4. EUROPEAN MEDICINE IN THE CONGO FREE STATE (1885-1908)\(^1\)

The initial stages in the establishment of European medicine in the Congo Basin may be seen metaphorically as a giant crossroads, with various pathways running parallel, intersecting, separating, converging, merging and again splitting apart. At this period spanning the end of the nineteenth century and the early years of the twentieth, a tacit coexistence took shape (in both thought and action) throughout Central Africa, between health concepts and practices of health care, born of utterly different historic backgrounds and traditions. The indigenous skills and methods already in place stemmed from empirical adaptation to Central Africa's very diverse conditions, knowledge gleaned from various pharmacopoeias, the identification of specific diseases, and a range of treatments that even included surgery.\(^2\) This concept of physical and psychological health was gradually to enter into coexistence with a totally foreign system of Western medicine that was itself in the throes of change. Although in the process of becoming more scientific and more professional, the Western system – in the tropics – was still reduced to time-tested empirical solutions and to trial and error, while its increasingly scientific nature was tempered by naivety and ignorance.

Towards the end of the 19th century science was rapidly gaining ground but its application was still limited mainly to treating Europeans who had emigrated to or were travelling in the tropics.

European medical practice, like African customs, is steeped in a cultural heritage. Historically, Western medicine has been linked to a religious tradition of reaching the soul through the care given to the body, a concept which situates physical health within the larger scheme of spiritual destiny. From the time they arrived in Central Africa the Christian missions, both Catholic and Protestant, had a less restrictive vision of their medical and religious concepts and put them in practice more widely than did the civil medical services. Finally, as the twentieth century dawned new possibilities took shape. The prospect was slowly emerging of a medically supervised society where health care was handled like a military operation in which the enemy (disease) was identified, assessed and conquered. This concept of medicine was more ambitious but the concept of health less so, since it was defined in physical terms only. This new vision germinated in the major work-sites established in the tropical regions, which served as laboratories for the medical methods and techniques used by major private companies, soon it would spread to the areas of European settlement. The new concept of medicine ran parallel to the extension of administrative control in the territories, and was inseparable from the overseas development of modern states based on European bureaucratic tradition. It developed in the Congo in the wake of the first railroads, constructed by mainly African and expatriciate European labour.

So the background is multidimensional, composed of different heritages and different methods, and as much social and cultural as scientific. Moreover there is the biological factor, that of the epidemics which developed symbiotically with the massive influx into Central Africa of foreign organisms. This influx was inseparable from the colonial movement: as repeating the tragic precedent of the Americas in the 16th century, Central Africa suffered the epidemics that would in turn serve to hasten greatly the development of tropical scientific medicine and lead to the comprehensive medical coverage of the population.

Finally, these myriad experiences and developments refer us back to a compartmentalized, hierarchical world. Perhaps nowhere outside the field of medicine, medical care, knowledge and the very art of healing, is there so strict a division between the worlds of the colonized and the colonizers. The historical interpretation of the medical coverage of the Congolese societies in the early colonial period contains many pitfalls. Which perspective should be foremost? Should it be that advanced by science, which is, an assured vision of progress, a light slowly dissipating the shadows of a world in need of regeneration, in the language of the day? Or should it be the reverse, the image of knowledge powerless to avoid damage to the environment and health, the image also of an authori-

\(^1\) I should like to thank the librarians of the Institute of Tropical Medicine in Antwerp, and Mr. G. Roelants in particular, for the efficient assistance they gave me in preparing this manuscript.

\(^2\) We have a description of a Caesarean performed in Uganda in 1879. A good overview of medical practices and knowledge in various parts of pre-colonial 19th-century Africa may be found in O. RANSFORD, *Bid the Sickness Cease. Disease in the History of Black Africa*, London, John Murray, 1983. This work includes identification of the links between malaria and mosquitoes, the tsetse and bovine trypanosomiasis in southern Africa, sleeping sickness in Central Africa, the treatments for dysentery and asthma, smallpox immunization, the reduction of fractures, etc. For the Congo-Zaïre region in particular (especially the Kongo cultural region), consult J.M. JANZEN, "Ideologies and Institutions in the Precolonial History of Equatorial African Therapeutic Systems,” *Social Science and Medicine*, 13B, 4 (1979), pp. 317-326.
tarian medicine that becomes a weapon of secular power?

In simple terms, there are two historiographic traditions that lead to contradictory assessments of colonial medicine's first groping achievements. The difficulty of making an objective assessment is not new. The regime set up in the Congo by Leopold II quickly generated violent controversy and medicine inevitably became one of the subjects debated. This was apparent very early, Stanley's enthusiasm and megalomania had to be either supported or opposed. It remains true twenty years later, when the Congolese regime was to be judged by the yardstick of one of his rash promises. Testimony was sought by both sides and documents were fabricated or doctored to remove anything damaging to the cause. Clearly this is a minefield, and one laid long ago.

For reasons of time, the brief essay that follows cannot contain an exhaustive analysis of all available sources. However we shall endeavour neither to accuse on the basis of intentions rather than facts, nor to disguise the truth. Within the narrow limits of this work, we shall try to show the variety of the existing sources and their possible interpretations. Our itinerary will follow the three medical approaches that seem to characterize the period. First we will show how the State organized its scanty medical care system, which remained unambitious until the development of health problems that threatened the very continuance of the colonial undertaking. Secondly we shall touch briefly upon the birth of the ambitious plans for systematic medical coverage, plans born of the necessity imposed by the spread of epidemics and by the creation of some major work-sites which brought together a huge and costly labour force. In both cases, the aims were to entrust the doctor with the task of saving man, the most precious capital. In the third and last part we shall outline the position of medical care in religious projects, since dispensing basic treatment was supposed to ensure the conquest of minds and souls.

