An outbreak of syphilis in a virgin soil : notes on syphilis in the Uganda Protectorate / by F.J. Lambkin.

AN OUTBREAK OF SYPHILIS IN A VIRGIN SOIL

NOTES ON SYPHILIS IN THE UGANDA PROTECTORATE

BY

F. J. LAMBKIN, Colonel R.A.M.C.

CHAPTER XXV

AN OUTBREAK OF SYPHILIS IN A VIRGIN SOIL

Of England's more recent Colonial acquisitions none is better known to the medical profession than the Protectorate of Uganda, as it has been made familiar to them as a part of the world which has been devastated by sleeping sickness. Unfortunate as this outbreak would have been at any time, it was doubly so at the precise time when it made its appearance. Before its advent another malady of an even more serious nature had begun to sap the life-blood of the tribes. Syphilis was very prevalent in the Protectorate, but the researches connected with sleeping sickness overshadowed all attention to the syphilitic outbreak, attracted to itself all interest, and set back all investigations with regard to syphilis in that part of the world. The consequence was that syphilitic disease gained a firm footing in the Protectorate, and, being left to itself, caused devastation everywhere among the inhabitants. Syphilis assumed such a serious aspect that the Governor, Mr. Hesketh Bell, C.M.G., applied to the Secretary of State for the Colonies for an inquiry to be made into the subject of syphilitic disease in Uganda by an expert from this country, who should consult with the medical staff of the Protectorate as to the best means of checking the ravages of the disease. For this purpose the author was selected, and proceeded to the colony. Before detailing his experiences a brief historical *résumé* may be of interest.

Historical Résumé

The kingdom of Uganda, which forms the nucleus of the Uganda Protectorate, was first brought to the notice of the world outside Africa by an expedition under the command of the cele-

brated explorers Speke and Grant, in the year 1862, who were endeavouring to discover the source of the Nile. Rumours of the existence of a powerful and semi-civilized African kingdom on the northern and western shores of the Victoria Nyanza had already been brought to Zanzibar by Arab traders, but the country was not even heard of by the Arabs of Zanzibar before 1852. Yet Uganda is an ancient kingdom of considerable stability, which has been ruled for several hundred years by a single dynasty, its reputed origin being hidden in a mixture of myth and tradition, and in all probability due to a conqueror from the North of that Hamitic race—the Bahima—which still forms the aristocracy of the western parts of the Protectorate.

The Bahima are certainly of Hamitic stock, and closely related in origin to the Somali, less closely to the Ancient Egyptian type. The Bahima at one time exercised widespread influence over the inner regions of East Central Africa.

In Uganda proper, though the Hamitic invaders probably founded the dynasty, they did not there remain to form the aristocracy as they do in Unyno Toro, and the countries to the west of Uganda. They encountered in Uganda proper a very vigorous race of mixed negro type, sufficiently sturdy to hold its own, but prone enough towards civilization to adopt the culture of the Hamitic race. This is the Baganda people.

Great power radiated from this kingdom of Uganda: the regular and abundant rainfall, the fertile soil, wealth of food, and banana plantations caused this country to become the seat of a relatively dense and powerful population, which imposed its rule over a large portion of the present area of the Uganda Protectorate.

Interest in the country was further excited by the visits of Stanley, in 1872. King Mutesa, the reigning monarch, had become interested in European civilization since the time he had met Speke and Grant, and was in search of a religion superior to the worship of the earth, water, and ancestral spirits; moreover, he was not satisfied with the tenets of Islam, which had begun to attract a portion of his people. Stanley, on his return, made a memorable

appeal to the missionaries of England to introduce Christianity at the court of Mutesa. The answer was immediate, and in 1876 the first British missionaries were on their way to Uganda. These were followed two or three years later by the emissaries of Cardinal Lavigerie, i. e. members of the mission of the White Fathers.

In 1884 King Mutesa died, and after his death Christianity, in its Roman and Anglican forms, and Mahomedanism made such rapid strides that soon comparatively few pagans were left in the kingdom of Uganda.

