



〈Special Issue Articles〉 Medicine in the Korean War

The United Nation's Civil Assistance Command in Korea's (UNCACK) Public Health Measures on Koje Island during the Korean War[†]

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1. Introduction

The Korean War had dual consequences for infectious diseases: the spread of diseases and efforts to control them. The control of infectious

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diseases remained incomplete during the colonial period, the United States (U.S.) military government period, and even after the establishment of the Republic of Korea (Shin, 2000).

During the Korean War, infectious diseases such as smallpox, typhoid, and typhus were widespread across the Korean Peninsula. These diseases significantly affected the lives of civilians and had implications for the military, affecting their composition and battles. Geoje (hereinafter referred to as Koje)¹⁾ Island, where the prisoner of war (POW) camps were located and refugees gathered from all over the country, played a crucial role in disease control efforts. Before January 1951, the population of Koje Island was approximately 100,000 people. However, within about a month, around 70,000 refugees arrived on the island, and the construction of POW camps began, accommodating around 100,000 prisoners. By the end of June, the total number of prisoners on Koje Island had reached approximately 140,000. These figures illustrate the significant population influx to Koje Island within a short period. Moreover, given that the health and sanitation of POWs was connected to the humane treatment of prisoners outlined in the 1949 Geneva Convention, it was easily understood that the United Nations Civil Assistance Command in Korea (UNCACK) actively worked to maintain sanitary conditions on Koje Island and in POW camps.

This study specifically focuses on the health and hygiene project of Koje Island during the Korean War, which was considered to be of significant importance in UNCACK's efforts. UNCACK conducted health and hygiene projects at the provincial level, and a team was located on

1) To avoid confusion with historical materials, it would be appropriate to refer to Geoje Island as "Koje" Island in the context of citing documents related to the Korean War. This corresponds to the historical usage and ensures consistency with the referenced materials.

Koje Island. This was because Koje Island had unique circumstances as it served as a destination for dispersed refugees and as an area for housing prisoners in war. This uniqueness can be considered as a distinguishing factor between public health initiatives in other regions of South Korea and those on Koje Island. UNCACK was actively involved in implementing health and hygiene projects on Koje Island, demonstrating a distinct approach compared to other areas. Therefore, UNCACK's infectious disease control project on Koje Island serves as a valuable example for studying infectious disease prevention initiatives and local medical projects in modern and contemporary Korea.

Cho and Lee conducted studies on the occurrence and control of infectious diseases during the Korean War (Lee, 2020; Cho, 2022). Imha Lee's book addresses the issues of infectious disease occurrence and control across the entire Korean Peninsula using documents from UNCACK. Cho Sung-Hun conducted research on controlling infectious disease in Busan. According to Cho Sung-Hun's article, regional studies on the Korean War era were not addressed apart from studies on refugee policies; notably, there was a lack of research specifically focusing on UNCACK's public health activities.

In this study, I examine the case of infectious disease control and vaccination promotion efforts on Koje Island based on the materials produced by UNCACK. I aim to analyze efforts for disease prevention among Koje Island residents, such as isolation, treatment, and improvement of living environments. Additionally, I closely review the characteristics of Koje Island's disease control measures to ascertain both the efforts and limitations of health problem resolution by UNCACK and the South Korean government during the Korean War era.

2. The Status of Koje Island and its Healthcare System during the Korean War

To identify the institution responsible for public health administration on Koje Island, it is necessary to understand UNCACK, which was a comprehensive economic organization with jurisdiction over military, civil, and economic affairs. Immediately after the outbreak of the Korean War, the U.S. military focused on preventing the spread of the disease in overcrowded refugee camps in Busan. In the early stages of the Korean War, UNCACK was responsible for refugee control, management, and relief operations. After 1951, UNCACK continued to provide refugee relief, economic assistance, regional management, and sanitation, as well as conduct surveys and provide assistance regarding economic conditions (Jeon, 2016: 151). The prevention of infectious diseases was performed under UNCACK's leadership.

In 1951, UNCACK consisted of the following organizational structures: Staff and Administration, Public Health, Welfare, Sanitation, Supply, Civil Information and Education, and Economics. Regional teams were assigned to each province. The Public Health Department was responsible for investigating the medical conditions necessary for disease prevention and assessing war-related damages. It also advised Korean health institutions. The Welfare Department focused on relief efforts for refugees and displaced persons and conducted research and investigations. The Sanitation Department directly handled tasks related to infectious disease control, such as the distribution of insecticides such as DDT, and provided training to Korean medical personnel. The health and sanitation tasks were not only to support health facilities but also to control the outbreak

of infectious diseases to protect the United Nations forces, including the U.S. military. The ultimate goal was to prevent the spread of infectious diseases and ensure the health and well-being of military personnel (Seo et al., 2010: 305-306; Jeon, 2016: 151).

UNCACK summarized its activities in the form of reports, which included regular reports from regional teams, such as weekly reports, weekly activity reports, daily activity reports, and semi-monthly reports. These reports covered various aspects of humanitarian and economic assistance in South Korea, including public health activities. These reports were known as Section IV. Social Affairs, and usually included a section on social affairs with information on public health activities. They consisted of:

- 1) Health, sanitation, infectious diseases (including non-communicable diseases), and hospitals.
- 2) Public welfare, refugees, displaced persons, orphans.
- 3) Public information.
- 4) Education, hygiene, supplies, medical and disease prevention supplies.

In addition to the general reports on sanitary conditions, the reports in Sections IV. Social Affairs also included information on the incidence of infectious diseases, vaccination programs, support for hospitals in various regions, and DDT spraying programs. Statistics were compiled on the incidence of diseases, such as cholera, diphtheria, smallpox, and typhoid fever, broken down by region into Seoul, Gyeonggi, Chungcheong, Jeolla, Gyeongsang, Gangwon, Jeju, and Koje.²⁾ In December 1950, at the

2) Lim, Gwang-soon, "Hygiene and Quarantine in Korea seen from the perspective of an

beginning of UNCACK's activities, public health officers were assigned only to certain regions; however, by March 1951, they were assigned to all regional teams, enabling uniform information collection nationwide. The system was formalized and standardized.