1. The early stages

Western doctors reached the shores of Africa long before the new colonial age of 1880-1900 was in sight. If we take just the 19th century, we find doctors frequenting the coastal regions and passing on their observations and experiences. For the western part of Central Africa, from which the conquest of the Zaire River basin was finally launched, obvious examples are Tito Omboni and George Tams, who are essential sources for Lower Guinea of the 1850s. These medical observations were not rare occurrences but part of a long tradition, for naval expeditions and trading posts occupied by Europeans had already been benefiting from the presence of doctors for almost three centuries: it was back in 1594 that a Portuguese ordnance appointed a physician to accompany the newly-appointed governor of Angola to his post. The aim, it is true, was limited to caring for the European colonists and their dependent relatives and slaves rather than for the population at large.

This medicine for emigrants formed the medium in which the first European knowledge of tropical diseases developed. Before the idea of laboratory medicine or chemotherapy emerged this empirical medicine borrowed copiously from the inherent knowledge of tropical native communities, concerning (for example) herbs, simples, inhalations, dressings for wounds and purges, etc.

This constant pattern of contributing and borrowing is an essential feature of the first phase of European expansion. The Inca and Aztec pharmacopoeias amazed the 16th-century conquistadors, and a catalogue of the native remedies (De las Drogas de las Indias, by Gonzalo de Oviedo y Valdés, 1565), was soon published. At the same time medical faculties were being set up in the first American universities. In fact America provided the first samples of China bark to reach Europe, via a Jesuit priest, in 1632. In the neighbouring Portuguese territory, Garcia de Orta, the father of

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3 The optimistic tradition of the conquests of colonial medicine is well represented in the Congo/Zaire by many publications due less to historians than to the active participants. This "constructive" current includes the still indispensable work by R.J. CORNET, Bwana Muganga. Hommes en blanc en Afrique noire (ARSONOM, Mm., N.S., 1971), whose very title shows the author's colours. He had historical ambiguities in writing this book and it is indeed comprehensive. Rather than revealing his sources, however, the author preferred to cover his tracks. For a more recent example of current trends in the historiography of colonial medicine see D. ARNOLD, Imperial Medicine and Indigenous Societies, Manchester University Press, 1988 (this book contains a chapter by M. LYONS on the sleeping sickness epidemic in Uele) and S. FEIERMAN, "The Social Roots of Health and Healing in Modern Africa," African Studies Review (Atlanta, Georgia), 28, 2-3 (1985), pp. 73-147. The journal Social Science and Medicine (Ser. B) is one of the main tribunes of the critical historiography of modern medicine and its political and social dimensions (special issues on Africa: "The Social History of Disease and Medicine in Africa," 13B (1979), pp. 289-356, and "Causality and Classification in African Medicine and Health," 15B (1981), pp. 169-437).

4 This document and the appointments of surgeons, hospital subsidies, organization of medical care, etc., for Angola between 1594 and 1895 may be found in Arquivos de Angola (Luanda), 2a Ser., Vol. IX, 35-38 (Jan.-June 1992).

5 Quinine itself, alcaloide of Cinchona, was not produced until the 1820's. At that time the Dutch started growing quinine in Java. They exported a part of it from the second half of the XIX century.
Portuguese tropical medicine, symbolized this curiosity and set an example that was followed until the 19th century. Indeed the Portuguese were teaching tropical medicine at the time in Goa and Funchal, whence came the doctors and surgeons who were sent to Africa. Similar steps were being taken by the Dutch, then the English, in India. The French also had their naval and military doctors, whose decisive encounters with a fever-ridden environment and unknown diseases date back to the pre-1850 Algerian campaigns.6

In the annals of European overseas expansion, the west coast of Africa long remained a hot-bed of fatal diseases. It is the region from which Leopold II's agents and emissaries set off for the interior with their armies of soldiers, craftsmen and workers recruited along the road from Dakar to Luanda. Many cultural traits of the colonial Congo were borrowed from this part of Africa, so it is worthwhile examining them briefly.

Towards the end of the 18th century a Brazilian doctor was cataloguing health conditions in Luanda. He gave careful descriptions of the known diseases and remedies and fevers, separating the latter into two groups: those with afebrile interludes, or the intermittent fevers, and those in which attacks were separated only by periods of remission, or the recurrent fevers. His inventory includes all the symptoms of malaria, blackwater fever, and the dysenteries that would remain the main sources of death many years later. Quinine (whose use was long contested), cola nuts and opium were some of the best-known remedies or preventive drugs. Scurvy, dysentery, tetanus and sleeping sickness were also reported as causes of death, but at the time the population relied on a pluralistic medical system. Thus, as the author noted, "the blacks, even when they live with whites, learn their customs, adopt their religion and speak their language, never forget their own rites and prejudices. And when they are sick, they are wary of new science and of pharmaceutical drugs, placing their trust rather in their own remedies and healers. It is a shame that many of the whites born in the area, even a few Europeans, have confidence in these remedies and, secretly, these healers."7

One recent study shows that Angola's history of famine, climatic fluctuations, of economic and social upheavals with drawbacks in land occupation in the 19th century, produced an overall context that can explain the spread of epidemics, especially smallpox.8 All this was still poorly understood, but as a general rule, the multiplication of European settlements in the tropics and especially on the West Coast of Africa led to greater awareness of the dangers the area held.

However an understanding of the roles played by the vectors of certain diseases was possible only through scientific research and laboratory work. The final solutions were reached at the end of the century when Ross in India and Grassi in Italy identified the mosquito vector of malaria almost simultaneously.

This knowledge had only partly infiltrated Belgian medicine when Leopold II organized the occupation of bases along the lower Zaire River. The work of setting up these camps began in 1878 under Stanley's supervision. Belgium had previously had fewer reasons than other countries to organize naval or tropical medical services. At most the Belgians could follow at a distance precedents of Algeria and the struggle against the ravages of yellow fever in the Gulf of Mexico and Cuba.9 Only scanty data on the dangers of the West African climate were available. Indeed, the climate was generally blamed for the dramatically high mortality rate awaiting the Europeans on the coast.

