

INFECTIOUS AND OTHER DISEASES.

(Exclusive of Maori, unless otherwise stated.)

The total number of notifiable diseases reported in 1936 was 3,652, compared with 3,349 cases in the preceding year.

Scarlet Fever.—This disease was of comparatively low incidence, but shows a rising tendency; 1,152 cases and 8 deaths were reported, as against 863 cases and 8 deaths in 1935.

Diphtheria.—Five hundred and thirteen cases of diphtheria were notified, as compared with 747 in 1935. Twenty deaths were recorded, giving a death-rate of 0·13 per 10,000, as compared with 33 deaths and a rate of 0·22 in 1935.

Dr. Maclean, Medical Officer of Health, Wellington, has given the following account of an institutional outbreak with some unusual features:—

“Some 20 cases occurred in an outbreak involving the Wanganui Hospital and the Karitane Hospital, Wanganui.

“The usual custom at the general hospital was to swab *all* children admitted to hospital to detect possible carriers of diphtheria. For some reason a baby was overlooked in this connection, and proved to have a diphtheritic condition of the skin of the face. During this child's stay in the ward and before its infectious condition was discovered, a baby was admitted from the Karitane Hospital and discharged back to it. Five nurses and three babies at Karitane Hospital were subsequently infected, and in several cases the infection took the unusual form of an acute otitis media without throat symptoms. Fortunately all the patients recovered, but the work of the hospital was considerably upset, and the Matron herself was one of those affected.”

Active immunization with toxin anti-toxin or with ana-toxin, which has been in use in New Zealand for a number of years, constitutes a method of prophylaxis which can be adopted more widely with advantage. Dr. Turbott, when Medical Officer of Health, Gisborne, immunized a large proportion of children in the East Cape Health District. In his current report he writes:—

“In 1931 was begun a district campaign to keep the whole East Cape Health District free from epidemics of this disease by immunizing all children whose parents consent every five years. The whole district was covered in 1931.

“In 1936 the task of immunizing the new generation of school-children, and infants offering was begun by Dr. Heycock, and will be continued until the territory is again covered. Five hundred and thirty-seven children were immunized during the last school term.”

Dr. Turbott then goes on to state that in 1936 only 15 cases of diphtheria, representing a rate of 2·45 per 10,000 population, occurred in the East Cape Health District. He contrasts this with the rate of 4·78 per 10,000 which has been experienced by the South Auckland Health District. These areas are regarded as comparable, and the figures in Dr. Turbott's opinion show the benefits of immunization.

Enteric Fever.—Sixty-one cases were notified, with a death-rate of 0·05 per 10,000, as compared with 87 cases and a death-rate of 0·07 in 1935. Enteric fever, however, remains a special problem of the Maori. Dr. Turbott, Medical Officer of Health, Hamilton, writes as follows of the incidence of enteric fever amongst the Maoris in the South Auckland Health District:—

“The relative incidence on European and Maori in the district is readily appreciated from the figures: 12 European cases (1·02 per 10,000), 39 Maori cases (23·92 per 10,000). The deaths occur more easily in the Maoris, as in this district they are still very backward in seeking attention, and would rather hide typhoids than willingly call nursing or medical help. When found, therefore, cases are often in the second and third weeks of the illness, sometimes later, and are very seriously ill when taken or sent to hospital by the district nurse. The hospital is blamed for the death, and the vicious circle of hiding of cases encouraged. A series of contact cases in one valley was solely due to the hiding for three weeks of the first case. The district nurse visited the area, but the case was transported from one house to another so that she missed discovering it, and only the occurrence of further cases led a more enlightened Maori to report the matter.

“Another series of cases in Maoris was almost certainly due to defective sanitation. A group of communal-living Maoris, with no privies at all, and shallow waterholes that really received the seepage from the huts on higher level, had typhoid cases in each house in the group. All contacts were inoculated, tube privies built, and the water condemned unless boiled—the typhoid ceased, and this little community is now installing tanks, having become a little more sanitary conscious than formerly.

“The attack on the typhoid problem demands a combination of inoculation and sanitation campaigns. The former helps to shield the susceptible population while the slower sanitary improvements are sought. The latter are slow in eventuating. First the Maori has to be educated to want better housing and sanitation. When this is achieved, there is still the dead-weight economic factor to overcome. For landless Maoris of the ‘squatter’ type there seems little hope unless the Government will give direct financial help; in the case of combating typhoid fever, this means safe water-supplies and sound privies. The ‘squatter’ type of Maori has not the wherewithal for either of these needed improvements, nor can he get any one to trust him with advances of money, as he has no tangible assets.”

The same officer, reporting on enteric fever in the East Cape Health District, states:—

“Twenty-one Maori cases gave a rate of 10·91 per 10,000 Maoris, less than half the Maori incidence in the Waikato area (23·92 per 10,000). It could reasonably be assumed that the systematic and district-wide adoption of inoculative protective measures since 1928 has helped to put East Cape in this favourable position as regards this disease. In South Auckland antityphoid inoculations have been prosecuted only as cases arose until very recent years.”