While UNCACK public health officers were deployed in various regions, their roles were primarily limited to requesting regular reports and statistics on disease incidence and vaccination programs from local authorities. The collection of basic information on disease occurrences in each region, such as at the local level (county, village, etc.), was designated as the responsibility of local government officials.³⁾ Thus, a standardized format for reporting was established. Although they were not medical professionals, Korean local government officials played an important role in conducting statistical surveys as part of their responsibilities.

The health, medical, and sanitation projects on Koje Island were managed by the UNCACK Koje-do team. Initially, there were no dedicated teams on Koje Island. From December 1950, after the establishment of the central organization of UNCACK, the Koje-do sub-team within the Gyeongsangnam-do Provincial team of UNCACK was in charge of projects related to Koje. However, on January 24, 1951, an independent team was formed on Koje Island. This independent team was set up by UNCACK to provide support for relief supplies, as Koje Island was used as a shelter for numerous refugees, including those from the Heungnam evacuation, and designated as a POW camp. In late January 1951, Major

American in the 1950s," Archive of Korean History, <http://archive.history.go.kr/reference/view.do?id=15>. Accessed 17 May 2023.

3) See the following document. The original source of this document is from the weekly report of Chungcheongnam-do on April 23, 1951. "An advice to Gunsu and Myeonjang," Lee, Imha, *Infectious Disease War* (Seoul: Cheolsu & Younghee, 2020), pp. 59-62.

Arnold was transferred to the Koje-do team.⁴⁾ As of September 1, 1951, the Koje-do team was under Lieutenant Colonel Nelson's command. The team consisted of administrative and public health officers, sanitation technicians, clerks, typists, engineers, and drivers.⁵⁾ Although a separate organization was established to oversee Koje Island, it reported its activities to the Gyeongsangnam-do Provincial Team. The Gyeongsangnam-do Provincial team frequently sent public health officers to Koje Island for sanitation assessments.

During the Korean War, the infectious diseases that required reporting under the Infectious Disease Prevention Regulations included 12 types, which expanded from the 10 types during the Japanese colonial period.⁶⁾ The additional diseases were plague and epidemic encephalitis, comprising a total of 12 types, including cholera, typhoid fever, dysentery, diphtheria, paratyphoid fever, meningococcal meningitis, scarlet fever, relapsing fever, smallpox, and typhus.⁷⁾ UNCACK placed great emphasis on typhoid fever, as it was one of the leading infectious diseases that killed soldiers during the war. In particular, typhoid fever outbreaks had been reported within the National Defense Corps (*Kukmin Bangwuigun*), which had heightened concern and attention to typhoid fever (Lee, 2020: 74).

4) "Weekly Activities Report, 22 January to 28 January 1951, both dates inclusive," 30 January 1951, UNCACK Kyungsangnamdo Team, RG 338, UN Civil Assistance Command, Korea (UNCACK), 1951, Box 17, HIST PROG FILES - WEEKLY ACT RPTS 1951 (1 of 2).

5) "Weekly Report," 31 January 1951, RG 338; Jeon, Gab Saeng, *Geoje Modern and Contemporary Literature Series V* (Geoje: Geoje Cultural Center Local History Research Institute, 2016), p. 155.

6) Relapsing fever was added to the list of notifiable infectious diseases in 1940. "Relapsing Fever; designated as an infectious disease," Chosun Ilbo, 4 June 1940.

7) Japanese encephalitis was designated as an infectious disease under the Infectious Disease Prevention Regulations through Health Ministry Decree No. 4 in February 1950. Jeollanamdo Public Health Department, *Practical Summary of the Public Health Administration (Bogeon Haengjeong Silmu Jeyo)*, 1951, pp. 139-140; Lee, Imha, *Infectious Disease War*, p. 73; "encephalitis (*Hagi Noeyeom*) as an acute infectious disease," Dong-a Ilbo, 1 February 1950.

Outbreaks of typhoid fever and cholera also occur when it is difficult to obtain clean water. According to patient statistics from 1951, typhoid fever was the most common disease nationwide, followed by cholera, typhus, and dysentery. In 1951, typhoid fever, dysentery, and typhus caused the most damage, accounting for approximately 92% of all cases. This damage had been attributed to long-standing problems in Korea, such as inadequate sanitation and waste management, the presence of rodents and insects, and contamination of food and drinking water. Moreover, in the case of respiratory diseases transmitted through air, the lack of adequate patient isolation and carrier identification has contributed to the significant occurrence of infectious disease cases. In 1952, there was a significant number of encephalitis cases, and both cholera and encephalitis had higher fatality rates than other infectious diseases.⁸⁾

Table 1. Number of cases and deaths by type of acute infectious disease in 1951 (units: persons)

Disease	Patients	Deaths	Disease	Patients	Deaths
Typhoid Fever	86,637	16,543	Relapsing Fever	1,481	87
Typhus	38,581	5,657	Scarlet Fever	1,504	754
Smallpox	42,026	11,236	Diphtheria	1,504	754
Dysentery	7,274	544	Epidemic Meningitis	156	28
Paratyphoid Fever	706	91	Epidemic Encephalitis	13	7
Cholera	1	0	Plague	0	0
Total	180,925	35,540			

(Record Group 338: Records of U.S. Army Operational, Tactical, and Support Organizations (World War II and thereafter), 1917-1993; General Correspondence, 1951-1955 [Entry A1, 1301])

8) Ministry of Health and Social Affairs, "About the Summer Preventive Measures," 16 June 1959; Lee, Imha, *Infectious Disease War*, pp. 76-77.