At the time accurate data were lacking, but today it is possible to measure the mortality rate of the European population residing in the territory of the Free State: disease-related mortality alone stood at 46% for the State's civil servants and railroad employees between 1885 and 1896 and an estimated 87% for the Catholic missionaries between 1895 and 1899, figures that should be compared with a mortality rate of 8.5%.

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9 As Leopold II's first plans for Africa were taking shape, following the Brussels Geographical Conference, E. Baez was collecting all the geographical and ethnological documentation that was available. An officer, E. Reuter (who was not a doctor), included a brief chapter on hygiene/sanitation in his study of the possible creation of an agricultural colony in Central Africa, Projet de création d'une colonie agricole belge dans l'Afrique centrale (...), Brussels, 1877. This was a manual written along the lines of a guide for emigrants who were leaving for the New World.
for Belgian males between the ages of 20 and 40 (1885-1896). But were these data really comparable? A medical report presented in Brussels in 1897 was undoubtedly right in preferring to compare the figures with those in other tropical regions. Considerable progress had already been made since the first three decades of the 19th century, when the European troops on Java succumbed year after year at the rate of 170‰ (1814-1828), or European mortality in Senegal stood at 106‰ per year (1819-1855). Various forms of dysentery, malaria and sometimes yellow fever were the major causes of death at this time. Towards the end of the century the total European death rate in the Congo was still high (57‰) compared with those reported in areas where years of patient effort had reduced the human losses (to 20‰ on Java in 1890), but could be considered a great success when compared with figures along the coast, such as 113‰ per year in Cameroon in 1890-1894, 264‰ by disease alone among the French troops fighting in the African campaign in Dahomey in 1892, and 75‰ in the British protectorate on the Niger coast in 1894-1895.

This was the situation confronting the first doctors sent to Central Africa. These men familiarized themselves on the job with the medical experience that had been accumulated on the coast over the centuries. In the eyes of some historians of medicine in the former Belgian Congo, a new era of construction was starting from scratch on virgin territory, but this was an optical illusion, caused by the improvised conditions that prevailed in the first years of Belgium’s presence on the continent. Take for example the case of the legendary Dr. Allart, who came to Boma in 1883 to work for the Stanley expedition (International Association of the Congo). He operated naked to the waist, protected by a rubber apron, doing his utmost above all to keep his European patients alive until they could be put on ships for Europe.

In this early period the doctors were not recruited in Belgium alone. Without direct colonial experience and lacking sufficient resources, Belgium made the colonization of the Congo a multinational undertaking. This remained the case until the 1920s. Non-Belgian Europeans occupied an estimated 40% of the various positions (including the most senior) in the administration, army and private companies in the Congo until World War I. The role played by West Africans in the lower echelons was just as decisive in the first thirty years of the Congo’s colonization. The medical profession was no exception to this rule of internationalization, and many doctors were recruited from countries with greater experience in such areas. These included the Scandinavian countries and Italy for naval medicine, and Italy again for her position at the forefront of malaria control and her extensive knowledge of overseas diseases.

At first, however, public health benefited from only the sketchiest of organizations designed either to provide medical support for the major expeditions setting off for the interior or to set up and run a very basic infrastructure for the major settlements. For example, we can cite the case of the first doctor who was undoubtedly recruited for Leopold II. This was Pierre Dutrieux, a Belgian military doctor who became a professor at the Cairo Medical School and accompanied an expedition of the African International Association to Lake Tanganyika in 1878. Moreover, empirical knowledge became more and more accurate as the map of the interior was filled in.

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11 Reports presented by A. BOURGUIGNON, G. DRYEPONDFT, and C. FIRKET at the National Congress of Hygiene and Medical Climatology of Belgium and the Congo (Brussels, August 9-14, 1897), 2 vols., Brussels, 1898, and report on tropical hygiene presented by VAN DURME at the International Congress on Global Economic Expansion, Mons, 1905, Section V, Civilizing Expansion in the New Countries. Accurate data are available for well-defined groups of Europeans who were on the West Coast of Africa and in the Gulf of Guinea. The 1816 Tuckey expedition into the Lower Congo had few survivors. Sixty percent of the CMS’s missionaries in West Africa between 1804 and 1825 died, as did 65 of the 222 Methodist missionaries sent there between 1835 and 1907 (RANSFORD, O., op. cit.). The English and French seem to have had different approaches to the preventive administration of quinine. To this is attributed the noticeable drop in mortality in the English tropical expeditions over the 19th century. For example, 42 of the 45 Europeans taking part in the 1841 Niger expedition succumbed to malaria, whereas during the second expedition (1854), when quinine was administered as a prophylactic, no one was lost (RANSFORD, O., op. cit., pp. 54-56). In contrast, no such decline in mortality was seen in the French territory over the 19th century. See W.B. COHEN (1983), “Malaria and French Imperialism,” Journal of African History, 24, 1, pp. 23-36 (p. 25).

12 In 1905 an Italian government inspector estimated that his companions filled some four out of ten doctors’ positions in the civil service. [L. ARMANI (1907), Dictoito mesi al Congo, Milan, Fratelli Treves, p. 119.] It was the Italians who organized the health care service and medical education in Egypt under Mohamed Ali and his successor Ismail. [V. BRIANI (1982), Italiani in Egitto, Rome, Istituto Poligrafico e Zecch dello Stato.]

What is most striking was the limited medical coverage of the area. During the period of the Free State the doctors recruited by the administration were never more than a tiny contingent. Mense was the only doctor upstream of the Lower Congo between 1885 and 1889. There were eight doctors in the territory in 1891, between 25 and 30 at the turn of the century, but 59 in 1910, two years after the Free State was annexed by Belgium. Moreover, more than one of the doctors did not practice.