In 1894 a British Protectorate over the kingdom of Uganda was declared, and this was further extended in the course of a few years until it gradually came to comprise the five provinces now included within its limits, i.e. Central, Nile, Uganda, Western, and Rudolph.

The total area of the Protectorate is 130,000 square miles. The population is 3,000,000. The population of the kingdom of Uganda is about 1,000,000, 100,000 of whom are Christians.

For the purpose of administration, the natives, especially those speaking Bantu, are encouraged to govern themselves. For this purpose the kingdom of Uganda (16,000 square miles) is divided into twenty districts, each of which is placed under a chief appointed by the King of Uganda, subject of course to confirmation by the Imperial Government. These twenty chiefs are under the control of the king, who is assisted in his government by a Lukiko, or native parliament, elected on lines laid down by the British Government. Similar arrangements exist in the other provinces. Throughout, the king, or his chief, as the case may be, is encouraged to govern his people on humane principles, with only a sufficient amount of interference from the nearest European official to protect the native from injustice.

Climate. With perhaps the exception of the Nile and Rudolph Provinces, the climate of the Uganda Protectorate is not unhealthy, and as large portions of it are 4,000 feet above the sea-level, the heat is not excessive, even under the Equator, and it is very rare that it is disagreeably hot at any time of the year.

Parts of it, such as Toro and Ankole, have a climate resembling the month of June in England. The Protectorate, as a whole, has a healthy climate, although many parts of it are insalubrious owing to the presence of mosquitoes and malaria.

Products. It would be out of place to discuss in any detail the many products which this wonderfully fertile country can show. Suffice it to say that it needs no expert to see at a glance that almost anything in the way of vegetation flourishes. About one-fifth of the total area of the Protectorate is covered with rubber-producing trees and vines; gutta-percha is now extensively cultivated, cotton—introduced only a few years ago—is growing in the most wonderful way, as are also sugar, coffee, and cocoa; in fact, even the casual observer cannot help recognizing what a jewel England possesses in holding this land, and what a splendid future is before it if the native can but be saved from extermination by disease.

Inhabitants. The Baganda is the predominating tribe. They are a race of mixed negro type, sturdy in physique, extraordinarily intelligent, willing, hard-working, and on the whole honest. They are brave, and have fought well in their own wars, and for us; but what struck me more than anything was their intelligence, and, personally, I never expected the negro to attain to the level they show in this respect. Their eagerness to learn is also a marked feature. I cannot help here quoting the words of Sir Harry Johnston with reference to the Baganda :—

'In my opinion there is no race like them among the negro tribes of Africa. They are the Japanese of the Dark Continent, the most naturally civilized, charming, kindly, tactful, and courteous of black people.'

Diseases. (*a*) Malaria is prevalent along the coast at certain times in the year, especially during the wet season.

(*b*) Blackwater fever is, on the whole, rare.

(*c*) Spirillum fever has of late years made its appearance. It was apparently unknown until the introduction of the tick from the West Indies. It is conveyed by that insect. Of late years it has unfortunately become very prevalent, and is proving a real

curse, more especially to Europeans. It has also in many cases assumed a very virulent type, sometimes leaving behind it blindness and local paralysis. This spirillum fever is causing anxiety among the authorities, as they fear its extension.

The two diseases, however, which at present threaten to exterminate the whole population are :—

(*a*) Sleeping sickness, and

(*b*) Syphilis.

As regards the former, all that need be said here is that barely seven years ago it made its way from the Congo basin to Uganda, and in this short time it is estimated that 300,000 of the inhabitants have perished.