Table 2. Number of patients with acute infectious diseases and deaths from 1951 to 1953 (units: persons)

Year		Cholera	Dysentery	Typhoid Fever	Paratyphoid Fever	Smallpox	Typhus	Scarlet fever	Relapsing Fever	Meningitis	Encephalitis
1951	Patient	-	9,004	81,575	886	43,213	32,211	84	2,728	224	27
	Death	-	824	14,051	180	11,530	6,154	14	246	14	13
1952	Patient	-	1,506	3,769	64	1,313	923	5	645	64	1,221
	Death	-	64	30	3	277	81	-	24	6	526
1953	Patient	-	1,139	1,352	58	3,349	410	2	21	43	280
	Death	-	17	70	2	571	24	-	1	10	112

(Ministry of Health and Social Affairs, "About the Summer Preventive Measures," 16 June 1959)

As shown in Tables 1 and 2 above, the statistics on cases and deaths from acute infectious diseases were compiled by both the Ministry of Health and Social Affairs and UNCACK, and there were variations in the numbers reported by each. Generally, UNCACK's data show a higher number of cases and deaths than the statistics provided by the Ministry of Health and Social Affairs.⁹⁾ The discrepancy between the statistics compiled by the Ministry of Health and Social Affairs and UNCACK can be attributed to the challenge of accurately aggregating the actual number of cases and deaths caused by infectious diseases. UNCACK not only served as the entity that dispatched public health officers to different regions to plan and implement the overall activities related to the project but also fostered organic relationships with government officials in each local area involved in the project. This facilitates the access to and aggregation of information. Therefore, it can be speculated that the statistics provided by

9) "Semi-Monthly Report," 31 December 1951, RG 338, Korean Communications Zone, 1952-53, Entry 11028, Box 19, Staff Section Report, Civil Information and Education Section, UNCACK; Staff Section Report, Public Information Section 1951-1951; Lee, Imha, *Infectious Disease War*, p. 82.

UNCACK may be more accurate.

In the late 1950 and early 1951, various diseases such as Diphtheria, Typhus, Paratyphoid, Typhoid, and Smallpox were reported in the entire region of Gyeongsangnam-do. During this period, epidemiological investigations were conducted, including information on the patient's location, date of occurrence, death, and additional remarks. However, it should be noted that there was a delay of two to three weeks in reporting cases or deaths. The rapid implementation of disease control measures was essential to prevent the spread of acute infectious diseases. However, epidemiological surveys conducted in Gyeongsangnam-do require a long time to collect and report information. Consequently, it was impossible to implement disease control measures based on this information alone. The effectiveness of this investigation in preventing the spread of infectious diseases can be considered negligible.

During this period, the governor of Gyeongsangnam-do decided to accommodate more than 100,000 refugees in Koje Island.¹⁰⁾ By the end of February that year, approximately 70,000 refugees had settled on the island (Jeon, 2016: 154). The UNCACK Koje Island team conducted monthly population surveys starting from January 1951 in accordance with the policy of refugee dispersion. Prior to the influx of refugees to Koje Island, the estimated population was about 100,000. Within two months, the population increased by approximately 70%, reflecting a significant influx of refugees (Jeon, 2016: 156). The construction of POW camps¹¹⁾ began in early 1951, and in the case of Koje Island, the camps were established in residential areas where civilians lived. Under the

10) "Re-evacuation of Refugees," Donga Ilbo, 15 January 1951.

11) One of the main reasons for choosing Koje Island as the site of the POW camp was its easy access to water sources.

pretext of optimal geographical conditions for the camp, residents living in the areas designated for camps were forcibly relocated (Gustafson, 1963: 43; Kim, 2016: 15).¹²⁾

As POW camps were constructed between January 1951 and June 1952, both refugees and residents of Koje Island had to adjust to the new environment, increasing the number of people who had to be relocated. Controlling the spread of infectious diseases and maintaining sanitary conditions had become crucial tasks owing to the influx of the population and the movement of indigenous inhabitants to new residential areas. As a result, disease prevention and control efforts were implemented on Koje Island, and medical facilities were established in key areas. The status of medical institutions on Koje Island and the activities related to disease occurrence and prevention can be found in the weekly reports of the Gyeongsangnam-do and Koje-do teams and the reports of Health Advisors sent by the Gyeongsangnam-do team.

According to a report by the Koje Island team, since the end of January 1951, when refugees began to arrive in large numbers and construction of the POW camp began, more attention had been paid to the control of infectious diseases. Previously, there were some areas where the reporting of the number of cases by Myon doctors was incomplete; however, the

12) On May 22, 1952, U.N. Command Headquarters implemented several measures in its camp policy, including increasing the number of security and surveillance forces, using overwhelming force against prisoners, breaking up the existing large prisoner compounds into units of 500, direct involvement in all camp affairs, proposing the construction of new camps on completely evacuated islands, and increasing intelligence and espionage operations. These measures were taken to facilitate the dispersal of prisoners and to initiate the construction of additional camps. RG 338, Eighth U.S. Army, Military History Section, Entry A1 224, Box 1650, Enemy Prisoner of War Records, 1951-53, Final Report to Control Prisoners of War, HQ KOOMZ, The Handling of Prisoners of War during the Korean War, June 1960.

reporting had gradually strengthened. This was made possible through the use of provincial doctors. Previously, the focus of epidemic prevention and medical activities was on refugee doctors. However, when the entire health system on the island had been organized, provincial doctors played a central role in carrying out epidemic prevention activities. They were responsible for maintaining treatment records and reporting all communicable diseases daily.¹³⁾

Hospitals and dispensaries were established in the major areas of Koje Island as follows: By the end of January 1951, three hospitals were established in Jangseungpo, Hacheong, and Koje (a specific region on Koje Island). The hospital, established in Jangseungpo, was run by staff at Severance Hospital in Seoul. Before the hospital equipment arrived on Koje Island from Seoul, the Severance Hospital staff set up a clinic at the YMCA and then at a local middle school to provide medical services. It had a capacity of 100 beds. The hospital in Hacheong had ten beds, a portion of the 40-bed unit supply. The hospital in Koje was also a 10-bed facility that the public health team was currently organizing. Although there were three hospitals, it was recommended that surgical residents and interns from Severance Hospital visit the other two. This refers to the organic relationship established between the staff of hospitals in various regions of Koje Island, which allows them to coordinate and monitor the medical situation on Koje Island, with Severance Hospital at the core.

13) "Weekly Report," to Commanding Officer, Koje Do Team, 25 January 1951, RG338, UNCACK, 1951, Box 17, HIST PROG FILES - WEEKLY ACT RPTS 1951 (1 of 2), p. 2.

