SOUTH AFRICAN OBSTETRICS AND GYNAECOLOGY

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After expressing his appreciation of the honour he had received in being nominated and accepted as the first Chairman of the South African Regional Council of the Royal College of Obstetricians and Gynaecologists, Dr. Black said:

Since its establishment the Royal College of Obstetricians and Gynaecologists has played a great part in improving the maternity services in Great Britain and (through its Regional Councils) in Australia, Canada and New Zealand. It has secured better training for students and set a standard for postgraduate training for specialism which has never been attained before. In all obstetrical problems the Government of Great Britain now relies upon the Royal College for advice.

In Great Britain 25-40 years ago the maternal mortality rate varied from about 4 to 7 per 1,000 live births and puerperal sepsis. accounted for 30-40% of this mortality. Maternal mortality is now down to about 0·75 per 1,000 births, and deaths from puerperal fever have almost disappeared. The greatest credit for this wonderful improvement must go to the discovery of the sulpha drugs and penicillin. Still, deaths from other causes associated with child-bearing have also been reduced in recent years, and much credit must be accorded to the Royal College of Obstetricians and Gynaecologists for the pioneer work they have done in drawing the attention of the various governments to the need for improving the maternity and infant welfare services of the country.

SOUTH AFRICAN MATERNAL AND INFANTILE MORTALITY

Turning to South Africa, we have much to be proud of in many ways but much to be ashamed of as well.

For our European population the figures of maternal and infantile mortality compare favourably with overseas countries. In 1951 (the latest figures I have) the maternal mortality rate was 1·12 per 1,000 live births—a contrast to that of 1926 when it was 4·56. Deaths from puerperal sepsis have practically disappeared.

The infantile mortality rate under 1 year also shows a remarkable improvement. In 1920, the rate was 90 per 1,000 live births and in 1951 it was 33—a reduction of almost two-thirds; and, in the annual report of the Department of Health for 1952, figures given for 12 countries show that this rate was bettered only by New Zealand (28) and Australia (29).

In Asiatics and Coloured there has also been a definite improvement, but nothing approaching the European rates; in 1951 the maternal mortality rate among Asiatics was 2·71 and amongst the Coloured 2·49—both almost 2½ times greater than that among the Europeans. The infantile mortality rates in 1951 for Europeans were 33, for Asiatics 62·5 and for Coloured 124.

These are figures of which we cannot be proud, and this state of affairs is something which I hope this Regional Council and the Society of Obstetricians and Gynaecologists will investigate and endeavour to improve.

MIDWIFERY IN NATIVES

You will notice that I have quoted no statistics regarding Bantus. Why? Because there are no statistics on which we can rely; but I can state definitely that the maternal and infantile mortality rates are much greater than those I have quoted. This will be confirmed by any medical man who has worked in Bantu areas. Specialist Obstetricians who have worked in Native maternity hospitals will also confirm my experience that far more difficult midwifery is met with amongst the Bantu than amongst the Europeans.

There is a common belief, even among some of our legislators apparently, that Bantu women have no trouble in giving birth to their babies. This, I assure you, is a travesty of the truth and I hope our Societies will be able to dispel this ignorance and so pave the way for improved maternity services for the Bantu. I have seen some Native maternity hospitals or departments of which I am extremely proud; but I have seen some others where there is certainly no reason for pride.

I have always been keen to bring about an exchange of trainees in obstetrics and gynaecology between this country and Britain and the Dominions, and I can never forget the remarks of a well-known obstretician in London when I was discussing this problem with him in 1946. 'What can you teach them'? was his first remark. I then pointed out, among other things, the experience his trainees from Britain would obtain in difficult midwifery among the Natives here and in the operative treatment necessary to repair the damage resulting from the complete lack of medical attention in many cases. 'Oh, we should call that bad midwifery', he said. There is the rub; we are very far away yet from the obstretricians' ideal, which is to see at the end of every pregnancy 'a healthy mother and a healthy child'. Owing to our distances and to the fact that we are dealing with a primitive race, our difficulties in reaching that ideal are far greater than those in Britain, but we must press on and gradually develop our maternity services till that ideal is reached. And here I would like to say that our legislators can do more to reduce the maternal and infantile mortality than we obstetricians can, for what would assist more than anything else is better nutrition, better housing, better education and less poverty.

It is time to say that all Native maternity hospitals are overcrowded to a dangerous extent. To have a number of mothers (I have heard of 12 or more) being delivered in one labour ward is revolting to our sense of decency. Mothers fulfilling their greatest function in life deserve better of us.

It is difficult to get statistics regarding the Bantu; and we obstetricians should collect what reliable statistics we can from the various provincial and mission hospitals so that we may have some idea of the maternal and infantile balance sheet; for to my

mind a balance sheet of a country's health is as important as a balance sheet of its finances.

Another difficulty is to provide sufficient maternity beds for the Bantu; we all know how hospital-minded the Bantu have become during recent years and how difficult it is to keep pace with the demand. Still we must press on towards the mark. I should like to see an investigation made into the maternity services of the country with a view to providing the best practicable service for each particular area. In my opinion it is advisable to appoint a man of considerable experience to act as Director of a Division of Maternity and Infant Welfare.

IMPROVED TRAINING IN OBSTETRICS

Another point I have always stressed is that in this country our students and interns require a more advanced and longer training in obstetrics than students in Britain, where a doctor is never so far away that he cannot obtain the assistance of an expert. In South Africa if he practises in the country he never knows when he may have to tackle an emergency on his own, no assistance being available. Practical postgraduate courses are also very necessary for men working in lonely places.

I have given a brief survey of some of the problems with which South Africa is faced on this question. There are many others which I cannot touch on; but I hope I have made those of the public who are here today realize that concerning maternity problems one might with truth apply Rhodes' last words, 'So little done, so much to do'. I have also tried to give you some idea of the lines along which we obstetricians intend to work to attain the ideal of 'a healthy mother and a healthy child'.