into the children's eyes to rouse it or to cure some ailment.

Leprosy.

Leprosy is the most important of the four maladies and many lepers deformed or with loathsome ulcers are still seen by the road-side in towns or at festivals. Several of these cases are, notwithstanding their hideousness, "burnt out" and so are not really contagious, "the fire in them having burnt out and left no spark to set others afire." The lepers as a class are shunned by their own relations and the community and being unable to work and earn their living are objects of pity and charity and go about begging. Leprosy and tuberculosis are products of semi-civilization and slow in their onset and course and they leave their victims, if alive, with some tissues always damaged. These do not attack people living a simple life in the country or the more educated and prosperous classes, but get their victims from among coolies and factory hands who have given up their original simple habits in favour of more advanced life but have not adapted themselves to the latter mode of living. There is now a raging campaign against leprosy and for the starting of leprosy clinics in many of our hospitals. Though no final cure has yet been discovered, it has been found possible, if treatment is available at or almost near the inception of the disease, to avert its advance and the person made less infectious. There is great necessity therefore in inducing the sufferers at the earliest stage to declare their condition,

have their cases properly diagnosed and to go for treatment. The fear of segregation induces many an individual to conceal his real condition until the poison had worked its mischief so that we get only very bad cases in our hospitals. The situation has since changed for the better. The "burnt out" cases need no more treatment, but what is wanted is that more patients in whom the disease has just appeared should be made to realize its gravity and to undergo the treatment. Several medical men have been trained to treat cases of leprosy (as a result of the campaign against leprosy in this Presidency) and several district and taluk hospitals are now undertaking the treatment of such cases. The hospitals at Mangalore and at the taluk headquarters have leprosy clinics and the Leper Home at the headquarters of the district in charge of the Jesuit missionaries has been doing excellent amelioratory work for a number of years for this class of sufferers. There are more males than females among the victims, due chiefly to greater opportunity for outside contacts and infection in the former.

Leprosy clinics are now being run under the control of the District Leprosy Council at the following ten centres—Coondapoor, Udipi, Shirva, Kaup, Bantvál, Puttúr, Kásaragód, Mulki, Kankanády and the headquarters hospital at Mangalore. Two more centres are being started at Vittal and Kóta. The District Leprosy Council proposes to appoint a full-time medical officer trained in leprosy work for the heavily infected area around Shirva.

Hospitals and dispensaries.

There are ten hospitals and nine dispensaries in the district of which the two hospitals in Mangalore town, the dispensary at Amindivi islands (1876)[1] and the four taluk headquarter hospitals at Coondapoor (1873), Udipi (1872), Puttúr (1872) and Kásaragod (1873), are entirely maintained by Government. The first two hospitals were taken over by Government from the Mangalore municipality on 1st April 1919 and the last four taluk headquarter hospitals from the taluk boards on 1st May 1928. All these four are in charge of civil assistant surgeons. Of the remaining medical institutions, one is the taluk headquarter hospital at Kárkal (1879) and is in charge of a civil assistant surgeon whose pay is entirely borne by Government the other expenditure being met by the district board. The hospitals at Bantvál (1879), Mulki (1887) and Beltangadi (1887), the eight dispensaries at Baindúr (1888), Manjéshwar (1892), Hosdrug (1892), Mudbidri (1887), Sullia (1887), Kadaba, Bárkur and Shírva are purely local fund institutions maintained by local boards and are in charge of medical officers of the grade of sub-assistant surgeons. The hospitals are all provided with

[1] The figures noted in brackets indicate the years in which the medical institutions were opened.

accommodation for in-patients and emergency wards are also available for urgent cases at all the local fund dispensaries except at Kadaba, Bárkur and Shirva. In addition to these medical institutions, nineteen rural dispensaries are in charge of private medical practitioners of at least L.M.P. grade who are subsidized by the district board and Government with a view to bringing medical relief within easy reach of the rural population. These dispensaries are situated at Shankaranáráyana, Wándse, Adúr, Hebri, Nárávi, Punjalkatta, Vittal, Gangolli, Malpe, Kota, Kunjal, Kaup, Kokkarne, Karnad, Uppinangadi and Mundáje. The principal diseases treated in these institutions are malaria, rheumatic fever, influenza, round worms, ankylostomiasis, disease of the skin, eye, respirative system, intestines, ulcers and digestive system, besides injuries and almost all sorts of surgical diseases.

Government Hospital, Mangalore.

The Government hospital at Mangalore was the earliest to be established in the district and the following brief account of its history may be of interest. Opened by Government in 1848 in pursuance of orders passed by the Hon'ble Court of Directors on a memorial submitted by the inhabitants, it supplied a really much-felt want at the time. It was located in a rented building, the rent being Rs. 14 per mensem and contained an establishment of servants whose bill came to Rs. 45 a month, and the allowance for the medical officer was Rs. 50. The hospital became increasingly popular and the establishment had to be increased and a separate building was also constructed for the hospital in 1851. In 1852, the Government appointed a native surgeon on a salary of Rs. 100 to aid the surgeon in his duties. In 1863, the towns-people who appear to have taken great interest in the maintenance and improvement of the institution resolved at a meeting convened for the purpose to relieve Government of a portion of the cost of its up-keep by raising annual subscriptions towards its support. This step met with the approval of Government who ordered that effect should be given to it and accordingly withdrew the allowance hitherto given for the food, clothing and attendance on the sick poor treated in the hospital. Until its transfer to its present place the hospital was located in the premises now used by the women and children's hospital. In 1871, the hospital was transferred to the care of the municipality under Act III of 1871 and since that date it was exclusively maintained from municipal funds until Government took it over (as it did all district headquarter hospitals about that time) in April 1919 under their own management. The hospital (since called after Lord Wenlock) is in charge of a Superintendent generally of the Madras Medical Service cadre who is also the District Medical Officer for South Kanara. The building (the old regimental hospital) notwithstanding the subsequent additions