Table 3. Current status of medical facility installations on Koje Island at the end of April 1951

Region	Type of Installation	Personal Employed			Bed Capacity
		Doctors	Assistant	Nurses	
Jangmok	Dispensary	1	1	1	
Yoepo	Dispensary	1	1	1	
Hacheong	Dispensary	2	2	2	10
Hacheong	Private Clinic	1	1		2
Jukto	Dispensary	1	1	1	
Eyoncho	Private Clinic	1	1		2
Jangseungpo	Private Clinic	1	1		
Jangseungpo	Private Clinic	1	1		
Jangseungpo	Severance Hospital	6	6	6	100
Okpo	Dispensary	1	1	1	
Seongpo	Dispensary	1	1	1	
Seongpo	Private Clinic	1	1		2
Chisepo	Dispensary	1	1	1	
Gujora	Dispensary	1	1	1	
Chisepo	Private Clinic	1	1		3
Seongnae	Dispensary	2	2	2	10
Seongnae	Private Clinic	1	1		
Sadeung	Dispensary	1	1	1	
Sanyang	Dispensary	1	1	1	
Sangyang	Private Clinic	1	1		
Jeogu	Dispensary	1	1	1	

(Korean Medical Installations, "Weekly Activities Report," RG338 UN Civil Assistance Command, Korea (UNCACK), 1951, Entry UNCACK Unit 11110, Box April 20 Index, Weekly Reports for April)

In 1951, as shown in Table 3 above, clinics and hospitals were distributed across Koje Island. However, according to reports issued thereafter, the number of clinics varied depending on the period. During the Korean War, there was only one hospital facility, Severance Hospital, which was

the most prominent medical institution operating on Koje Island.

Alongside the hospital, there were clinics across several locations, as well as the Myon Team in 10 different areas. Additionally, three sub-teams were established in Jangmok-Myon, Jangseungpo-Eup, and Dongbu-Myon, respectively, apart from the central team. As of March 1951, Koje Island had 10 Myon teams, 3 sub-teams, 25 doctors, 25 assistants, and 25 nurses. In addition, there were 3 preventive medical teams consisting of three members each, as well as three active sanitation teams. These teams report to the official Myon Public Health Doctor and operate under his supervision in the designated area. All their work was included in the doctor's weekly report. Therefore, the content was accurate, as it was based on local research and observations. In addition, 8 to 10 refugee doctors volunteered their time throughout the island to assist with the program.¹⁴⁾

3. UNCACK's Activities to Control Diseases and Improve Public Health Conditions on Koje Island

3.1 Disease Control on Koje Island and UNCACK

During the Korean War, population movements were rapid, leading to outbreaks of infectious diseases not only among the military but also among the civilian population. Koje Island, in particular, had received refugees from various parts of the country, including a significant influx from North Korea, despite its geographical distance. These refugees lived in temporary shelters rather than in proper housing facilities upon

14) "Weekly Report," 3 March 1951, RG 338, UNCACK, 1951, Box 18, Supply Report, File No. 400, Box 18 (3 of 4).

their arrival at Koje Island, and the conditions in these facilities were unsanitary, leading to an outbreak of various infectious diseases among the refugees. This situation affected not only the refugees but also the living environments of residents.

UNCACK conducted inspections of the public health status of Koje Island, dividing it into categories such as infectious diseases, non-communicable diseases, and medical supplies, including Hospital Units (HU), Basic Medical Units (BMU), and sanitation. The supply of HU and BMU was continuously carried out, and activities such as the investigation of infectious disease patients and deaths and the implementation of various infectious disease prevention programs were carried out. Sanitation activities, including general sanitation, lindane¹⁵⁾ programs, insect and rodent control, and public sanitation, were conducted separately. These investigations also included surveys of the entire population of Koje Island, including refugees and residents, with data collected separately for each group. Separate measures were taken in refugee camps.¹⁶⁾

Analyzing UNCACK's report provides insight into how disease control was conducted on Koje Island. By the end of February 1951, vaccination efforts had commenced in almost all regions of South Korea. The distribution of the smallpox vaccine followed the sequence of Gyeongsangbuk-do, Gyeongsangnam-do, and Koje Island. Substantial disease control measures may have been initiated on Koje Island in March

15) Lindane is a powder containing 1% gamma B. H.C. for use against lice. It is used as lice had been found on North Korean prisoners who were resistant to DDT. Harsant, A. G., "Discussion on Military Medical Problems in Korea," *Proceedings of the Royal Society of Medicine* 46 (1953), p. 15.

16) "Field Trip to Koje Do," 3 July 1952, Pusan City Sub-team, 37. Koje Gun, RG469, Unclassified Subject Files, ca. 1955-11/03/1961 [Entry P321].

of 1951.¹⁷⁾ Since the epidemic on Koje Island was not confined to specific areas but spread to several regions, ten public health teams conducted vaccination campaigns and DDT spraying throughout the island.¹⁸⁾ In March 1951, the estimated population of Koje Island was 190,000 people.¹⁹⁾ Based on this figure, the vaccination rates for typhoid fever, typhus, and smallpox were 23%, 37%, and 95%, respectively. Primary and secondary vaccination campaigns had been conducted for these three diseases. Because of consistent vaccination efforts, vaccination rates increased in April 1951.²⁰⁾ Disease-control measures were highly effective in the early months of 1951. The results of prevention campaigns conducted in June of that year showed a 100% vaccination rate for these three infectious diseases.

Table 4. Immunization coverage for major infectious diseases (31 August 1951)

Province	Smallpox		Typhoid		Typhus	
	Number	Percentage	Number	Percentage	Number	Percentage
Seoul	-	-	-	-	-	-
Gyeonggi	1,025,548	51	2,100,990	100	1,725,141	86
Chungbuk	932,100	70	981,000	74	897,580	68
Chungnam	2,106,528	76	1,945,054	70	1,433,700	52
Jeonbuk	1,881,493	81	3,174,660	100	1,421,742	66
Jeonnam	2,318,900	75	2,170,550	70	1,634,660	53

17) "Consolidated Weekly Activities Report," to Commanding General, 28 February 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, HIST PROG FILES - WEEKLY ACT RPTS 1951.

18) "Weekly Report," 31 January 1951, RG 338, UNCACK, 1951, Box 17, HIST PROG FILES - WEEKLY ACT RPTS 1951.

19) UNCACK's population count for Koje Island did not include the number of prisoners of war (POWs). The number of POWs was counted separately.

20) "Weekly Report," 3 March 1951, RG 338, UNCACK, 1951, Box 18, Supply Report, File No. 400, Box 18 (3 of 4).