For the Europeans of the time, the African experience was one of social mobility, offering wider horizons to the many of them who felt hemmed in by their own society. Thus it is not surprising that Edward Schnitzer studied medicine in Breslau before offering his services to Turkey and eventually becoming the legendary Emin Pacha of Sudan’s Equatoria Province. Nor does the Congo lack examples. Joseph Meyers stepped off the boat at Boma in 1896 as a doctor, but history remembers him primarily for his military talents during the great rebellion of the Dhanis expedition. Dr. Briart accompanied the Delemmune expedition in Katanga in 1891-1892. Five years later he was running a foreign trading post in Kinshasa. Briart had a rather turbulent career as a herbalist, scientific observer, a prolific author and unrefined traveller, while successfully incarnating Shumpeter’s entrepreneurial model.14

While there were cases of doctors who became soldiers of fortune or were tempted by the most varied kinds of adventures, it was less common for simple travellers to serve as doctors. Relating his medical activities in the Lower Congo in 1888-1889 a French journalist confessed that, “in the natives’ eyes, any white man had to be a doctor. I thus allowed myself to carry out minor surgical operations at Kabongo that were rather agilely performed”. Indeed, he quickly moved beyond the confines of bandages and disinfectants to the manipulation of knives and scalpels. “I performed my new functions marvelously well and never backed away from sutures, punctures, incisions, etc.... There was always a line of people at the door of my hut.”15

These alternative careers were not unusual in a still unstructured colonial society. In medicine, for example, the Congo had no administrative structure to oversee health problems and until 1909 the budget included funds for a meagre health service in the Department of the Interior. These rough data give an initial basis for assessing the administrative history of medicine in the Free State.16 On paper, the first stages were as follows:17

- First organization: decree of August 5, 1888, organizing the State’s public health service. Medical coverage would be provided in the major population centers as the settlement of the area progressed and the State’s financial resources increased.
- Public health (hygiene) commissions were set up in the districts or zones starting in 1889. They included the resident doctor, if any.
- Administrative measures taken in the European settlements in response to the threats posed by epidemics of smallpox and then of sleeping sickness; drainage and land reclamation and the first steps of colonial town planning (notably in Leopoldville and Coquilhatville) with malaria in mind.
- Operating subsidies for hospitals and dispensaries and a medical laboratory in Leopoldville. Private initiatives contributed greatly to this by foundations (see below pp. 75 and 82). There was only one pharmacy in the Congo Free State and most of the doctors made up their prescriptions themselves. While common drugs were theoretically sent out at regular intervals to the stations and posts, in practice the shipments either never arrived or were often broken and unusable. Each doctor did have, however, “a certain quantity of Claret, Port, and Madeira wines, Champagne, jams, biscuits, Liebig, and arrow-root at his disposal”.18 This reveals the attitude prevailing at the time as regards the morale of isolated travellers.

16 DUBOIS, A. & DUREN, A. (1947), Soixante ans d’organisation médicale au Congo Belge, Ann. Soc. Belg. Méd. Trop., 27, Suppl. Lib. Jub. J. Rodhain, pp. 1-36. The essence of the triumphantalist perspective of this article had already been published in L’Assistance médicale aux Indigènes de l’Etat Indépendant du Congo, Brussels, 1907. This was a brochure published by the Federation for the Defense of Belgian Overseas Interests (Fédération pour la défense des Intérêts belges à l’Etranger), an active propaganda arm of the King’s business office. Dubois and Duren each filled the government position of “Doctor of the Colony”, the former from 1911 to 1917 and the latter from 1917 to 1933.
17 L’Assistance médicale aux Indigènes de l’Etat Indépendant du Congo, op. cit.
18 Ibid. The administrative authorities strove to impose fuzzy regulations governing the use of these reserves, which were classified as “medical comforts”, a term that was yet another borrowed from the culture of the West African coast. “Under no pretext may the items sent under the mark M.C. be confused with supplies of ordinary victuals” but must be handed over to the doctor. Governor-General’s circular of Sept. 4, 1903, in Recueil Usuel, IV (1901-1903), Brussels, 1906, p. 816. Government employees received a theoretical ration of “a half-bottle of Portuguese wine” a day. (A. DUBOIS, La médecine au Congo Belge, op. cit., p. 351.)
- Controlling the major epidemics, first smallpox, through the vaccination of the State's employees and creation of vaccine-producing institutes from 1895 onwards (for the major work sites, especially the Matadi-Leopoldville railroad line, but extended later to include the Upper Congo Region to Kasongo), then sleeping sickness, essentially through administrative measures to monitor population movements and the quarantining of contaminated individuals in lazarets. A first attempt at administrative and medical surveillance was made. We shall return to this.

- Health care for the rural population, (that is for the vast majority of the population) remained a project for the future. A circular sent out by Governor-General Wahis on March 24, 1906, expressed the wish that the State follow the catechists' example and send "blacks instructed in the principles of hygiene" to the villages. As far as we know this circular remained no more than a pious wish.

The first health services should be evaluated in relation to their human resources and budget allocations. Manpower remained very limited, but one should not overlook the number of doctors recruited by private entities (missions and railroad or mining companies) and the mixed (privately and government-owned) CSK (Comité spécial du Katanga) that ran Katanga from 1901 onwards. The government funds allocated to the State's health service amounted to 101,000 francs in 1888 and 557,000 francs in 1906, or 2.24 and 1.90%, respectively, of the ordinary budget. These figures may be compared with military expenditure, which accounted for 36.4% of the State's budget in 1906, as well as with the 60 million francs generated by the Congo's resources alone and spent on major civil engineering works in Belgium during Leopold II's reign.\(^{19}\) According to the report prepared by Dr. Meyers concerning 1896 (the early period), the State was not a philanthropic organization. However almost twenty years later little had changed. In 1909 Prince Albert noted the remark made by an Italian physician, Polidori, working for the CSK, that no progress had been made in the colony during the past eight years, almost no money had been allocated for health matters and the situation in Katanga (was) even better than in the rest of the colony.\(^{20}\)

A series of special subsidies must be added to these figures for the ordinary budget. In 1903, as the sleeping sickness epidemic was spreading and a huge movement of public opinion against the management of the Free State was forming in England, the King offered a 60,000-franc subsidy to the Liverpool School of Tropical Medicine to enable it to send a trypanosomiasis research mission to the Congo.\(^{21}\) In 1906 he opened a 300,000-franc credit for the search for a treatment and a means to prevent the disease. However it was not until Belgium's annexation of the Congo that more substantial investments were made in the health sector.

