Life & Times

Lessons from history:

primary care at Yakusu in the Belgian Congo, 1921–1960

In the UK, primary care is delivered largely through general practice. By looking at the slow rise and rapid fall of another system of primary care, set in the 'Province Orientale' of the Congo, at Yakusu, between 1921 and 1960, can we learn something about our own system of general practice?

THE BEGINNINGS OF PRIMARY CARE AT YAKUSU

The early years of the colonisation of the Congo, until at least the 1920s, saw a decline in population, whether due directly to the notorious brutality of Leopold's early rule or, more likely, the spread of diseases through a now much more mobile population.[1,2] The disease that most captured the attention of the Belgian colonial authorities was sleeping sickness (trypanosomiasis). They instituted, from the early days of Leopold's rule, a draconian 'vertical health programme' directed against it.[3] Those diagnosed were forcibly incarcerated and treated with atoxyl, which was an arsenical, effective against trypanosomiasis, but causing 2% to 30% blindness. By the 1930s, a safer arsenical, tryparsamide, was used and mass treatment of human cases turned out to be an effective way of controlling sleeping sickness, an approach that is used to this day.[4]

Yakusu mission is in the east of this vast country. The area served by the mission had a population of 110 000 and is about the size of Wales.[5,6] Yakusu mission was founded by the Baptist Missionary Society in 1896, but the first missionary doctor, Clement Chesterman, was not in post until 1921. His initial successes lay in the vertical sleeping sickness programme of the Belgian colonial state, a programme notoriously unpopular with the Congolese.[3] When he arrived, 25% of the population had sleeping sickness. By 1947, sleeping sickness had been eradicated.[5]

But, thanks to success with trypanosomiasis, other elements were added to the vertical programme, so that it gradually became a horizontal programme covering all areas of health. By 1935 there was a network of rural dispensaries, a medical aide training school, and an annual medical examination of the population (chiefly for sleeping sickness).

Stanley Browne. Children, babies, and nurses of the baby clinic, leper camp, Yakusu, Belgian Congo. **Credit: Wellcome Collection.**

FROM A FLOURISHING PRIMARY CARE SYSTEM TO ITS COMPLETE DESTRUCTION

There is good evidence from the 1960s that, at independence, the health services in the Congo were some of the best in sub-Saharan Africa.[7,8] Primary health care at Yakusu was described as follows.[5,6,9]

There were 18 brick-built dispensaries throughout the area. Each was staffed by a medical auxiliary with 5 years' training. Each dispensary had a laboratory with a microscope. A doctor from Yakusu visited every 6 weeks. The medical auxiliary held baby clinics and antenatal clinics weekly, and performed smallpox vaccination. Over the years, leprosy, onchocerciasis, TB, schistosomiasis, and malaria were tackled.

After independence in 1960 came the Simba rebellion in 1964. The Simba were deeply hostile to all Western influence. Educated Congolese who escaped with their lives had to hide in the forests for 2 years. Gradually hospital care was restarted, but effective primary care had not returned to the area in 1989. What an anthropologist found was a post-apocalyptic situation.[10] Both the village midwives and the government health post provided unsafe obstetric care (including fundal pressure for obstructed labour) based on partially remembered elements of Western biomedicine mixed with local tribal lore, but lacking a comprehensive grasp of either system.

PRESERVING GENERAL PRACTICE

How is this relevant to primary care and general practice in the UK? Like Yakusu, our primary care service has been gradually built up, but could it be as suddenly destroyed? I cannot foretell the future, but

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Aneurin Bevan, the Health Minister, visits Park Hospital, Davyhulme, Manchester, for the official launch of the NHS in June 1948. **Photograph: PA.**

threats to general practice exist. Imagine a trade deal with the US including health care. Under tendering rules, the NHS could be forced to give primary care contracts to firms with greater financial reserves who would undercut traditional general practice in the short term. The price of drugs to the NHS may increase considerably.

What can we do, as GPs, to ensure the persistence of the service we provide? The generation who were grateful to universal general practice because they remembered what came before, has departed. Most people in the UK now take universal health care for granted. Yet patients' consent and understanding of our service is crucial to its survival. If we do not explain to them how valuable general practice is, they will never know. We need to move to a service where our patients do appreciate its value and, hence, will fight for it.

We need, in my opinion, to involve them in its organisation and delivery. We need to move from a situation where primary care is essentially provided by a contract between the state and the providers with the patients as passive recipients, to a new system where the state, the providers, and the patients all take an active part.[11] This is already the case in the education system with its boards of governors. Could patient groups play an analogous part in general practice?

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