Gyeongbuk	2,980,092	74	3,585,138	89	3,510,550	87
Gyeongnam	2,691,611	73	2,990,633	89	2,526,803	68
Gangwon	217,741	16	497,049	37	503,563	38
Jeju	258,188	70	281,484	77	271,698	74
Koje	284,735	100	267,335	100	320,889	100
Total	14,696,936	70	18,003,893	87	14,246,326	67

(Lee, 2020: 121)

Table 4 shows that all inhabitants of Koje, including refugees, had been vaccinated. This result is remarkable when compared with the vaccination rates in other areas. What made this possible? In 1951, hospitals and clinics were established, and a dedicated team was organized to oversee Koje Island. It can be said that at that time, the entire organization of personnel who could actively participate in field operations had not yet been achieved. However, UNCACK's report analyzing the number of infectious disease cases in mid-May indicated that, although not everyone had been immunized, the immunization effort was judged to be effective.²¹⁾ Weekly reports documented the occurrence of infectious diseases. Although there were sporadic instances of three-digit cases, it is noteworthy that there were no explosive outbreaks of infectious diseases on Koje Island, as mentioned by the Koje team. To determine the effectiveness of disease control, particularly vaccination, I examined the specific timing and number of vaccinated individuals. The vaccination rate exceeded that of the entire population of Koje Island beginning around April 1951. The UNCACK report initially estimated the population of Koje Island to be approximately 230,000 in early 1951 and later revised it to approximately

21) "Weekly Activities Report," 12 May 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Weekly Activities Reports for the Month of May.

170,000.²²⁾ However, the number of vaccinated individuals exceeded both the initial and revised population estimates.²³⁾ UNCACK compared the total population of Koje Island with the number of vaccinated individuals and reported 100% vaccination rates for cholera, typhoid fever, and typhus.

Table 5. Comparison of the Immunization Programs in June and October 1951²⁴⁾

	June			October		
	Immunizations This week	Total Since 1 JAN 1951	Percentage of Population Immunized	Immunizations This week	Total Since 1 JAN 1951	Percentage of Population Immunized
Smallpox	2,271	275,934	100	0	284,735	100
Typhoid	3,679	269,884	100	0	267,355	100
Typhus	1,952	319,047	100	0	321,489	100

(“Annex I to Weekly Activities Report (June 23, 1951)” and “Annex I to Semi-Weekly Activities Reports (October 3, 1951)” in RG338)

As shown in Table 5, intensive vaccination against smallpox, typhoid fever, and typhus was administered on Koje Island in the first half of 1951. After the completion of vaccination for all inhabitants of Koje Island was reported to be 100% in a weekly report in June 1951, UNCACK continued to report a vaccination rate of 100% until October of the same year. However, UNCACK pointed out discrepancies in the claimed 100%

22) The correction in the population count of Koje Island is related to the accurate aggregation of refugee statistics.

23) “Weekly Activities Report,” 19 May 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Weekly Activities Reports for the Month of May.

24) The contents of the table are excerpts from the UNCACK report, highlighting the necessary sections. UNCACK calculated the prewar population as 100,000 and added the present population, including refugees. The total population was 173,532 in June and 172,523 in October. The population did not change significantly during this period. See “Annex I to Weekly Activities Report (23 June 1951)” and “Annex I to Semi-Weekly Activities Reports (3 October 1951)” in RG338.

vaccination rate and acknowledged that it did not correspond to reality.

“That is not a true picture. Many had been vaccinated twice or more for smallpox and completed two or more shots of Typhus and Typhoid, whereas in some of the more isolated areas, none had been vaccinated or inoculated. This was mainly because no record of immunization was kept by the individual in the early stages of the program.”²⁵⁾

The discrepancy between the vaccination rate and reality can be attributed to several factors. First, personal records of the initial vaccination phase were lacking. Furthermore, the residents of remote/isolated areas were not vaccinated. Additionally, at least two doses of the vaccine should be administered for these infectious diseases; however, the total number of completed vaccinations did not reach twice the population count. This discrepancy indicates that the 100% value was inaccurate.

Despite the flawed data, the effective control of epidemics on Koje Island can be understood as the result of concentrated and sustained control measures. All refugees were targeted for vaccination and vaccinated twice between February and April 1951. The local and native populations were selectively targeted for vaccination.²⁶⁾ When the total number of people vaccinated in October is examined from Table 5, it can be seen that the number did not increase significantly compared with June. However, the number of people vaccinated increased slightly each month, this indicates that the vaccination effort was ongoing and

25) Immunization Program, 15 April 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Hist. Prog. Files-Weekly Act Rpt. 1951.

26) “Semi-Monthly Activities Report,” 16 October 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 23, Semi-Monthly Activities Reports.

sustained.²⁷⁾ Epidemic control through vaccination had not been fully implemented; however, stable containment of the disease is evident. This indicates the effective implementation of epidemic control, which focused on the clinics mentioned above and Myon teams in cooperation with UNCACK.

In addition, UNCACK made efforts to maintain trust in epidemic control efforts conducted jointly with the South Korean government. When residents of Koje Island complained about the DDT used for disinfection, UNCACK promptly changed its composition. Residents expressed reluctance to use the 10% powdered DDT for dusting because of its killing effect. An urgent request was made for the pyrethrum powder to be mixed with 10% powder to prevent a complete loss of confidence in the effectiveness of the fogging program. These measures were taken out of concern that such actions would lead to a loss of trust in the DDT dusting program when refugees returned to the Korean Peninsula. However, owing to a lack of manpower and resources, this task could not be performed as quickly as expected.²⁸⁾ However, these swift actions by UNCACK and the province demonstrate a collaborative approach not only to the local epidemic problems on Koje Island but also to the broader epidemic concerns within Korea. This indicated a cooperative effort between the two parties.

In contrast, malaria control operations were particularly challenging. According to the Weekly Activities Report, while the number of infectious

27) "Monthly Immunization Report (16 Nov. 1951)," RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 23, Semi-Monthly Activities Reports.