One of the most visible failings was overcome at the time of annexation by the creation of the Public Health Services (Service de l'Hygiène). As we have seen, the number of doctors doubled in just two years.\(^{22}\) Starting in 1911 a fund of 50 million francs was created to subsidize hospitals in the Congo. In 1914 King Albert allocated a special fund of 1 million francs for disease control. However, goodwill alone was not enough to change habits, and it was discovered in Brussels purely by chance that the subsidized hospitals existed only on paper and the funds were...
used to ship cases of pharmaceuticals which also contained champagne or foie gras.23 In 1922 the new Governor-General, Lippsens, readily provided the Minister with various passages from the Head of the Health Services’ report for 1920 which uncompromisingly described the pitiful state of the hospitals. The buildings were constructed for other purposes; there was no separation between wards for infectious diseases, for prisoners and for tubercular patients; and hospitals for blacks were generally non-existent. In Leopoldville there were no sewers, the wells and community pumps were undescrably filthy, there was no sanitation service, rubbish was removed manually by prisoners, there were mosquito breeding-grounds everywhere but, according to the report, the native town was generally rather well kept. This requisition had been removed from the report by order of the Vice-Governor-General’s Bureau, who commented in the margin: “...it is not the Government’s job to make self-accusations in its report on its own administration. Such things have no place here.”24 Nothing could have been clearer.

These examples remind us of the use of disinformation techniques in official documents as well as in propaganda leaflets. All too often complacency was the rule and a veil was cast over the real situation. Additionally, however there are all too few well-informed and really outspoken witnesses, free of any suspicion of connivence. It is not enough to say that there was a health administration were set up in the Congo in 1899. We must know whether they actually functioned. It is not enough to report that hospitals for blacks existed in Boma and Leopoldville – we need first-hand information from visitors to determine what they actually comprised. Here we must settle for a few points of reference.

First one must bear in mind that medical coverage of the Free State was at an early stage, and improvisation had to compensate for disorganization. Let us consider a few examples. The Emin Pasha relief expedition led by Stanley in 1887-1888 was marked by the health disasters encountered on the way. These episodes are well known, thanks mainly to the diary kept by the expedition’s physician, Thomas Parke. The massive losses must be attributed primarily to the lack of organization and knowledge, but the almost total absence of equipment and drugs definitely did not help.25 It is true that in the months preceding the expedition’s departure there was more concern for politics and ivory than planning. The great Van Kerckhoven expedition towards the Uele and Nile Rivers in 1891 was accompanied by a physician for whom summary supplies had been prepared: very little quinine, abundant supplies of purgatives and ipecac (an emetic drug), no chloroform for anaesthesia but, by mistake, some veterinary surgical instruments.26

Almost twenty years later, when Prince Albert took stock of the situation in 1909, little had changed. One of the main military camps in the country, a camp of 900 men garrisoned at Lisala, had no medical care, no doctor, no nurse. The closest doctor, who was in New Antwerp (Mokanga) had to care for the sick in three districts covering a territory ten times that of Belgium and completely lacking a road network. The expeditions conducted during this period remained just as perilous. For example: the Declercq expedition sent out in Katanga in 1909 to quell a revolt of former members of the military force (combined army and police) known as the Public Force. In what the prince described as an unheard of action, the column of 600 African soldiers and 14 European officers took neither doctor nor nurse, nor even medication, with it.27

This apparent lack of interest in health matters should not surprise us. This was a state operating first and foremost as a financial enterprise. The other African colonies fared no better, however. Take the example of the French possessions. There were only 37 doctors in all of the Black African territories under French administration in 1890. Twenty-one of them were in Senegal (a special case), twelve in Sudan, and four in Gabon. Medical assistance for the natives began to be organized in French West Africa in 1905. Five years later it boasted 140 doctors and had made a huge effort to train 163 African medical aids and nurses. French Equatorial Africa was, as always, far behind.28 The colonial medical services in the British colonies were set up in

24 Governor Lippsens to the Minister, Boma, Feb. 3, 1922, Papers of M.-L. GÉRARD, 4/21/A2, (in French), Archives of the Royal Palaces, Brussels.
26 DUBOIS, A. La médecine au Congo belge (…), op. cit., pp. 353-354. A collection of accounts by doctors who survived the Free State period. The statements referred to here were given by É. Van Campenhout.
1902-1904. We should not lose sight of the fact that organized medical care in Europe itself at the time was mainly limited to the towns. Medical care for the populations was kept to a strict minimum, and two health care systems coexisted. The medical care provided by the medical profession in turn-of-the-century Europe operated side by side with the folk healing provided by healers, bone-setters, etc. 29

Some thirty doctors covering a territory almost as large as Europe after twenty years of colonization seems to us a ridiculously low figure, and the tranquil assurance of the Secretary-General of the Free State, de Cuvelier, when he told the Belgian Government in 1904 that “applications which might be sent in by doctors could not be processed as there were no vacancies at the time” 30 can only be met with disbelief. At the same time, the syphilitics of the State did not cease to repeat that a flawless health service was looking after the health of everyone, both blacks and whites. 31

