UNAMIR MEDICAL MATTERS 14 AUG 1994 - 12 OCT 1995

PLEASE RETAIN
ORIGINAL ORDER

[7 STRICTLY CONFIDENTIAL]
[1 CONFIDENTIAL]
RH/WG MAY 2009

UNITED NATIONS
ASSISTANCE MISSION FOR RWANDA

NATIONS UNIES
MISSION POUR L'ASSISTANCE AU RWANDA

UNAMIR - MINUAR

A: Monsieur le Chef du Personnel
de la MINUAR

De: _____ ID.No: _____

Titre: _____ Departement: _____

Objet: Demande de congé

J'ai l'honneur de demander le congé suivant :

	De	A	Nombre de jours ouvrables ou heures à récupérer
Congé annuel :	_____	_____	_____
Récupération :	_____	_____	_____

Date :..... Signature du Fonctionnaire:.....

RESERVE AU PERSONNEL

La fiche de congé a été vérifiée et le demandeur a :
..... jours de congé annuel accumulés à la fin du mois de.....
..... jours ou heures à récupérer.

OBSERVATIONS : Section du Personnel : .....

OBSERVATIONS : Section des Finances :.....

Date Accord : ..... Signature du supérieur immédiat.....

Date Accord : ..... Administration du Personnel Local.....

To circulate

CPPO

= IVP ... copy to Geneva

UNITED NATIONS
ASSISTANCE MISSION FOR RWANDA

UNAMIR-MINUAR

HQ UNAMIR MED BR
File: 44-6-1
Med : 969/95

To : List A,B,C,D & E

From: MAJ M.E. FENSOM
FMO

Date: 14 Sep 95

Subject: MEDICAL/DENTAL INSTRUCTIONS FOR UNAMIR PERSONNEL ON LEAVE

1. Should "emergency" medical/dental care be required while on leave in NAIROBI it is requested that personnel seek treatment at:

a. The Nairobi Hospital. This is the preferred facility.

b. The Aga Khan Hospital. This is the alternate facility.

2. Personnel on leave at other locations should report to the nearest medical facility.

3. Please note that "emergency" treatment (e.g. short term illness, relief of pain, danger to life or limb) only may be provided. No elective procedures are to be undertaken. If treatment other than emergency care is required this will be determined by the FMO.

4. If medical/dental care is received while on leave personnel are requested to report to the Medical Branch So Med Admin or G3 Med Ops, on return from leave to facilitate follow-up and invoice processing.

5. Queries should be directed to So Med Admin or G3 Med Ops at 11116.

CALog 6

UNITED NATIONS

ASSISTANCE MISSION FOR RWANDA

NATIONS UNIES

MISSION POUR L'ASSISTANCE AU RWANDA

UNAMIR - MINUAR

HQ UNAMIR MED BR
FILE: 445-16-1
MED 508 /95

To: **LIST A**
AUSMED
PUBLIC AFFAIRS OFFICER
UNREO

From: **FMO**

Date: **13 MAY 95**

Subject: **HEALTH THREAT ASSESSMENT - OUTBREAK OF EBOLA HAEMORRHAGIC FEVER VIRUS IN ZAIRE**

Reference: WHO report May 95

1. Recent press reports have indicated an outbreak of the Ebola virus in the city of Kikwit, 300 km east of Zaire's capital Kinshasa. WHO have subsequently confirmed that the Ebola virus is the cause of the outbreak of haemorrhagic fever that has killed in excess of one hundred and sixty people as of the 10 May 95.

2. On the basis of the reports received, FMO has prepared a health brief detailing the nature of the disease, the current situation and the assessed health threat to UNAMIR personnel. A copy of the brief is enclosed for further action as appropriate.

B.R. CURREN
LTCOL
G3 MED

Enclosure:

1. Outbreak of Ebola Haemorrhagic Fever Virus - Health Threat Assessment

[redacted]

13/5/95

Logo note and put in appropriate file pack
18/3/95.