28) "Weekly Activities Report," 12 May 1951, RG338; "Weekly Activities Report," 9 June 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Weekly Activities Reports for the Month of June.

disease patients remained stable each week, several hundred malaria cases occurred. In addition, anopheline larvae at all stages were found on Koje Island during the malaria control efforts.²⁹⁾ It was estimated that there was a high likelihood of malaria carriers entering Koje Island owing to an influx of refugees.³⁰⁾ The anti-malaria program was implemented in conjunction with Sanitary Teams and Myon dispensaries. Myon doctors were responsible for reporting the mosquito situation in the areas under their jurisdiction.³¹⁾

The anti-malaria program required both equipment and manpower, but there was a shortage of personnel responsible for carrying out disinfection and a lack of necessary equipment. Therefore, it was challenging to perform disinfection.³²⁾ Over time, the size of medical teams decreased, making it difficult to provide adequate medical care in areas where refugees were living.³³⁾ This situation continued during the malaria outbreak in July, which was exacerbated by heavy rain.³⁴⁾ Malaria had led to increased morbidity and mortality among young refugees. Several factors contributed to this, most notably overcrowded and damp living conditions, insufficient medical supplies, and an acute shortage of essential food and nutrition.³⁵⁾

UNCACK requested that national or provincial governments provide

29) "Weekly Activities Report," 22 July 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 21, Weekly Activities Report Month of July.

30) "Semi-Monthly Activities Report," 16 October 1951, RG338.

31) "Weekly Activities Report," 12 May 1951, RG338.

32) "Weekly Report," 21 April 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Weekly Activities Reports for the Month of April.

33) "Semi-Monthly Activities Report," 16 October 1951, RG338.

34) "Weekly Activities Report," 15 July 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 21, Weekly Activities Report Month of July.

35) "Weekly Activities Report," 22 July 1951, RG338.

the necessary funds to compensate the staff implementing the programs. Although UNCACK was responsible for managing and supervising the anti-malaria program, the local government provided funds. However, as with other epidemic control operations, problems arose due to delayed payments to individuals involved in epidemic control, including doctors and nurses, making it difficult for programs to proceed as planned.³⁶⁾

3.2 U. S. Laboratory Ship and Rapid Experimental Outcome

Compared to other areas in Korea, Koje Island can be seen as having effectively controlled infectious diseases. This can be attributed to the organic collaboration with external institutions. When infectious and non-infectious diseases occurred, laboratory testing of specimens was critical. Although the Severance Hospital on Koje Island was equipped with a laboratory, in-depth testing could not be done there. Therefore, when experiments were needed, they were sent to outside institutions, and the U.S. Laboratory Ship played a role in conducting these experiments.

According to the Koje-do team report, in mid-March 1951, Commander H.S. Hurlbut and a party from the laboratory ship, Far East Command Epidemic Control Unit #1, visited the Koje-do team to support preventive measures in controlling communicable diseases. They utilized the facilities of the Laboratory Ship to enhance their efforts in this work.³⁷⁾

The U.S. Laboratory Ship appeared to be operated by the U.S. Navy Fleet Epidemic Disease Control Unit #1. The unit was a medical research

36) "Weekly Report," 28 April 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Hist. Prog. Files-Weekly Act Rpt, 1951.

37) "MAR: Koje Do UN Civil Assistance Command Korea Team," RG554, United Nations Command Adjutant General's Section, UNCACK Adjutant General Section, Entry A-1 1303, Team Reports, 1951-1953, Box 80.

and control unit located aboard the USS LSIL 1091, a converted landing craft, and had a modern and adequate public health laboratory on board. Personnel within the unit consist of medical officers, allied science officers specializing in bacteriology, entomology, epidemiology, sanitation, venereal disease control, and other related specialties, along with enlisted technicians with similar technical expertise.

This Unit was established in Japan in October 1950 and arrived in Korea in early February 1951 and operated in the facilities of 64th Field Hospital which was responsible for the care of the prisoners in Koje Island Camp.³⁸⁾ The initial task involved a journey to Wonsan Harbor in March to investigate a suspected plague outbreak. Subsequently, in March, the Unit received orders to head to Koje to provide laboratory and preventive medicine support to the 60th General Depot and assist in any possible way with the ongoing study of a dysentery epidemic among POWs. The Commission on Enteric Infections of the Armed Forces Epidemiological Board was involved, and a Joint Dysentery Study Group was formed to conduct an intensive investigation. This research effort brought some leading scientists to the field of biological science in Korea. The group included renowned scholars from American universities and institutions, such as The National Institute of Health, the Far East Research Institute, and the commanding officer of the 406th Army Medical Laboratory in Tokyo.³⁹⁾ These researchers were involved in experiments related to infectious and non-infectious diseases on Koje Island. Through such

38) Garfinkel, Bernard T., "Enteric Diseases among Korean and Chinese Prisoners of War," *Recent Advances in Medicine and Surgery II* (Washington D.C.: Army Medical Service Graduate School, 1955), p. 127.

39) "Memorandum," 24 October 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 23, Semi-Monthly Activities Reports.

human connections, it appears that experiments related to diseases occurring on Koje Island can be promptly conducted in places such as Korea and Japan.

The U.S. laboratory ship played a significant role in controlling Japanese encephalitis and malaria. On Koje Island, unlike the nationwide outbreaks of smallpox, typhoid fever, and typhus, noticeable occurrences of Japanese encephalitis and malaria were observed. When suspected cases of Japanese encephalitis arose, autopsies were conducted on deceased patients, and brain samples were immediately sent to the U.S. Laboratory Ship located at Kohyun for examination.⁴⁰⁾ In the case of Japanese encephalitis, some samples were examined in laboratories located in Japan, where investigations were conducted to confirm the presence of the virus.⁴¹⁾ Additionally, the U.S. Laboratory Ship conducted regional malaria surveys and compiled reports. It also handles tasks such as examining blood films⁴²⁾ and conducting tests on DDT resistance in fleas.⁴³⁾ In cases involving suspected tetanus, the individuals were admitted to Severance Hospital, and laboratory samples were sent to the laboratory ship for examination and verification.⁴⁴⁾

40) "Weekly Activities Report," 26 May 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Weekly Activities Reports for the Month of May.

41) "Weekly Activities Report," 9 June 1951, RG338.

42) "Weekly Activities Report," 12 May 1951, RG338.

43) "Weekly Report," 21 April 1951, RG338; "Weekly Report," 28 April 1951, RG338; "Weekly Activities Report," 12 May 1951, RG338.

44) "Weekly Activities Report," 29 July 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 21, Weekly Activities Report.