Syphilis in the Protectorate

If the opening of Africa from the west has been responsible for the introduction of sleeping sickness, the opening up from the east has introduced a still more appalling visitation in the shape of syphilis. In saying this I do not intend to maintain that the disease was unknown in the land prior to its invasion from the east, for there is evidence of its having been known there for many years, and it is supposed to have been originally introduced during the Arab invasion, more than sixty years ago, but it is certain that it existed only to a very small extent. About twelve years ago there was a more or less sudden outbreak of the disease among the Baganda tribe, and since that time it has gone on increasing both in frequency and in virulence, until at the present time more than half the population of the Protectorate is infected. In some districts, such as Ankole, 90 per cent. suffer from it. Infant mortality is as high as 50 to 60 per cent. owing to it, and it is the chief cause of the sterility which exists throughout the country. In fact, as things stand at present, owing to the presence of syphilis, the entire population stands a good chance of being exterminated in a very few years, or left a degenerate race fit for nothing.

In connexion with this sudden outbreak, the question arises

as to what was the cause of the outbreak, and investigation has convinced me that the causation has a twofold origin, viz. :—

1. The introduction of Christianity.

2. The abolition of the punishments formerly meted out among the tribes for all immoral offences committed by either sex.

With regard to the first cause, repugnant as it may seem to assert it, I fear it is none the less true that the introduction of Christianity, and the consequent abandonment of polygamy and the old restrictions on the liberty of the women, is probably the chief cause of the outbreak. This conclusion is based on the evidence, not only of members of the Church Missionary Society and the White Fathers, but also on that of some of the most intelligent of the native chiefs, who themselves are Christians.

The following are extracts taken from the summary of evidence of some of the principal witnesses :—

The Rev. J. Roscoe, C.M.S., Chief of the Theological College at Kampala, who has spent twenty-five years of his life in Uganda, states : ' The cause of the outbreak was, in my opinion, the following : Among the Baganda, up to about twelve years ago, a custom prevailed of keeping the women belonging to the tribe under strict confinement and surveillance ; in fact, so strictly was this adhered to, that they were more like prisoners than anything else —hence immorality and promiscuous intercourse did not exist. At, approximately, the time of the outbreak of syphilis, the chiefs of the Baganda tribe, the majority of whom had become Christians, decided to remove these restrictions, as being contrary to Christian teaching, and to set the women free. This was done, and from that time the women were released henceforth to roam where and whither they willed and do as they liked. Other Christian tribes followed the example of the Baganda, and even those who had not embraced Christianity followed their example, as they usually do in almost all affairs of life—the Baganda being the predominant tribe. The result of the removal of those restrictions was exactly what one would have expected, i.e. promiscuous sexual intercourse and immorality. I consider the above to have been the main

cause of the outbreak of syphilis among the tribes of the Protectorate.'

The Very Rev. Père Laane, Father Superior of the White Fathers, Entebbe, says: 'As to the cause which has led up to this outbreak, I believe it to have been the emancipation of the Baganda women from the restrictions in which they were formerly held.'

Sir Apolo Kagwa, K.C.M.G., the very enlightened native Prime Minister, remarks: 'The probable immediate cause of the outbreak was the emancipation of the Baganda women from the surveillance to which they had hitherto been subjected.'

The evidence of many others, as given in the summary of evidence, is strong proof that the abolition of polygamy had at least a very great deal to do with the outbreak of the disease.

As to the second cause, doubtless the custom which had previously existed among the tribes of administering punishment for immoral offences had a deterrent effect, and in this way acted as a safeguard. The abolition of these punishments encouraged the commission of these crimes, and lent itself to the propagation of the disease among the people.

With regard to the spread of the disease, with its consequent intensification, there can be little doubt as to the main cause. The country has been opened up from the east. This allowed of free ingress of the Indian and Swahili traders from the coast, who not only acted as mediums for the spread of syphilis in their wanderings throughout the country, but also introduced into the Protectorate many fresh diseases. The evidence on this point is unanimous.

