

APPENDIX B.

CARE AND AFTER CARE OF THE MAORI TUBERCULOUS.

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PLANNING A SCHEME.

The Maori race in New Zealand have equal status with the Whites. The Maori tuberculous have theoretically equal privileges in diagnosis and treatment. Medical practitioners are available to all but the most remote; public hospitals are open for diagnosis, classification, and treatment; and sanatoria are ready to care for the early case or train the chronic advanced tuberculous, when such are referred to them through the public-hospital system. In addition, and a privilege peculiar to the Maori, the Health Department employs district nurses to Natives, with duties both curative and preventive, who seek out the Maori sick, endeavouring in the tuberculous to persuade the Natives towards correct diagnosis, institutional care, and treatment. Theoretically, then, there appears little excuse for wide discrepancies in care statistics, as between Maori and Pakeha.

The writer, in 1933, carried out a thorough survey of a typical Maori county population to determine the true position. Maori morbidity-rate from tuberculosis, all forms, was 56·8 per 1,000. The mortality for all forms was severe, 49·4 per 10,000, as compared with 4·5 per 10,000 in Europeans. There was a widespread failure to seek aid, although the facilities described above were adequate and available. Of the tuberculous, only 26·9 per cent. obtained hospital treatment, 2·6 per cent. sanatorium treatment, 9·5 per cent. domiciliary treatment by medical practitioners, while 60·8 per cent. had no institutional or practitioner's treatment whatsoever. It became immediately obvious that the facilities as provided for the European tuberculous were in practice being neglected by the Maori.

This led to a search for underlying causes. General educational standards and attainments were inferior to European ones, and particularly health education. Perception of the real cause and means of spread of tuberculosis was lacking. Pulmonary tuberculosis was called the wasting sickness, the argument commonly presented that it was sent as an affliction from heaven, and European attempts at prevention therefore useless. Alternately, it was recognized as "running in families," and strongly regarded as hereditary in origin. The services of a medical practitioner or district nurse were not sought in a large number of cases. In the minority who had attained hospital treatment there was rarely the disposition to remain a sufficient time in the institution. The place was strange, the staff of another race speaking a language unintelligible to the older patients, and the urge was always to get away home where their wants would be readily understood, and where friends could come and go as they pleased. The few who succeeded in reaching sanatoria rarely did well. As these institutions were usually hundreds of miles away from the home county there was no possibility of relatives visiting, and among a European nursing staff, with every wish to further their recovery, they usually wilted and went downhill. The psychological emerged as a weighty factor in explaining non-utilization of institutional facilities. Poverty accounted for some holding back; rather than receive unpayable accounts afterwards, they stayed at home, some of the Maori people having a fierce pride and independence.

In the field work it was definitely proven that the bovine form was a negligible factor in the incidence of Maori tuberculosis. The infection was human. Ready spread was achieved through contact, rendered easy by overcrowding in defective houses, by faulty hygiene in the home, and by malnutrition. Poverty was not always to blame by the faulty environment, though playing a potent part; often lack of desire for betterment maintained conditions facilitating spread of infection from person to person.

The accurate knowledge gained from the survey enabled the planning of care and follow-up work suited to the peculiar needs of these people. Any proposed scheme should have educational value, be psychologically suited to the Natives, should break the chain of contact infection, and help ameliorate faulty environmental conditions. Such a scheme should be limited to small proportions until proved successful, and be possible of extension rapidly to cover all Maoris when this end was achieved. A care and after-care scheme was begun at the conclusion of the survey, and in the same county, covering about 4,000 Maori population. After three years' trial, it has proved sufficiently successful to recommend for adoption for Maoris throughout New Zealand.

SCHEME IN OPERATION.

At the end of the field survey there were 115 Maori cases of tuberculosis in the county. It was impossible to hospitalize these, the county hospital having only thirty beds for all purposes. A district nurse was detailed for the special work of a tuberculous visitor, herself a Maori, and the 115 cases came under her care. None of the cases were early in type. Follow-up work was undertaken along these lines:—

1. Regular Visitation of the Cases:—

(a) To oversee the domiciliary treatment of the case, always keeping in view the hope of a clinical cure. Rest in bed for long periods until the sputum was negative at repeated tests was aimed at. Periodic X-ray check of progress was arranged at the county hospital, whenever it was possible to transport the case. This base hospital admitted those cases suitable for special care or treatments—*e.g.*, artificial pneumothorax, and those few cases where it proved impossible to arrange rest at home, or continuous proper feeding and care. On the field the nurse supplied necessary drugs and medicines, and taught the proper nursing care of the tuberculous case. She arranged through the base hospital the supply, in cases of poverty, of extra food, of extra blankets and clothes.

(b) To teach the patient and other members of the household how infection was spread. Sputum flasks were provided; the proper use and care of these, and correct sputum disposal was taught. The patient was encouraged to reduce handling, kissing, or touching others, especially children, while the other household members were taught how to protect themselves—*e.g.*, to wash hands immediately after touching the patient, or anything belonging to the sick person.