4. Challenges Encountered in the Preventive Measures on Koje Island

As the living conditions for refugees stabilized, diseases occurring on Koje Island began to be somewhat controlled. In examining the medical and preventive activities predominantly observed on Koje Island in 1951, several characteristics stand out. First, with the establishment of clinics and hospitals operated by UNCACK, systematic control of infectious diseases became feasible. There was a well-organized system to identify patients in clinics and transfer infectious or suspected cases to hospitals. Additionally, the rapid confirmation of pathogens through the U.S. Laboratory Ship allowed UNCACK to swiftly obtain results and subsequently take necessary follow-up actions. In addition, although not discussed in detail in this study, it is worth mentioning that preventive vaccinations were mandatory when UNCACK employed or sent workers to the Korean Peninsula. Furthermore, patients with tuberculosis were not kept on the island, but were transferred to the tuberculosis sanatorium in Masan, thus maintaining health and hygiene conditions on the island.

However, the timely disbursement of funds to cover expenses for crucial roles in epidemic control, such as doctors, nurses, assistants, and DDT sprayers, was lacking, thus significantly compromising the stability of their duties. Here is the case for the POW camp. The Surgeon's Office at the POW camp had been continuously advertising doctors and nurses, and as of April 1951, approximately 20 medical personnel were working at the camp.⁴⁵⁾ However, because UNCACK was unable to pay

45) There were few U. S. Army professional personnel, physicians, nurses and paramedics, so in order to handle the problem captured medical personnel as well as friendly Korean civilians were employed. Leedham, Charles L., "Tuberculosis," *Recent Advances in Medicine*

them, they were forced to leave. To continue medical activities, voluntary assistance with payments or bringing doctors and nurses from Busan or other locations on the Korean Peninsula to the POW camp hospitals was necessary.⁴⁶⁾

There were differences in perspectives between UNCACK and provincial authorities. The preventive medicine teams operating on Koje Island were employed by the province, but were not compensated. They expected to receive salaries to assist in UNCACK's programs and maintain their organization. However, provincial health authorities claimed that they lacked funds and suggested the dissolution of these teams. As the malaria season approached, UNCACK argued that provincial health authorities needed to sustain these teams as much as possible and create additional teams. They also emphasized that all teams should consist of one doctor, one nurse, and one medical technician. While carrying out epidemic control activities, UNCACK and provincial health authorities showed differences in their positions concerning the issue of cost payment.⁴⁷⁾

The issue of cost payments also emerged during hospital operations. Each region on Koje Island has hospitals and dispensaries, with medical teams stationed at each hospital and dispensary, excluding private clinics.⁴⁸⁾ Dispensaries were managed by UNCACK, whereas hospitals were jointly managed by UNCACK and the South Korean government.⁴⁹⁾ They

and Surgery II (Washington D.C.: Army Medical Service Graduate School, 1955), p. 136.

46) "Weekly Activities Report," 14 April 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Hist. Prog. Files-Weekly Act Rpt, 1951.

47) The DDT dusting teams operated voluntarily without receiving payment from the beginning. *Ibid.*

48) Korean Medical Installation, "Weekly Health Report," 28 April 1951, RG338.

49) Around June 1951, the operating agency changed from UNCACK to UNCACK+ROK.

operated under the UNCACK administration but received salaries through financial support from the Ministry of Health via the local (provincial) government.⁵⁰⁾ UNCACK managed infectious disease prevention and public health programs, while provincial health offices and local medical practitioners were responsible for fieldwork.

Consequently, they needed to maintain highly cooperative relationships. However, there were evident differences in perspectives regarding funding the implementation of these programs. One significant challenge in program execution is the untimely arrival of medical supplies intended for epidemic control, such as vaccines and DDT. Furthermore, a significant issue arose as the salaries of personnel involved in practical implementation were not disbursed over time. Most teams, including the mobile sanitary and preventive medicine teams, participated in the programs without receiving salaries, leading to frequent instances of individuals quitting their positions midway through their work.⁵¹⁾

This issue revolved around the public health and hygiene program initiated in 1952. At that time, Severance Hospital, the only general hospital on Koje Island, faced economic challenges, making it difficult to sustain its operations and hindering the implementation of other programs. While the Ministry of Health and local government emphasized the necessity to continue hospital operations, they did not commit to providing financial support.⁵²⁾ Furthermore, the shortage of medical supplies had been exacerbated. In 1952, there was an epidemic of Japanese encephalitis that

50) Korean Medical Installation, "Weekly Health Report," 28 April 1951, RG338.

51) "Weekly Activities Report," 5 May 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 20, Weekly Reports from the Teams, May 1951.

52) "Report of Public Health Conditions on Koje-Do," 16 June 1952, RG469, Unclassified Subject Files, ca. 1955-11/03/1961 [Entry P321], 37. Koje Gun.

required cerebrospinal fluid testing for diagnosis. However, no facilities were available for chemical testing or culturing of cerebrospinal fluid, making it difficult to accurately identify cases of suspected Japanese encephalitis.⁵³⁾ In 1953, physicians were unable to perform blood tests; therefore, they relied primarily on clinical photographs to diagnose Japanese encephalitis. There was a significant shortage of santonin during the deworming campaign. UNCACK discussed how to prioritize the administration of anthelmintics to school-aged children and orphans following Japanese practice. Although this may not fundamentally resolve the issue, it was suggested as an experimental campaign that could be attempted. This approach was based on the assumption that Koje Island has a small population, a well-functioning prevention program and that the facilities of Severance Hospital could provide adequate laboratory control. However, with the reduction in the budget allocated for epidemic control and the challenges faced in hospital operations, it was deemed difficult to execute these programs smoothly.⁵⁴⁾

Furthermore, the increase in tuberculosis and venereal diseases poses a challenge. While epidemics such as legally notifiable diseases and malaria were under control, other infectious diseases began to emerge. UNCACK had made efforts to investigate patients with tuberculosis and set up clinics for those with venereal diseases. However, effective control of chronic infectious diseases requires more resources and expenses than acute infectious disease management.⁵⁵⁾ Tuberculosis cases were prevalent not only among refugees but also among indigenous populations, making it

53) "Visit to Ko Je Do," 9 September 1952, Kyongsangnam-do provincial team, RG469, Unclassified Subject Files, ca. 1955-11/03/1961 [Entry P321], 37. Koje Gun.