ZAIRE - OUTBREAK OF EBOLA HAEMORRHAGIC FEVER VIRUS
HEALTH THREAT

BACKGROUND

1. Kikwit, Zaire: The World Health Organisation (WHO) has reported an outbreak of the highly transmissible, highly infectious Ebola Haemorrhagic Fever Virus, in Bandundu Province, 500km east of the Zairian capital of Kinshassa. From January 95 through April, cases of a bloody diarrhoeal disease with fever , thought to be Shigella Dysentery, were reported in Kikwit, a city of 600,000. One hundred eighty nine cases and fifty five deaths were reported in early May. From the first week in April, unconfirmed reports of Ebola Virus began circulating and the city has now been quarantined. As of 10 May over one hundred sixty deaths have been reported. Samples from patients were sent to the Centre for Disease Control (CDC), Atlanta, Georgia, USA, for evaluation and have reportedly confirmed the Ebola Virus. Two WHO officials are now in Kinshasa and an international team of experts from the CDC (USA), National Institute of Virology (South Africa), and the Pasteur Institute (France) are expected to arrive in Kinshassa today (12 May). The US government has already issued a travel advisory for Zaire and the city of Kikwit is under enforced quarantine.

NATURE OF THE DISEASE

2. Ebola Virus is a member of the filovirus group endemic to sub-Saharan Africa and Asia, and is believed to be a zoonotic disease infecting non-human primates that has crossed evolutionary lines to humans, although the exact natural vector is unknown. Two separate strains of the virus were first recognised in Sudan and Zaire following outbreaks in 1976 and again in Sudan in 1979. The 1976 outbreak in Zaire resulted in 318 cases with an 88% mortality rate.

3. Transmission of Ebola is believe to be by direct contact with infected body fluids and possibly by the aerosol route. Clinical signs may appear within two days of infection , and are manifested by severe headache, fever and chills, followed by watery diarrhoea, coughing, vomiting and abdominal pain. Between five and seven days from onset, haemorrhaging occurs from all body orifices as well as eyes and gums, and haemorrhagic lesions develop on the skin. Liver, spleen, pancreas, kidneys and heart become involved with haemorrhaging and tissue necrosis, with death occurring between day eight and sixteen. There is no known cure or vaccine for Ebola and all cases must be strictly isolated and nursed under conditions for Class Four pathogens. Ebola in Zaire has a 90% mortality rate.

CURRENT SITUATION

4. As of last reports, the city had been cordoned by the Zairian Army, however soldiers have accepted bribes to allow some to flee the area. The city has a curfew imposed and residents are advised to stay indoors. Some of the residents have made it to Kinshassa. The governor of Kinshassa has closed all routes leading into the city from the east to prevent more from arriving. Cases of Ebola are reported 700km from Kikwit. Problem with quarantine is that some people with status and money may be "above" the quarantine and act as carriers to other areas.

5. WHO officials have stated that "this is not a public health emergency in the sense of a wild spread either in Zaire or internationally, however it is a very serious outbreak in the area it concerns". Further advice from WHO indicates that the disease seems to be self limiting, once confirmed it runs its course very quickly and previous outbreaks have originated in hospitals with very poor hygiene or from African funeral rituals that involve cutting open the corpse.

THREAT TO UNAMIR

6. Given the physical distance and poor road infrastructure from Kikwit to Rwanda and quarantine measures in place, the threat to UNAMIR personnel from the Ebola virus is assessed as low. The threat to NGO and other UN agencies moving into Zaire is assessed as marginally higher, but still low.