and improvements to it looks no doubt antiquated but it is fairly well-equipped and is one of the few centres where nurse pupils are trained. Besides the Superintendent, there are now an assistant surgeon, three sub-assistant surgeons and an up-to-date nursery staff with the requisite menial staff.

To meet the needs of numerous patients seeking admission to the hospital, accommodation had to be found by the additions of subsidiary semi-permanent new buildings and by the improvements to the existing buildings, thus increasing the sanctioned number of beds from 68 to 100, though actually on an average, 115 in-patients are treated daily. The Police hospital which was a separate institution has been amalgamated with this and a new ward of ten beds was added from 1st April 1925. A skin clinic has also been opened from 1st November 1926. There is no separate infectious disease hospital nor is there any suitable accommodation to be had at the headquarter hospital for treating infectious diseases. Since April 1926 the municipality is maintaining temporary buildings for the accommodation of patients suffering from small-pox, plague, chicken-pox, etc., and the patients are looked after by the municipal health officer. Plans and estimates for the construction of an up-to-date hospital at Mangalore have been approved by the Government but the actual construction is held up for want of funds.

The Government hospital for women and children at Mangalore is in charge of a lady assistant surgeon assisted by a lady sub-assistant surgeon. In this hospital midwives and *dhais* are also trained. Trained and diplomed midwives are entertained at all the 19 medical institutions and also at some of the important villages like Kumbla, Niléshwar, Pallikere, Uppinangadi, Vittal, Bájpe, Ullal, Surathkal, Gangolly, Shankaranáráyana. Kóta, Kunjal, Kaup, Malpe, Punjalkatta and Gurpúr.

Private medical institutions.

There are two important private hospitals in the district which have been extremely popular. One of these is at Mangalore and is maintained by the Jesuit mission and is known as Father Muller's Charitable Institutions. In 1895 the Bishop of Mangalore agreed to Fr. Muller's proposal to open a small hospital for the relief of poor Catholics in Mangalore town and its suburbs. A hospital consisting of two large wards and a chapel was erected, the funds being provided by contributions raised in Mangalore town and a donation from Count Caesar Mattai of Bologna. The names of the donors have been engraved on a marble slab on the wall of the visitors' room in the hospital where also is exhibited the effigy of His Holiness Pope Pius X and his autograph message blessing Father Muller and his institutions. There are two sections in the hospital, one for men (known as St. Mary's hospital) and another for women (the Sacred Hearts hospital), with 50 beds in each open

only to Roman Catholics, people of other castes being admitted free to the out-patients department and treated. There is also a leper asylum among these institutions and it is aided by Government. In the chapels attached to each section are the paintings by Brother Moscheni, S.J., whose artistic work in the St. Aloysius College chapel is an object of attraction to all visitors to Mangalore. The cost of the original building was Rs. 10,000 out of which Rs. 7,700 was met by contributions from the people of Mangalore. Additions were made to the buildings later at a cost of Rs. 12,000, part of which was realized from contributions from all over India. Medical as well as surgical cases are admitted in the hospital. The staff receive no payment for their services and it is due to this gratuitous co-operation that the hospital is maintained at a comparatively low cost. The Homœopathic Poor Dispensary (also known as St. Joachim's dispensary) was also opened by Father Muller in 1880. It started with a single chest of homœpathic medicines which Father Muller brought with him from Paris. With this small supply he treated the students of the St. Aloysius' College and the poor people who applied to him. The demand for medicines increasing, a small dispensary was built on the premises of the college and medicines were sold to the public at reasonable prices. The dispensary has since grown up and its buildings at Kankanádi near the Jeppo Main Road were built in 1891. Additions were made to the original building in 1905 and 1906. The object of this dispensary is to supply homœpathic medicines to the public in India at low rates. Father Muller died in 1910, but the institution has been continued by the Jesuit mission and supplies medicines to patients all over India, Ceylon and Burma who correspond with the dispensary by post and get their advice gratis and pay for the medicines, the poor being supplied with medicines free of charge and the profits being used for the maintenance of the mission's medical institutions and the poor. The staff consists of a number of clerks who are mostly engaged in correspondence work, and several carpenters making chests for the despatch of medicines. An idea of the great demand for homœopathic medicines from this dispensary may be had from the fact that in the year 1913, 23,148 parcels were despatched and that the Kankanádi Post Office was largely occupied with the work of the dispensary. The postage spent in that year amounted to Rs. 11,755. From 1911 to 1st October 1914, a customs duty of Rs. 35,374 was paid on medicines imported from Europe and America (or an average of Rs. 11,000 a year). In 1934 nearly 20,000 parcels of medicines and 3,600 prescriptions were sent by post to patients outside Mangalore and principally distributed all over India and Ceylon.