Two other causes are alluded to as aiding the spread of syphilis. The first is, in my opinion, at least a 'doubtful' cause. It is said that the Bahima were to a great extent responsible for its dissemination. This tribe, otherwise known as the 'Cow tribe', are shepherds, and live a wandering or bedouin life. The Rev. J. Roscoe, C.M.S., who has made a special study of this people, says in his evidence: 'There is another medium through which I think syphilis has widely spread, viz. the presence in Uganda of a certain

number of the Bahima tribe (the cow people of Ankole), a migratory tribe, amongst whom some curious customs exist. Thus, after a woman is married, all sexual restrictions are thrown to the winds. She may welcome to her bed any of her husband's friends or relatives with impunity. When a friend visits a man, he sleeps in the same bed with him and his wife, and the rules of hospitality are such that the host must leave his wife to his friend in the early morning. When a man is absent from home, and a visitor arrives, the wife must entertain him, and, if he should so desire it, act as his wife. Thus it can well be imagined what a fruitful source for the dissemination of syphilis and other venereal diseases the Bahima are.'

Lieut.-Col. Will remarks: 'In the province of Uganda, the Bahima (Cow tribe), who are migratory, are responsible in a great measure for spreading the disease.'

In the course of my investigation I discovered the existence of a third and much more real cause for the spread of syphilis. I had heard rumours of a practice which was said to exist in some of the provinces of deliberate vaccination of healthy infants with the syphilitic virus from affected persons, the reason given for the practice being that syphilis communicated in this way during infant life conferred immunity from it to the adult. As stated, investigation proved that this dreadful state of things does exist, and to a very great extent, in some of the provinces.

The following are extracts from the summary of the evidence of some of the witnesses as regards this:—

The Rev. Père Laane, Father Superior of the White Fathers, says: 'Undoubtedly a practice exists in some parts of the country of deliberately inoculating infants with syphilitic virus to prevent a repetition of the disease in grown-up life. This is especially the case in and about Haima, in the Province of Unyoro. The people there have told me over and over again about this. The practice is to wrap the infant when only a few days old in clothes which have been smeared with syphilitic discharges. Of the existence of this practice I have no doubt

whatever, and have had to make it the subject of my sermon on more than one occasion.'

Sir Apolo Kagwa says: 'Yes, it is well known that in certain places this practice does exist, in Buyagu, Bugangadai, and Haima. The people vaccinate infants with the virus of syphilis with a view to preventing their getting the disease in adult life. The consequence is that in these countries probably 90 per cent. of the population is infected.'

The Rev. Father Moullin, of the White Fathers, says: 'I am in a position to say that this practice does exist to this day among the Bunyoro—not so with the Baganda.'

Chief Mugwanya, Second Regent, remarks: 'Deliberate vaccination with syphilitic virus is common in some parts, especially Buyagu.'

Dr. Goodliffe, Colonial Surgeon, says: 'I have heard it stated, and, although I have no direct evidence of it, I have reason to believe that it is true, that in some parts of Unyno Province a practice exists of deliberately inoculating infants with the syphilitic virus, to prevent their getting the disease again.'

Incidence of the Disease

Unfortunately the statistics are of such a meagre description that no accurate conclusion can be arrived at as regards the actual incidence of syphilis in the Protectorate as a whole. The following account may assist in some degree :—

Syphilis as it Exists. Syphilis as seen to-day in Uganda presents the same picture as in the past when the disease has been implanted on a, to some extent, fresh soil, and allowed to run riot without treatment. It is the same picture which was depicted by William Fergusson of what he saw in our own army under similar circumstances in 1813, whilst in Portugal—mutilation everywhere (see also vol. i, p. 187). He said then of the garrison in Lisbon, that more cases of mutilation from syphilis could be seen in that city in one day than could be observed anywhere else in a year, and I imagine the same could be said of almost any station

in the Uganda Protectorate to-day. Under the circumstances the disease has assumed all its well-known characteristic virulence. In the primary form the true Hunterian chancre is the rule, and this as often as not takes on a phagedaenic character, resulting in wide destruction of the surrounding soft parts. The second stage is characterized by intense and confluent eruptions, ulcerations of the mucous membranes, laryngitis, iritis, periostitis, and joint affections, profound anaemia, cachexia, and general disturbance of the nutrition. In some cases the principal secondary manifestations are of a nervous kind, as exemplified by neuralgic pains, asthenia, paralysis, and analgesia.