Reg 300
19/12

UNITED NATIONS
ASSISTANCE MISSION TO RWANDA

UNAMIR-MINUAR

NATIONS UNIES
MISSION POUR L'ASSISTANCE AU RWANDA

ADMINISTRATIVE INSTRUCTION N° 016/94

DATE: 16 December 1994

TO: All UNAMIR Personnel

FROM: Ally H. Golo, Officer-in-Charge
Administration

SUBJECT: **Malaria Alert**

Introduction

As you may be aware, malaria is endemic in Rwanda and occurs all year round and in all parts of the country including urban areas. It is a disease caused by parasitic protozoans that occupy and destroy the red blood corpuscles that carry oxygen from the lungs to the tissues and return carbon dioxide from the tissues to the lungs. The malaria parasite is transferred to the human bloodstream by mosquitos. There are four different types of malaria parasites but the main type present in Rwanda, and the only type that is fatal, is *plasmodium falsiparum*. *Plasmodium falsiparum* can give rise to a form of acute malaria known as cerebral malaria, in which the malaria parasites multiply quickly in the capillaries of the body organs and especially the brain. Cerebral malaria is a progressive condition; it can follow a less malign episode of malaria that is left untreated. Cerebral malaria can cause an apparently healthy adult to fall into a coma within two hours of infection.

(a) Malaria and its symptoms

The typical symptoms of malaria include fever, chills, headaches, joint pain and general weakness. However, the absence of any one or all of the foregoing symptoms at a particular time cannot be taken as conclusive evidence that a person does not have malaria. Many other symptoms that are typically and more frequently associated with other conditions, such as nausea, vomiting, liver problems, jaundice and labial herpes, can be symptoms of malaria in particular cases.

The fever almost invariably experienced in malaria is episodic and occurs with a variety of frequencies. Fever episodes are correlated with periodic discharges by the malaria parasite into the bloodstream; hence, it is easier to detect the presence of the malaria parasite shortly a[illegible] an episode of fever. However, the potentially low frequency of fever episode[illegible]gests that the absence of fever in a patient during the previous 48 hours is not a s[illegible]ent basis on which to conclude that that patient

does not then have malaria. The more subtle the case of malaria, the more experience with the disease the clinician requires, and the more careful patient history need to be taken, in order to detect it. Many people believe that if they have been exposed to malaria over a prolonged period they do not need to take medications to prevent malaria. While this is true for those exposed to the more benign forms of malaria it is not true for plasmodium falciparum. Past exposure to plasmodium falciparum may mask the symptoms of malaria but will not prevent the individual from contracting cerebral malaria. Should you experience any of the above symptoms, please report immediately to your medical officer or to one of UNAMIR medical facilities for diagnosis.

(b) Prevention

There are two general categories of prophylaxis against malaria: protection against mosquito bites and chemical prophylaxis. The first category includes such measures as using mosquito repellent on exposed areas of the skin; using a mosquito net; and using insecticides in work and living areas. There are a variety of courses of chemical prophylaxis. The two major approaches are the regular ingestion of both chloroquine and paludrine and, alternatively, the regular ingestion of mefloquine. Both courses of chemical prophylaxis have side effects associated with long term use ranging from vertigo to damage of optical nerve, and mefloquine is contraindicated for pregnant women and persons with a history of hypertension, epilepsy or psychiatric problems. For UNAMIR, Headquarters New York has advised that the chemical prophylaxis to be used by personnel is mefloquine. Mefloquine (250 mg) is taken at weekly intervals. In addition to protection against mosquito bites which should be part of your daily precautionary measures, you are therefore urged to take mefloquine only as advised. The UN may not bear any responsibility, should complications develop as the result of the use of any other anti malaria-prophylaxis.

(c) UNAMIR policy on testing for malaria

There are two basic tests that a diagnostician can perform to check for malaria. One is called the "quick smear test." A drop of blood is taken from the patient's finger, spread on a slide and fixed with alcohol. The slide is allowed to dry, which can take as little as two minutes. Giemsa solution is then added to color the contents of the slide. Although the clearest results are available between four and 24 hours after the slide is made, in clinical practice the slide, can usefully be examined under a microscope less than 20 minutes after the Giemsa solution has been applied. The other test is called the "thick layer malaria test." In clinical practice the slide can be examined under a microscope less than 20 minutes after the giemsa solution has been applied. The "thick layer malaria test" has the advantage of allowing the clinician to distinguish the type of malaria, if any, present. This

advantage is of limited utility in Rwanda, where *plasmodium falsiparum*, the only potentially fatal strain of malaria, is dominant. In this connection, UNAMIR's policy is to administer either of the basic tests to all admitted patients, depending on symptoms.

