The Midwife.

OBSTETRICS IN UGANDA.

The *British Medical Journal* publishes an interesting leading article on "Obstetrics in Uganda," in which it is stated that in the beginning of 1884 Dr. R. W. Felkin read before the Edinburgh Obstetrical Society a paper on labour in Central Africa, largely founded on his experience in Uganda, then a little known and even less considered part of the world; now, thirty years later, there exists an East Africa and Uganda Branch of the British Medical Association, and its first President, Dr. A. R. Cook, has taken as the theme of his presidential address at its annual meeting the subject of obstetric medicine in Uganda. Dr. Felkin described midwifery as practised by the natives themselves, and gave details of some wonderfully advanced obstetric surgery done by the men of Uganda. Dr. Cook tells of midwifery as practised by British doctors there, giving his own statistics, and enumerating the operations performed. Dr. Felkin had the greatest difficulty in gaining permission to see labour cases. To Dr. Cook the native women come now to the number of more than two hundred a year to be aided by him in their confinements; but this is only in recent times, and at first he had to be content with an annual list of six or eight obstetric engagements. Nothing could speak more eloquently of the change which has come to Uganda in these thirty years, and to the medical missionaries working under the Church Missionary Society (such as Dr. Felkin and Dr. Cook) no little share of the credit in bringing about the change is due.

In one respect Dr. Felkin and Dr. Cook are in complete agreement: both discovered that contracted pelves were far from uncommon among the Bantu people. Thirty years have done much to disabuse the medical mind of a belief in the invariably easy labours of the native and savage races of Africa, but even yet there is some scepticism regarding dystocia among primitive peoples. Dr. Cook's statistics of 329 forceps cases in a total of 2,232 labours clearly show that all confinements are not easy matters in Uganda; and when to these forceps cases are added 11 craniotomies, 5 cephalotripsies, 4 decapitations, 6 Caesarean sections, and an embryotomy, it is obvious that obstetrics has its strenuous side in Africa as at home. Dr. Cook is able to furnish average measurements not only of the fetal head, but also of the maternal pelvis, and these show that, whilst the baby's head in Uganda is somewhat smaller than in this country, the mother's pelvis is very distinctly so, both in its external and internal diameters. The pelvic contraction is not due to rickets, which is a rare disease in Uganda, but probably to the almost universal custom of making even young children carry heavy burdens on their heads; the sacrum is thus pressed downwards and forwards, and the brim narrowed antero-posteriorly.

A curious and unexpected result of the analysis of the statistics is the proportionate frequency of the four vertex positions of labour in Uganda. Out of each hundred cases of vertex presentation 44 were L.O.A., 44 were R.O.A., 7.1 were R.O.P., 2.7 were L.O.P., and the remainder (2.2 per cent.) were unclassified. In ordinary practice in this country the proportions, quoted by Dr. Cook, are 60.9, 22.3, 14.2, and 2.6. What the cause of this remarkable difference may be is by no means clear, and Dr. Cook leaves it dark.

Dr. Cook's brother (Dr. J. H. Cook) states that it has been calculated that 70 per cent. of the children in Uganda either die from premature birth or are stillborn, or die in the first week after birth; in other words, nearly three children die to each one that survives. Dr. Cook touches upon several other interesting obstetric matters; but enough has been said to show that neither in the ease of her confinements nor in the immunity of her pregnancies from venereal infection is the Baganda woman at present in advance of her European sisters.

Dr. Cook's experience is certainly borne out by that of other observers. The present writer was personally acquainted with two young African women who died in childbirth in East Africa, one because no skilled assistance was within reach at the up-country station where she lived, and, after many hours of fruitless labour, she died before delivery was effected. The other from eclampsia, on the third day after her confinement. The premonitory symptoms were slight, but the temperature rose rapidly to over 109° F., and the mother died before medical assistance arrived. The child lived for some years. The experience of doctors and midwives in India also, is that many cases are abnormal.

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