The tertiary stage is represented by early rupial syphilides, which extend rapidly over the body and limbs; osteo-arthritic manifestations, with severe nocturnal pains; periostitis, necrosis of the femur, tibia, clavicle, and bones of the forearms; the joints become distended with fluid and sometimes become ankylosed.

Gummatous ulceration destroys the eyelids, nose, and ears, bringing about many varieties of mutilation which we may see daily in Uganda.

Saddest of all is the number of cases of hereditary syphilis. One is constantly coming across in every part of the country boys and girls between eight and ten years of age affected in one way or another, one of the commonest affections being osteo-arthritis of both knees. Caries of the bones of the face and base of the skull is common; whilst it need not be said that blindness due to corneal opacities or choroiditis as the result of interstitial keratitis is a common occurrence.

With regard to the effect that syphilis has on the child-birth and infant mortality, Dr. A. C. Cook, C.M.S., makes the following statement: 'From statistics based on obstetrical out-patients, I calculate that 75 per cent. of the pregnancies among the people of Uganda end either in abortion or miscarriage, premature labour, or still births; or else the infants die within the first week of life. This latter result is mainly due to syphilis, which in this connexion the Baganda call "Munyo".'

Parasyphilitic affections are not very commonly seen. In fact,

they are rare, the reason probably being that the disease has not existed in the country for a sufficiently long time to allow of their frequent occurrence. Further, it is hardly to be expected that syphilitic nervous affections would be found to any great extent among the class of Africans who inhabit the district under consideration. A certain number of cases, showing early tabetic symptoms, came under my notice, and there were many young able-bodied men with syphilitic histories who suffered from complete loss of sexual power.

Proposed Methods for checking the Disease

Preventive Measures. One's first idea is that the most effectual method of combating a widespread syphilitic outbreak is compulsory legislation. A Contagious Diseases Act might be imposed. Under the circumstances, this measure could not be entertained, owing to the strong consensus of opinion against it. All classes, whether medical, clerical, or lay, are opposed to it. Doctors and laymen alike object to a Contagious Diseases Act on the grounds that the state of civilization in the Protectorate does not lend itself to any such measures. The Anglican Church Mission strongly urged objections of a moral character. The only religious body with whom the suggestion found favour was the White Fathers, and they were unanimous for its adoption.

I was consequently obliged to look in other directions for means of dealing with the prevention of the dissemination of syphilis, and fortunately one method gave great prospects of success.

I have already pointed out that, for the purposes of government, the various provinces are divided into districts, each of the latter being under a chief, appointed by the Government at home. The influence this chief exercises over the people in his district is very great. He can do almost what he chooses with them. It struck me that, by enlisting the sympathy of these powerful chiefs for the stricken people under their charge, great assistance could be obtained, and I formulated in my mind a scheme for gaining their

co-operation and powerful aid in this matter. This enabled me to trust to prolonged treatment, both for the prevention and cure of the disease. The chiefs could influence the people to report their sickness and attend at suitable places for regular treatment. This I thought preferable to any legislative measures.

This object being in view, I proposed to limit the experiment in the first instance to the kingdom of Uganda. I suggested that, throughout this part of the country, small centres, which I term 'Treatment Rooms', should be established, situated within reasonable access of all patients. Each of the 'Rooms' would be placed under the charge of a medical subordinate, and visited once a week by a medical officer for the purposes of carrying out continuous treatment. Syphilitic patients would attend weekly for treatment and observation. Reliance was thus placed on the influence and sympathy of the chiefs, to ensure regular attendance of the afflicted. In each 'Room' a register would be kept, in which the names of all syphilitic patients would be entered and forwarded to the respective chiefs, who would enter them on registers which they would also keep. A card should be given to each patient, on one side of which are printed the more important facts about syphilis, its dangers both to the patient himself and to others, as well as the precautions which he ought to take. On the other side, instructions as to the day for attendance for treatment are set out. Should a patient fail to attend on more than one, or two, occasions, without sufficient excuse, the fact is to be notified to his respective chief.