Conclusion

Malaria is a very common illness that may be fatal. A range of preventive measures exist including personal protective measures and chemoprophylaxis. If these measures fail and an individual contracts malaria it often presents itself as a flu like illness. Individuals should report to their medical officer or to one of UNAMIR medical facilities if they fear they have contracted malaria. Following diagnosis by a medical officer, appropriate treatment regimes will be instituted in a timely fashion and should prevent the very serious if not fatal complications of malaria. Please be guided accordingly. The FMEDO and the CCPO are requested to provide copies of this Administrative Instruction to all incoming troops and civilian personnel when rotating or being assigned to Rwanda.

circulate

CALog Reg. 110
Reg 1/2.

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HQ UNAMIR II

MINUTE

538-12-1
MED BR 87 /95

All Military and Civilian Staff
HQ UNAMIR II

UNAMIR HQ REGIMENTAL AID POST

1. Since the closure of the Canadian Unit Medical Station it has been necessary to establish a Regimental Aid Post (RAP) within UNAMIR Headquarters to provide UNAMIR staff with medical treatment during the working hours.

2. The RAP, provided by Ausmed, is located near the Cafeteria in the new office block (last room on the right) and will be open for business on Tuesday, 31 Jan 95.

3. Timings for the RAP will be 0800 - 1700 hours Monday to Saturday, and 0800 - 1200 hrs Sundays, there will be a medical officer present between 1400 - 1500 hours Mondays to Saturdays.

4. Branch and department heads are requested to advise all staff of this new service.

R.J. CRAWFORD
MAJ
Medical Branch
UNAMIR HQ

31 Jan 95

Arms and Ammunitions

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UNAMIR - MINUAR

Med Cell

3

Office of the DFC/COS
UNAMIR Force HQ
KIGALI
Rwanda

1000.7(DFC)/G/11

23 August, 1994

See Distribution

MINE AND MUNITION ACCIDENT QUESTIONNAIRE

1. Find attached copy of Mine and Munition Questionnaire for your retention and necessary action.

2. Kindly treat with utmost importance.

HK ANYIDOHO
Brig Gen
DFC/COS

Enclosure:

A. MINE AND MUNITION ACCIDENT QUESTIONNAIRE

Distribution:

Action:	Information:
MILOB Gp HQ	FC
GHANBATT (Sector 4A)	CAO
MALAWI COY (Sector 3)	C Med O
9 Parachute Sqn RE	
Force Engr Coy	
Force Sig Sqn/FSO	
Force Fd Hosp	
UNCIVPOL	
ETHIOBATT (Sector 4C)	
FRAFBATT (Sector 4B)	
TUNBATT (Sector 5)	
CANSIGS	
HAC	
AUSMED	

MEMORANDUM

RWA

Date: 12 August 1994

To: Chief Medical Officer

Copy to: FC, CAO, DFC/COS

From: Paddy Blagden

MINE AND MUNITION QUESTIONNAIRE

1. There is still little hard information as to where mines and munitions may be located, either in areas left over from the previous phases of the war, or the recent battles.

2. One unfortunate method of locating mined areas is through mine victims. We need some method of systematically questioning such victims when they reach hospital. I have therefore produced the attached letter and questionnaire, for distribution within UNAMIR medical units and the local hospitals.

3. Could this please be distributed as necessary.

PM Blagden
UN Demining

MEMORANDUM

RWA

Date: 12 August 1994

To: Chief Medical Officer, King Feisal Hospital
Chief Medical Officer, Kigali Hospital
Commanding Officers, UNAMIR Medical detachments

From: Paddy Blagden, UN Demining Expert

MINE AND MUNITION ACCIDENT QUESTIONNAIRE

1. Many landmines have been laid in Rwanda, both during the previous phases of the war and during the recent conflict. Unfortunately few maps exist of where the mines are located, and many of the mines were laid by the Government Forces, so access to those who laid them is now denied.