Yet we must guard against anachronisms. According to the thinking of the time, a handful of doctors should have sufficed for an area in which the European population of the largest settlement: Boma, numbered 253 in 1901, the white population of Leopoldville stood at 162, that of nearby Kinshasa 56, that of Stanleyville 39, and Coquilhatville 24. 32 Moreover in the early 20th century the idea of State intervention in public health matters was still rather unfamiliar. In a country such as Belgium, charitable (usually Catholic) institutions, in some cases subsidized by local government authorities, covered most of the health care costs throughout the 19th century. The level of state participation was very low. Not until the last two decades of the 19th century did health expenditures begin to appear in the state ledgers in Belgium. 33 Even today, health expenditure in the ordinary budget of the Republic of Zaïre falls far short of the meager 2% found in the Free State’s budget. Paradoxically, the Congolese State even led the way in at least one sector of public health when it tackled the problem of smallpox epidemics, to which point we shall return. At the same time, the King’s loudly-voiced philanthropic claims, his image as a modern entrepreneurial monarch, and the impudent disinformation machine that he financed unsurprisingly were the factors which, far from defusing the critics, eventually sharpened their vigilance. Moreover few colonial systems would have had such international manpower, and few would have to face up to such systematic challenges. In fact the pressure of critical opinion often caused the most flagrant abuses to be dealt with.

The case of the hospitals for blacks is to be considered. Originally improvised from simple sheds, they prompted disillusioned or indignant outcries from visitors. The hospital in Boma, for example, described in 1906 as an assortment of huts that was a hospital only in name, was kept in a state of undescrivable filth, to the great dispair of its director whose requests for financial help were constantly refused. The same applies to the facilities in Leopoldville. In 1890 these consisted of two cob-walled rooms. Ten years later the situation had not improved. Because of the negligence of the authorities (not of the doctor), the “hospital” for blacks consisted of three earth huts, all of them in ruins. Patients lay on the bare ground. When these facts were known and reported by even some of the régime’s most steadfast supporters, the State hastened to redress the situation, notably before the visit of the 1904 Commission of Inquiry. This Commission was thus able to verify the progress that had been

29 On the subject of the medicalization of European society with special references to 19th-century Belgium see VELLE, K. (1986), “Medikalisering i Belgien i historisck perspektif: een inleiding.” - Revue belge de philologie et d’histoire, 64, 2, pp. 256-285. Just to give an idea of the situation, there was one doctor per 5,000 population in Belgium in 1800, one per 1,888 in 1900. There was one doctor per 4,167 population on the African continent in 1980.

30 Secretary-General of the Congo Free State de Cuvelier to the Belgian Foreign Affairs Minister de Favereau, Archives of the Ministry of Foreign Affairs (Brussels), A.F. I, I, No. 1667 (in French). I should like to thank Professor J. Stengers for so kindly having provided me with this document.

31 “Most of the diseases affecting the natives, such as smallpox, elephantiasis, even sleeping sickness, soon will exist only as memories, thanks to the marvelous organization of the health service...hospitals and lazarets are flourishing over the length and breadth of the territory. Free medical care and medication are provided upon request to both whites and coloured.” Le Congo Belge in Liège-Exposition (publication of the Liège Exhibition of 1905), ix, 42 (Sept. 24, 1905), pp. 347-349 (p. 349). This presentation is a pure figment of the imagination, down to the smallest detail: “eligibility for free medical care does not extend to private individuals and Europeans outside the administration...The fee for a visit has been set at one pound sterling (25 F) along the entire West Coast of Africa since time immemorial. This is also the practice in the Congo.” Dr. DRYEPONDT (1897), Secours médicaux, in Guía de la section de l’Etat Indépendant du Congo a l’exposition de Bruselles-Tervuren en 1897, Brussels, pp. 231-237 (p. 233). This practice of setting fees for medical consultations is further evidence of the West African influence on colonial culture in the early Free State. Another doctor who served in Africa during this period, L. Bertrand (he worked along the Matadi-Leopoldville railroad line in 1897-1899), stated that the fees were 25 francs for private persons and 10 francs for civil servants. (A. DUBOIS, La médecine au Congo belge..., op. cit., p. 358.)

32 Statistics taken from Mouvement géographique, 3, Nov. 1901,Cols. 559-560.

33 Health sector salaries paid by the Belgian State amounted to 200,000 francs in 1900 and 500,000 francs in 1910. (J. PIRARD [1980], Le pouvoir central belge et ses comptes économiques, 1830-1913. Brussels, Palais des Académies, p. 485.)
made in Boma and Leopoldville. While the merchant State actually proved indifferent to unprofitable investments, it was very careful not to wage an active propaganda campaign to the contrary. It overlooked nothing in these efforts, whether in Europe or the United States.

Some of the most visible gaps in the organization of the State health services were filled by private initiatives which were, it should be added, partly encouraged and supported by public resources. This was the case with the medical care for Europeans (the continuation of the old concept of trading-post and naval medicine), for which the Congolese and African Association of the Red Cross was founded in 1888. Leopold II would not have been true to himself if he had not used the founding of this branch of the International Red Cross to try out a new financial and colonial combination. The idea of an armed colony of the Congolese Red Cross to be set up on Juby Cape, on the Moroccan coast, was soon relegated to the cemetery of stillborn projects to which his fertile brain gave birth. However, all these dreams did leave as their heritage the Congolese Society of the Red Cross, which enjoyed considerable private support and to which we are indebted for the construction of hospital facilities for Europeans in Boma and Leopoldville. The wards of Boma’s hospital for Europeans each consisted of two furnished single rooms very different from the anonymous style of large hospital wards. The Red Cross also supported some of the expeditions by providing them with drugs and equipment. At this stage, however, the assistance it provided to the native population was accessory.