In addition to the 'Treatment Rooms', I proposed that in each province a large hospital for the treatment of venereal diseases should be established for hospital cases, each to be placed under the charge of medical men specially qualified to deal with venereal diseases.

By means of this 'continuous treatment' the patient would have a chance of being cured of his disease, and in any case he and his offspring would be safeguarded against its future ravages, and, whilst undergoing the treatment, he would be rendered harmless to others.

Everything in this method of dealing with the Uganda outbreak depends on the sympathy of the chiefs. In view of this, I had private interviews with a great many of them, including the Prime Minister and the two other Regents, and soon discovered that all of them not only showed the greatest interest in the subject, but were most willing to assist. They took a most comprehensive view of the whole matter, and quite appreciated the necessity of long continued treatment. The official summary shows how greatly the chiefs appreciated the scheme which I proposed, and how easily they concluded it could be carried out.

On January 6, 1908, I gave an address before the young King of Uganda and his assembled Parliament, the object being to explain to them the nature of the disease we had to deal with, the ravages it had committed and was still doing, and to lay before them the scheme which I proposed to adopt to check its further progress.

The address was listened to with the greatest interest and attention, but nothing surprised me more than the speeches which were delivered by some of the chiefs, showing the most complete and intelligent grasp of the subject under discussion as well as a thorough knowledge of the ravages which syphilis had already perpetrated among the tribes, which, if left unchecked, would ultimately end in practically complete racial extermination. Listening to these speeches, one could hardly believe that one was hearing them from the lips of negroes in the centre of Africa. In the end, I found that I had the entire and intelligent sympathy of the assembly of chiefs, as they were prepared at once to do their share in carrying out the proposals of my scheme. I may add that the whole population showed interest in the subject. Previously, losses from syphilis had come to be regarded as ' Kismet '. These new proposals gave them fresh hope, at which these poor people eagerly grasped. This meeting under the King of Uganda in Lukiko will, I feel sure, turn out to be as important an event as it will certainly be memorable to me.

As regards the question of any special line of treatment which should be followed, that of course would be optional for medical officers to select as they thought best, but for continuous treat-

ment I believe it will be found that the only feasible method to carry out effectually in the circumstances under consideration is the 'Intramuscular Injection' treatment.

Here I may mention an interesting fact. When I arrived at Uganda I found that both there and in other parts of East Africa the medical men were prejudiced against administering mercury in any shape or form to the natives. They assured me that the natives were peculiarly susceptible to its action, and became salivated after minute doses. Dr. A. C. Cook, C.M.S., whose experience among the natives is unique, told me that such was his experience, and he had been giving mercury of late years only when forced to do so, and even then only in the smallest doses. In spite of all precautions salivation occurred, and he warned me to be on my guard with mercury when treating the African native. However, I felt confident from previous experience that the drug would be far better borne when given by intramuscular injection than when given by the mouth. At a demonstration at the Church Missionary Hospital I gave a number of native patients injections of half my usual dose, viz. gr. $\frac{1}{2}$ of metallic mercury, and not one was followed by any untoward effect; the following week I gave a number of full dose injections, with similar results. Since then, Dr. Cook, as well as many other district surgeons, have continued to give the injections both for syphilis and sleeping sickness, and have found no bad effects from them.

The conclusions arrived at may be set forth as follows :—

1. That until recent years syphilis existed in Uganda only to a very limited extent, and was of the mildest type.

2. About twelve years ago there was a more or less sudden outbreak of the disease.

3. That the causes of this outbreak were probably :—
   (*a*) The emancipation of the Baganda women.
   (*b*) The abolishment of punishments—hitherto meted out for sexual immorality.