2. One unfortunate method of locating mined areas is through mine victims. We need some method of systematically questioning such victims when they reach hospital, and we have therefore produced the attached questionnaire, which we would be grateful if you could distribute to your medical staff. The questions are designed to tell us where and when the incident happened, and what kind (and even model) of munition was involved.

3. It would be apprceiated if completed questionnaires could be returned as soon as possible to:

The Mines/Explosive Ordnance Coordination Cell
HQ UNAMIR
Kigali

4. Your help in this matter would be greatly appreciated.

PM Blagden
UN Demining

MINE AND MUNITION ACCIDENT QUESTIONNAIRE

1. When did the accident take place?

2. Where did the accident take place?

   Village?
   District?
   In a house?

(We need to locate the exact area if possible, because other mines may be present at the same spot)

3. Were there any marks to show that the place was dangerous?

4. What age was the victim?

5. What happened? Try to establish:

   a. Was it a mine explosion?

   b. Was it a grenade?

   c. Was a tripwire involved?

   d. Was the munition put near a fire?

<u>For the medical staff</u>.

6. Was there loss of limb?

7. Was the damage to upper limbs?

   Lower limbs?

   Trunk?

8. Was there fragment damage?

9. Were the fragments of plastic or metal?

10. Any other marks that would indicate type of munition?

<u>MANY THANKS FOR YOUR HELP</u>

Headquarters UNAMIR II

MINUTE

Med 07/94

See Distribution

UNAMIR II SOP - CASUALTY EVACUATION

1. The new SOP for Casualty Evacuation is enclosed for your use. It should be included in all unit SOP. In particular you should note that Annex A provides the standard format to use when requesting CASEVAC. Ops Branch should be the first point of contact when a CASEVAC is requested.

2. Any questions regarding format and/or procedures can be directed to me in room 2084 of this HQ.

R.J CRAWFORD
MAJ
SO2 MED OPS
15 Aug 94

Enclosure: 1. SOP- CASEVAC

Distribution:

INTERNAL

MILOB GP HQ
CANCON X 2
BRITCON
USCON
GHANBATT
MECH BN 2
MECH BN 3
MOTORISED BN

INDEP COY 1
INDEP COY 2
INDEP COY 3
FORCE ENGR COY
FORCE SIG SQN
AUST MED SPT FORCE X 2
2 FD AMB
23 PARA FD AMB
UNCIVPOL
CANADA 1 (PILOTS)

INTERNAL

COO
CLOGO
AIR OPS CELL
CMPO
CAMP COMDT
FILE
SPARE X 2

CASUALTY EVACUATION

General

1. Casualty evacuation CASEVAC is the process of moving any person who is wounded, injured or diseased to and or between medical treatment facilities. It includes surface evacuation and aeromedical evacuation (AME) .

2. The purpose of this SOP is to define the casualty evacuation process and to describe the procedures to be followed in the evacuation of all casualties.

Evacuation Priorities

3. All cas and especially those with major injuries require special consideration of their individual treatment and evacuation needs. Consequently the following priorities are assigned to cover this requirement:

a. Priority one. Pri one cas are those whose life is immediately threatened. Rapid evacuation, urgent resuscitation and or surgery are required.

b. Priority two. Pri two cas are those whose life or limb is in serious jeopardy. Evacuation to allow early resuscitation and or surgery is required.

c. Priority three. pri three cas are those for whom neither life nor limb are in serious jeopardy. Evacuation should be as soon as possible.

Types of Evacuation

4. Aeromedical evacuation (AME). AME is the movement of patients to a medical facility by air transportation. It may be by fixed wing or rotary wing aircraft. AME is the preferred means of evacuation for all priority one and two casualties.

5. Road evacuation. Is the movement of patients to a medical facility by any road means. Road evacuation should be used for all prio three casualties, the preferred road means is a dedicated ambulance.

Casualty Regulation

6. Casualty regulation in the AO is necessary to ensure that the most appropriate evacuation assets are used. The control of casualty evacuation also ensures that the casualty is transported to the most appropriate medical facility.