The role played by private initiatives in the development of medical research should also be stressed. Belgian private interests were active in this field from the 1890s onwards. Their efficacy won over even those observers who were least well disposed towards the State. This was an essential field for, in measuring the dangers and needs, medical research helped to lay the foundations of a more ambitious scheme of colonial medicine, such as was developed later under the Belgian regime.

The impetus was given by the Belgian medical profession, which saw the Congo as a challenge. In 1895 the Belgian Royal Society of Public Medicine and Medical Topography managed to carry out an investigation of mortality, morbidity and climate in the Congo. This was a great success. The doctors in the area and other collaborators gathered a wealth of information that was presented at the Congress of Hygiene and Climatology of Belgium and the Congo (the official title is revealing) held in Brussels in 1897.

The aim at that moment was akin to that of emigrants medicine, namely to protect the health of European immigrants in Africa and determine the right conditions for setting up European towns and villages. However, this perspective would soon broaden to include the entire population. It was the epoch of the first investigations: we owe to it the conviction that malaria was the main enemy of whites and blacks alike.

The private sector was also the origin of the research centers located in the Congo itself. A medical laboratory was set up in Leopoldville in 1889 with the help of some major Belgian companies; the State covered its operating costs. Discoveries came thick and fast at the end of the 19th century. A military physician who had already served a number of years in the Congo, E. Van Campenhout, was put in charge of

35 Borna, 1896: Dr. J. MEYERS, op. cit., pp. 27-38 (this testimony was not published until 1946); testimony of Dr. E. VAN CAMPENHOUT, quoted by A. DUBOIS, La médecine au Congo belge..., op. cit., p. 353. 1903: “Le Rapport Casement,” introduction and notes by D. VANGROENWEGHE (1985), in Enquêtes et Documents d'Histoire africaine (Louvain-la-Neuve), 6, p. 31. On its visit in 1904 the Commission of Enquiry recorded that High Commissioner Malfeyt had overseen the hospital’s rebuilding and the situation was satisfactory. A.M. DELATHUY, E.D. Morel, Leopold II et le Kongo, Antwerp (Berchem), Uitgeverij Eppo, 1985, p. 278. From then on Leopoldville’s ‘Native Hospital’ would be cited among the model institutions held up for worldwide admiration by the State propaganda.

36 The tangled skein of the Congolese Red Cross’s Moroccan episode was patiently untangled by A. DUCHESNE in “Leopold II et le Maroc (1885-1906)”, ARSOM Mém., n.s., 32, 2, 1965.

37 One of the authors of the reports presented at this congress, Dr. FIRKET, who was also the first Belgian professor of tropical diseases, took advantage of the sourjourn of some Congolese natives at the 1897 Expo to subject them to medical examinations that revealed traces of filariasis and intestinal schistosomiasis. (R. BRUYN- HOEGHE, entry “Firquet, Charles, 1852-1928,” in Biographie coloniale belge, I, Brussels, IRCB, 1948, Cols. 375-377.) G. Dyepons, co-author of these reports, was one of the best purveyors of popularized knowledge of tropical medicine in Belgium and the Congo (biographical entry by M. COSIMANS, Ibid., III, 1952, Cols. 265-268).

38 Charles Lemare’s well-informed study of the medicinal plants of the Congo dates back to this period. The work was widely disseminated because of its publication in several issues of the popular science magazine, Le Congo illustré, in 1895.

39 The first bacteriological research conducted in the Congo had been undertaken a few years earlier by Dr. De Marbaix, who was soon repatriated because of illness and died in Belgium shortly after his return (1897). This former naval doctor had become familiar with the study of malaria while in Italy. He opened the first vaccine-producing laboratory in the Congo in 1895, in the Bas-Fleuve region. This was Boma’s first laboratory. It was not replaced by the Leopoldville laboratory until 1899. (Biographical entry by A. DUBOIS (1952): Marbaix (De), III. (1868-1897), in Biographie coloniale belge, Brussels, IRCB, III, Cols. 594-596.)

40 Biographical entry in the form of an obituary by A. DUBOIS (1967): Campenhout (Van), Jean-Emile, 1865-1956, in Biographie belge d’outre mer, VI, Brussels, ARSOM, Cols. 167-171. Van Campenhout was a military doctor before setting foot in the Congo, where he accompanied the Van Kerckhoven expedition. He is one of those doctors who, on the occasion of the conquest, took up arms and played the sometime soldier—quite an unexpected prelude to a close to 40-year career in Belgium’s health administration.
setting up the new laboratory. He spent some time in the tropical diseases wing of Greenwich Seamen’s Hospital, and in Rome where decisive progress was being made in identifying the mosquito that transmits malaria. It is under the impetus of first Van Campenhout and then of his successor, A. Broden, that the laboratory of Leopoldville focused its attention on malaria (“malaria dominates the entire pathology”) and one of its most serious complications, blackwater fever (which caused many deaths), right from the start, at a time when quinine continued to have its critics and much was still unknown.

As in the French territories, the Belgian Congo long held reservations about the use of quinine. For many years doctors contented themselves with merely advising its use. In 1897, advice published for the White Fathers (missionaries in Africa) continued to make the following recommendations: “...in case of swamp and other fevers: an herbal tea of centaury, or orange blossom teas, or even a handful of vervil in a litre of milk.”

More time was still required before urban hygiene and sanitation would meet the demands of malarial vector control. The improvised construction of the first European settlements in the Congo betrayed the inexperience in Africa of this first generation of colonials. The laboratory’s reports showed that stagnant water, lack of drainage etc., in Boma and Leopoldville helped to increase the incidence of malaria.

