I became Senior Medical Staff Officer at the Headquarters of the Organisation de Nations Unies au Congo at short notice from 17th July to 3rd August, 1960. This is an account of some problems I encountered. The circumstances in which U.N. troops were called into the Congo are well known; the situation was so urgent that men from the African continent were flown in without delay. There had, therefore, been no opportunity for making an operational plan, and a small cosmopolitan headquarters, hastily assembled from the U.N. Force in Gaza, was trying to establish itself in Leopoldville and assume control. Working conditions were difficult: essentials were lacking, there was no medical staff whatsoever, and A/Q branch was represented by a single hard-pressed major. There were no clerks, no office equipment and indeed no offices, save for a small hotel bedroom set aside as an operations room. Unless one were a good French linguist, the telephone was likely to prove more of a liability than an asset. Transport was provided quite haphazardly by the Force Publique and later through a transport pool, but in each case one was dependent on the whim of the Congolese driver who, growing weary of waiting for the reconnaissance or conference to finish, would drive off, leaving one to make one's way back as best one could. In these circumstances troops were deployed as they flew in, and some logistic support arrived on the spot; medical arrangements except at battalion level were non-existent.

On 18th July U.N. Forces numbered some 3,000 all ranks: a battalion of Ethiopians at Stanleyville about 1,000 miles away; a battalion of Moroccans at Thysville, and two Ghanaian battalions with part of the headquarters of the Ghana Infantry Brigade located at Leopoldville. We expected a rapid build-up, and with re-inforcements from these countries and contingents from Tunisia, Sweden, Guinea, Liberia, Eire and Mali, the U.N. Force on 3rd August had some 12,000 men deployed in all the provinces of the Congo with the exception of Katanga.

All battalions arrived complete with regimental medical establishments, and included in the Ghana Infantry Brigade Group were two sections of its Field Medical Company. These apart, there were no medical units in the Force, and no arrangements had been made for hospitals or evacuation for casualties. Two things were, therefore, immediately necessary. First, the production of an outline medical plan, and second, temporary arrangements to provide some sort of medical cover until medical reinforcements could arrive.

We needed one 200-bedded general hospital, two field ambulances, two surgical teams, one forward medical equipment depot, and a medical staff headquarters consisting of a Senior Medical Staff Officer, an Assistant S.M.S.O., an Army Health
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Specialist, a Medical Stores Officer, five Hygiene Assistants and five Clerical staff. This demand was cabled to U.N. Headquarters, New York, on 18th July, with a recommendation that the further medical build-up should be in accordance with British Field Force Scales. The main points of the medical plan were:

- The establishment of a 200-bedded base hospital at Leopoldville.
- The field ambulances with surgical teams to provide local medical cover.
- Long term and special cases to be evacuated by air to Leopoldville.
- Casualties not likely to be fit for duty within 28 days to be evacuated.
- Medical re-supply system to be established at Leopoldville.

Until the Field Medical Units arrived in the Congo the care of casualties would have to rest with unit Medical Officers who could call on the civilian hospitals in their areas.

Meanwhile the provision of a hospital in Leopoldville was urgent but difficult, because although most of the Belgian doctors in government employ had left the country, the hospitals were full, and the Minister of Health was, not unnaturally, concerned that the taking over of hospitals by U.N. Forces should not prejudice civilian needs. After much discussion with Ministry Officials we were allowed to use Kintambo hospital for U.N. troops: it was in a poorer part of Leopoldville and had 650 beds; it was readily divisible into two, and the Congolese staff and the one remaining Belgian doctor agreed that the civilian patients should be concentrated in one part, while the other with some 250 beds could be used by the U.N. By the afternoon of 20th July all civilian patients had been transferred, and with the agreement of Ghana Infantry Brigade, two sections of the Field Medical Company took over 50 beds for immediate use. Ghana was urgently asked for the third section and a field surgical team, and these hastily mobilized units arrived on 25th July together with three Ghanaian nursing Sisters. Thanks to this speedy Ghanaian effort a small force hospital capable of emergency surgery was established.