CASEVAC Procedures

7. Request for CASEVAC. All CASEVAC requests will be transmitted on the command net and should be in the message format described at Annex A. This format is to be repeated in all unit SOP.

8. Casualty Regulation. All requests for CASEVAC will be transmitted to Ops Br HQ UNAMIR. Casualty regulation will be conducted by Medical Branch, HQ UNAMIR. Ops staff will consult Medical Branch for advice on the most suitable means of evacuation and the destination of the casualty. The use of AME dedicated aircraft will be authorised by the CMedO or his representative. The use of other aircraft requires authorisation by COO on the advice of CMedO. Ops Br procedures with respect to CASEVAC are outlined at Annex B.

9 AME. If AME is the preferred means of evacuation then the:

a. AME medical team will be drawn from AUS Med Spt Force (AUS MSF) and CANSIG med elements; the team will be dispatched from CANSIG (Amahoro Stadium) to KIGALI airfield;

b. Aircrew will be notified of the CASEVAC request by Air Ops staff;

c. Air Ops staff should also advise the control tower at KIGALI Airport and gain clearance for the AME team to approach the CASEVAC aircraft; and

d. Receiving medical facility will be notified of incoming cas by Ops Br.

10. Road Evac. Will be used for all pri three cas and all cas that occur in the KIGALI area. The process of arranging road evac will be:

a. Road evac from RAP to AUS MSF facilities will be provided by AUS MSF assets; and

b. AUS MSF will be tasked by Ops Br to conduct road evac on advice of Med Br

11. Reporting. The receiving medical facility is to notify Ops Br on the completion of the CASEVAC task.

Annex:

A. CASEVAC REQUEST PROFORMA

B. Ops Br CASEVAC procedures

ANNEX A TO
CASEVAC SOP

CASEVAC REQUEST

Purpose

1. The purpose of this form is to standardise the format of CASEVAC requests.

. All requests are to be titled CASEVAC REQUEST and are to include the following serials

Serial	Description of Serial	Example
A.	UNIT NAME	A. GHANBATT
B.	CALLSIGN AND FREQUENCY OF UNIT	B. GOLF OA, FREQ 3830
C.	PRIORITY OF CASUALTIES	C.ONE X PRI 1, TWO X PRI 3
D.	NUMBER OF CASUALTIES- LYING	D. TWO
E.	NUMBER OF CASUALTIES- WALKING	E. ONE
F.	NATURE OF INJURY OR ILLNESS	F. GUNSHOT WOUND TO CHEST, FRACTURED ARM, LACERATED FACE
G.	GRID REFERENCE AND DESCRIPTION OF LOCATION OF CASUALTY	G. GR 123456, BUTARE GIKONGORO ROAD JUNCTION
H.	REQUIREMENT FOR SPECIAL EQUIPMENT	H. NIL
I.	TACTICAL SECURITY AT PICKUP POINT	I. SECURE
J.	ANY ADDITIONAL REMARKS INCLUDING MARKING AND APPROACH TO L/	J. RED CROSS PANEL MARKER, APPROACH FROM NORTH

ANNEX B TO
CASEVAC SOP

OPS BR CASEVAC PROCEDURES

1 Monitor comd net for CASEVAC request.

2. On receipt of CASEVAC request, notify Medical Branch.(Medical Branch advises on means of evacuation and the destination of the casualty)

3. AME:

a. Task AME team located at CANSIG to move to airfield. Tasking is to include all details of CASEVAC request. You should allocate the CASEVAC a tasking number. For AME the number should start with an A and be sequential eg. A01, A02 .....

b. Notify AirOps to task aircraft.

c. Notify receiving medical facility of CASEVAC.

4. ROAD EVAC:

a. Task AUS MSF to conduct road evac. Tasking is to include all details of CASEVAC request. You should allocate the CASEVAC a tasking number. For road evac the number should start with an R and be sequential eg. R01, R02.....

5. Reporting:

a. Inform FC on commencement of CASEVAC

b. Report to Med Br at completion of CASEVAC.