54) "Semi-Monthly Activities Report," 16 October 1951, RG338.

55) Ibid.

challenging to apply existing control methods targeting specific groups or areas. Additionally, with the increasing number of military personnel on Koje Island, controlling venereal diseases had become necessary. Despite efforts to establish dispensaries in Kohyun for treating venereal diseases among women, there had been a mismatch with government initiatives, such as a decline in visits to disease clinics due to police crackdowns on prostitution, resulting in a discrepancy in strategies.⁵⁶⁾

5. Conclusion

The Korean War was distinctly different from previous conflicts and catalyzed the establishment of a new public health system in Korea. The unique circumstances of war require rapid action against infectious diseases. New epidemic control methods and systems had been established, including vaccination, distribution of DDT and lindane, and establishment of clinics and medical facilities.

In particular, Koje Island served as a temporary refuge for refugees and as a POW camp; therefore, its hygienic environment was very different from that before the Korean War. In addition, considering the potential health and hygiene problems that may arise when they return to the Korean Peninsula, it is imperative to implement health and hygiene initiatives in this area. Therefore, epidemic prevention efforts on Koje Island were significant not only in addressing local health concerns but also in their connection to broader national health issues that transcended regional boundaries.

56) "Monthly Report of Operations, UNCACK Dispensary and V. D. Clinic, Month of September 1951," 6 October 1951, RG338, UNCACK, 1951, Entry UNCACK Unit 11110, Box 23, Semi-Monthly Activities Reports.

Owing to its geographical nature as an island, Koje was able to conduct systematic public health initiatives in a controlled space, and this program was judged as highly successful. Several factors contributed to this assessment. First, the UNCACK controlled the entire island and quickly implemented disease response and prevention measures. This experience provides an opportunity to analyze the efficiency of disease control made possible by the stable population and limited mobility within the area. Second, the public health initiatives on Koje Island were conducted in a highly community-oriented manner within a controlled environment. In addition, owing to the unique circumstances of the coexistence of war prisoners and refugees on the island, direct collaboration with international medical and scientific experts and institutions enabled rapid and accurate identification of the causes of the disease. Subsequently, the application of these findings for the detection and prevention of infectious diseases had increased the effectiveness of public health initiatives.

Koje Island served as a testing ground for the infectious disease management policies developed by the United States during World War II. It was also a place characterized by civil administration, which included the operation of a massive POW camp in addition to housing refugees. The civil administration, with limited resources, manpower, and a limited number of Korean health professionals, had provided opportunities to cultivate the skills necessary for effective infectious disease management.

However, public health initiatives on Koje Island during the late war were limited. In 1952, these initiatives began to stagnate, and in 1953, there was a significant outbreak of smallpox. This was the beginning of exposure to deficiencies in seemingly stable public health operations on Koje Island. Projects aimed at improving local medical services were

halted. UNCACK planned to establish a health center by renovating the UNCACK dispensary in October 1951 to provide various public health services, including maternal and child health, health education, nutrition, nursing, and medical social services.⁵⁷⁾ This project may have been linked to local healthcare systems since the war. In the end, however, this did not materialize. Owing to the repatriation of prisoners of war and the movement of refugees, public health initiatives carried out on Koje Island did not transition seamlessly into immediate local health initiatives.

Koje Island, which served as a space where refugees, prisoners of war, and locals coexisted, showed significant differences in its healthcare environment between the prewar and postwar periods because of its uniqueness as an island. Consequently, Koje Island was deprived of medical resources for some time after the war. However, the experience gained from limited public health initiatives during the war, although modest, had some continuity in the postwar period and seemed to create a strong demand for medical services among the local population. Toward the end of the war, the Canadian Mission implemented public health initiatives in a building formerly occupied by Severance Hospital. The driving force behind this initiative was a medical missionary working at Severance Hospital and its affiliated nursing schools. In addition, Aegwangwon, a wartime infant orphanage, established a hospital to provide local healthcare. In the 1970s, Koje Island became a testing ground for a new form of medical enterprise, known as community-based healthcare, which combines prevention and treatment. From these facts, it can be confirmed that the public health initiatives on Koje Island during the Korean War had a significant influence not only on UNCACK, which

57) "Memorandum," 24 October 1951, RG338.

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promoted these initiatives but also on postwar public health initiatives on Koje Island.

Key Words : Koje (Geoje) Island, public health, disease control, preventive measures, infectious disease, U.S. laboratory ship, United Nations Civil Assistance Command in Korea (UNCACK)

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Abstract

The United Nation's Civil Assistance Command in Korea's (UNCACK) Public Health Measures on Koje Island during the Korean War[†]

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This study focuses on the health and sanitation projects carried out on Koje Island by the United Nations Civil Assistance Command in Korea (UNCACK). Koje Island was unique as it served as a destination for dispersed refugees and as an area for housing prisoners of war. Unlike in other regions, UNCACK was actively involved in the implementation of health and sanitation projects on Koje Island. Their infectious disease control projects on Koje Island serve as a valuable example for studying infectious disease prevention initiatives and local medical projects in modern and contemporary Korea.

In this study, I examine the documents produced by UNCACK to assess the status of infectious disease control and vaccination plans.

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Additionally, I analyze the disease prevention initiatives implemented among the residents of Koje Island, including isolation, treatment, and improvement of living conditions. Finally, I explore the characteristics of the Koje Island preventive measures and assess the efforts and limitations of both UNCACK and the Korean government in addressing health issues during the Korean War.

Despite the presence of refugees and POWs, Koje Island managed to implement systematic public health initiatives in a controlled environment, widely regarded as highly successful. The public health initiatives on Koje Island, led by UNCACK, provided an opportunity to utilize limited resources, manpower, and Korean health professionals, cultivating the skills necessary to manage infectious diseases effectively. Moreover, these initiatives on Koje Island, although modest, continued into the postwar period, influencing medical missionary activities, the demand for health services among residents, the establishment of independent medical institutions, and the implementation of local health projects.

Key Words : Koje (Geoje) Island, public health, disease control, preventive measures, infectious disease, U.S. laboratory ship, United Nations Civil Assistance Command in Korea (UNCACK)