4. That it was spread through :—
   (*a*) The opening up of the country generally, allowing of free ingress and egress.

(*b*) The doing away with the custom of isolation as regards syphilitics, which had hitherto been in vogue among the tribes.

5. That syphilis was spread mostly by Swahili and East Indian native traders from the coast, and to a lesser extent by members of the Bahima tribe.

6. That the disease has spread and continues to do so throughout the land.

7. That its incidence varies in different places, being placed as high as 90 per cent. in certain districts, the inhabitants of which it threatens to destroy.

8. That syphilis is the chief cause of the high infant mortality, as is seen from the rough figures showing the deaths from ' Munyo ', by which name the native knows infantile syphilis.

9. There is every reason to think that syphilis is the chief cause of miscarriage and abortion among the native women.

10. There is at least strong presumptive evidence that a practice exists in some of the districts of deliberate syphilitic vaccination.

11. With regard to prevention and treatment it was recommended :—

(*a*) That the present state of civilization in the country does not permit of any legislative preventive measures.

(*b*) That for the present reliance must be placed upon the better and more thorough treatment of the disease.

12. For this purpose it is recommended that :—

(*a*) ' Treatment Rooms ' should be established, and be so situated as regards distance as to be within reasonable reach of all patients. Syphilitic patients could then attend on one day a fortnight, or oftener as the case may be, for treatment.

(*b*) Each treatment room to have a resident medical subordinate (Indian native) in charge, and to be visited regularly on one day a week by a medical officer.

(*c*) That in each room a syphilitic register be kept in which will be entered the names of all syphilitic patients.

(*d*) That a similar register be kept by each chief.

(*e*) When a patient has reported himself as sick, and his case has been diagnosed as syphilis, his name should be entered in the ' Room ' register, and also sent to his respective chief for entry in the chief's register.

13. Irregular attendance on the part of a patient to be reported to his respective chief.

14. Much reliance may be placed on the influence of the chiefs to ensure regular attendance.

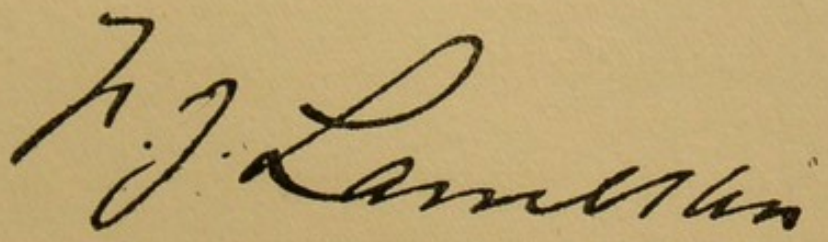
15. That a special venereal hospital be established in each province for the reception of hospital venereal cases. That such a hospital be placed in the charge of a medical man with special knowledge of venereal diseases. It would also serve as a venereal clinique for the medical staff of the Protectorate, a very desirable matter.

Of our chances of being able to grapple successfully with syphilis in Uganda I am very hopeful, as I consider that the general conditions are favourable. In the first place, we have a naturally healthy and sturdy race to deal with ; they are intelligent enough to recognize the dangers of the disease, as well as the ravages it has already committed among them and their children, and they are desirous of being rid of the disease, and are willing to undergo any treatment to that end.

For the successful treatment of syphilis experience has taught us that complete control of our patients so as to ensure regular attendance with consequent regular treatment is absolutely essential. In the army in India, through having this control of our patients, and by means of the intramuscular method, the invaliding rate for syphilis has been reduced some 70 per cent.

Now in the Uganda Protectorate I believe we can count on an even more complete control of our patients than in India, for the influence of the chief over the people is remarkable, and his word is law ; hence with his sympathies enlisted on our side complete and regular attendance can be relied upon, so that there

is every reason to think, without being too optimistic, that our chances of being able to deal successfully with syphilis in Uganda are as good as they were ten years ago in India. If we can bring about anything like the brilliant results achieved in that country, we shall have cause for congratulation.



SYPHILIS IN OBSTETRICS

BY

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