Meanwhile New York had reacted promptly to the request for medical units. Switzerland offered a team of civilian doctors and nurses to staff the base hospital; there were also offers of Italian and Polish medical units. The Swiss offer was immediately accepted, and an advance party of four doctors under their director, Dr. Rubli, arrived on 28th July. By early August this Swiss team had relieved the Ghanaian unit in Kintambo, and had taken over the whole hospital, caring for the needs of both civilian and U.N. patients alike. Before accepting the Italian and Polish offers, U.N.H.Q. New York was asked for more information on the composition and organization of these units, because we thought that the Force Commander should have some field force medical units that could, if required, be rapidly deployed to any troubled area, which could not be done with civilian medical teams.

A problem no less urgent than the provision of hospital cover was that of medical re-supply. Most battalions had arrived with about one month's medical supplies, but we were uncertain when the medical stores and personnel demanded on 18th July would arrive. However, a signal was received from U.N.H.Q. New York on 22nd July stating that medical supplies for 10,000 men for one month at U.N.E.F. scales were being prepared and would be despatched by sea to reach the port of Matadi by 19th September. This was too late to meet units' first anticipated demands,
but the arrangement was allowed to stand, for we had discovered a large Central Medical Government Pharmacy in Leopoldville with stocks worth nearly £1 ½ million which was capable of supplying the needs of the whole country. Obviously it would be far more practical and economical for the U.N. Force to obtain its medical supplies from this well established and equipped depot, rather than bring in its own requirements separately. We therefore opened negotiations with the Congolese Ministry of Health. We confidently hoped that we could agree for U.N. to buy their supplies direct and so received full co-operation from the Belgian pharmacist and the Congolese assistants at the Central Pharmacy, who met small urgent demands for medical supplies at all hours. We realized, however, that when using the Central Pharmacy to meet the full demands of the U.N. Force, a separate military medical organization would be required to handle and account for them, for the existing civilian staff could not then cope. It was with great relief we met a Danish Naval quartermaster and five pharmacists and clerks at Leopoldville airport on 31st July, for their arrival averted a possible crisis over medical re-supply.

We were very lucky to have the services of Major J. W. Parsons, R.A.M.C., Assistant Director of Army Health, Ghana Defence Forces, who did invaluable work not only in this field, but also as a general medical staff officer. Later he was relieved of his duties as S.M.O., Ghana Infantry Brigade, and worked whole-time with the medical branch of U.N. Headquarters. All U.N. troops had been protected against small pox, yellow fever, the typhoid group and tetanus, and the inoculation state was remarkably high. We were also pleased to find that all troops of the U.N. Force were taking malarial prophylaxis, either Paludrine, Daraprim, Chloroquin or Dara-chlor. All kinds of diseases, tropical and non-tropical, are endemic in the Congo, which covers a million square miles with much variation in temperature, rainfall and topography. Both bacillary and amebic dysentery were universally prevalent and likely to be of military significance. The mundane infectious diseases, such as measles and chicken pox, were also likely to make themselves felt, African troops being particularly susceptible to these infections. If conditions became more settled and boredom set in, venereal disease might become a major problem. Water-borne diseases would also have their effect, particularly as the standard of water discipline among the troops was very variable, and in several instances not even the medical staff had much knowledge of field sterilization of bulk water supplies. In these instances it was quite impracticable to introduce the medical officers to the mysteries of the Horrocks Box or neutral red test, and we suggested that either all drinking water should be boiled, or water sterilizing tablets, of which the Central Pharmacy had a plentiful supply, should be used.

All battalions arrived with regimental medical establishments which, in numerical strength at least, compared favourably with the higher establishment of the British infantry battalion, and included medical orderlies and hygiene assistants. Many had two and even three medical officers, but battalions varied in size and some had over 1,000 men (e.g. the Moroccan). The Swedish battalion of 600 men had two medical officers, a dental officer and a warrant officer hygiene assistant within establishment, and two specialists in internal medicine accompanied them to decide on preventive measures. That professional standards and methods varied among the different
national medical officers was only to be expected. It was clear that any attempt at standardization of treatment was impracticable; national practices must be accepted and allowed to continue. For instance the medical officer of one contingent was unqualified even in his own country's cognizances; an emergency indent from him included a demand for a dental chair, six sphygmomanometers and an electric razor, which suggests that the checking or indents at medical H.Q. is not always without value. Another unit had three medical officers within establishment; the fourth member of the team, the anaesthetist, vehemently disclaimed medical officer status.

The Medical Service established by the Belgians in the Congo was of a very high order. The hospitals were well equipped and staffed by competent government medical officers, the nursing being in the dedicated care of Belgian nuns. The public health service was equally efficient, and the most thorough and vigorous preventive measures were carried out, notably against malaria, trypanosomiasis and yellow fever. Large scale anti-mosquito measures were regularly undertaken from the air, and Leopoldville and many other of the more important towns were free from mosquitoes. With the coming of independence, and as the political situation deteriorated, more and more Belgian doctors resigned their appointments and the medical services were left in a critical state. By the 17th July only some 200 doctors remained out of the original 450 in government service, and with the imminent withdrawal of Belgian troops it was feared that the majority of those still remaining would also leave the country.

The problem facing the Belgian doctors was twofold. First, there was the possibility of personal attack upon themselves, their families and their property, in the wave of anti-Belgian feeling that had been intensified throughout the country since independence was obtained. Second there was the question of working conditions. Many Congolese working in the Government Medical Service held a quasi-medical qualification like that of an apothecary or surgeon's mate. The Congolese were good technicians and did most useful work, but the appointments they held were subordinate to, and under the supervision and control of, the Belgian medical officers. With independence the Congolese Medical Assistants demanded recognition of full medical status, and that if Belgian doctors did remain in the service they should be allowed to act only in an advisory capacity, while the professional appointments should be given to the Congolese, with of course the corresponding salaries. It is doubtful whether this represented official government policy, but in many hospitals and laboratories the medical service was brought virtually to a standstill; and in some hospitals, however, work carried on almost normally. An outstanding example of this was seen at the Louvanium University hospital some 15 miles outside Leopoldville. The reputation of this splendidly equipped teaching hospital was above political strife, and its Belgian professional staff, under the principal, M. Gillon, and the director of medicine, Dr. Ronse, continued to work in complete harmony with their Congolese assistants. Arrangements were made for the admission of U.N. Officers and special cases to the Louvanium hospital where U.N. Forces were allocated 30 beds in the first instance, extending to 130 beds later if necessary.

On 20th July Dr. Evans of the World Health Organization arrived in Leopoldville to examine civilian medical requirements. He soon was followed by Dr. Kaul (late of the Indian Medical Service), the Deputy Secretary General from Geneva, and Dr.
Mackenzie Pollock. Very rapidly a team of medical administrators was built up. Their task was immense; it was simply to assess the situation created by the crisis and to re-form a medical service for some 13 million people. The International Red Cross also were naturally prominent in the medical relief work. Appeals were made through the United Nations for medical assistance, and the response was remarkably rapid. In a short time teams of doctors and nurses were being flown into the Congo from many different countries, and by the beginning of August six teams were at work in civilian hospitals, from Israel, Norway, Denmark, Canada, Ghana and Sweden, and there were offers of teams from ten other countries.

The civilian and military medical staffs worked in close collaboration, and it became clear that if the civilian hospitals re-organized by the U.N. through W.H.O. were made available to U.N. troops as well as to Congolese civilians, economy and efficiency would be achieved. The wide dispersion of the U.N. Force made the idea of a separate military hospital extravagant, and in view of their primary police role, unnecessary. Thus civilian teams which worked near troops would set aside a military wing. Reciprocally, the Swiss civilian team of doctors, who were obtained through military medical channels, undertook the care of civilians as well as military patients in Kintambo Hospital, Leopoldville. We later heard from New York that military medical units were extremely difficult to obtain; that Poland was unable to provide the military unit referred to earlier, and that the Italian offer turned out to be a team of mixed civilian and military medical personnel.
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