How many other tragedies were caused by inexperience! In this respect, the sleeping sickness epidemic that broke out along the river in the 1890s and in Uganda in 1901 demonstrates the extent of ignorance at the time. The first report from Leopoldville’s laboratory gave a rundown on the sleeping sickness decimating the Bobangi villages along the river upstream from the Kasai River. The disaster may be symbolized by the so-called School Colonies who, as in the Old Regime, served to unite the Belgian missions and the Free State’s administration for a brief while. The Congo Free State sent its abandoned children, as they were known at the time, to the missions, where it paid for their upkeep and education. The children received an education that was both religious and military, and were then divided up: 80% for the State and 20% for the missions. One such mission was Berghé-Sainte-Marie, at the junction of the Congo and Kasai Rivers, which had 1,134 children under State guardianship in 1890. Of this total, a mere 250 were still alive in 1900. Deaths during the first five years were caused by dysentery, but 184 out of a total population of 461 died of sleeping sickness in 1898. The situation was hardly better in New Antwerp.

where the colony had to be closed in 1898 after the loss of 1,000 children out of a total of 1,500. Kidnapped, abandoned, sold... what trials had these children survived before ending up under this harsh, military camp-like regime? The story of their fates should be included among those of the martyrs of an age rich in tragedy.

The next reports from the Leopoldville Medical Laboratory, covering 1900-1905 and 1907-1908, were devoted almost exclusively to the epidemic. Castellani and Bruce’s identification of the Trypanosome in Uganda had been confirmed after Dutton and Todd’s mission to the Congo (1903-1905); but the treatment required tight administrative control over the entire area and thus, prior to 1908, was limited to the colonial employees. However the prospect of mass treatment was starting to emerge, and with it a new phase in the country’s medical history.

40 For a discussion of the state of knowledge of malaria and its complications towards the end of the 19th century see M. KIVITS, “Que savait-on de la situation sanitaire...” op. cit., pp. 286-295. Even as late as World War I the French forces fighting in Solonika did not use quinine systematically, as a result of which many men were lost. Only after World War II did the Frenchmen residing in the malarial regions take quinine regularly as a prophylactic. (W.B. COHEN, Malaria and French Imperialism, op. cit.)

41 Advice found in Chronique de la Société des Missions de l’Afrique (Pères Blancs), July 1897, pp. 427-428.


43 A treatise published in Brussels in 1902 (J. TROOST, La santé au Congo) did not yet make any reference to sleeping sickness. C. Mense, who has already been cited as one of the Free State’s first doctors, published his treatise on tropical medicine, in which he speaks of sleeping sickness, that same year. He identified sleeping sickness as a disease specific to Africans (“lethargia negrorum”) and diagnosed the consumption of cassava chikwango as one of its causes. However, Mense recognized no more than an ostensible success (Scheinerfool) of the treatment (injections of scrotal fluid from a ram) practiced by Portuguese doctors. (C. MENSE, 1902. Tropicke Gesundheitslehrer und Heilkunde, Berlin, pp. 206-208.) J. Ford has published a fundamental article on the history of the understanding of the epidemic, but it is based primarily on the British colonies, with a cursory look at the Belgian and French experiences (J. FORD, 1979, “Ideas which have influenced attempts to solve the problems of African Trypanosomiasis,” Social Science and Medicine, 13 B, pp. 269-275). For a recent examination of the history of trypanosomiasis control, see J. GIBLIN (1990), “Trypanosomiasis Control in African History: an evaded issue?” Journal of African History, 31, I, pp. 59-80.


It was the combined pressure exerted by these research institutes and the results of the Dutton-Todd mission that led the Free State to encourage the teaching of tropical medicine in Belgium. The *School of Tropical Medicine* was founded late, in 1906, twenty years after the creation of the Free State and in the wake of a variety of courses on trade, agronomy and administration in the tropics. However the universities of Liège and, later, Ghent did not wait until this date to offer courses in tropical diseases. Moreover the Free State’s decision bears the stamp of the conviction of Charles Firket, professor of tropical diseases at the University of Liège from 1896 and an advocate of very practical instruction for trained physicians. In the case of Belgian doctors, he realized from experience that those who were going to work overseas did not take the decision to do so during their studies. It came to them later, when they were faced with the shortage of posts and the overcrowded profession in Belgium; and it was then that they needed specialized courses.

The School of Tropical Medicine did not become a research centre until thirty years later, after its move to Antwerp and when renamed the *Institute of Tropical Medicine*.

In the Congo itself, in the Free State – a country where the population was just learning how to read and write – organized medical instruction was practically nonexistent. Boma was reported to have a nursing school for Congolese who had graduated from the so-called *education establishments*, but we have very little other information on this subject. Some rare sources nevertheless indicate that practical training for Congolese and West African nurses was being given. There is also the special case of the native microscopists, who were to play a major role in the country’s screening campaigns.

One last aspect of the medical profession in the Congo has not been covered in this brief overview. It is the situation of the men who set it up, with minimal resources and preparation. The portraits of some individuals can be sketched, although the published facts are more like funeral orations or pious obituaries composed by fellow doctors than true biographies. Some of their names have already been mentioned. However there is no study of the group as a whole for the period that interests us. The total number of people involved is not even known. Figures are available for 1910–1918, and show that about sixty physicians did indeed spend time in the colony. If we allow for their comings and goings we have a group of 112 people, of whom 57 were Belgians and 40 Italians. There is a list of 41 Italian physicians who served the Free State between 1898 and 1908, to which should be added the doctors hired by the *Comité Spécial du Katanga* and private companies. Finally, doctors of other nationalities – Scandinavians, Britons, etc. – also worked in the area; but, to my knowledge, no systematic index of such individuals exists.

Whether they are Belgians, Italians or Scandinavians, we do have biographical indexes enabling us to paint a collective portrait of the group, a rapid study of which raises some questions. The first generation of Belgian doctors in the Congo included a strong contingent of military doctors, who were the keenest to work overseas, and in the first wave of departures there were also many graduates from the Free University of Brussels. This is not surprising since Catholic circles were, at the time, poorly disposed towards emigration, especially to the Congo. A change in attitude was noticeable around 1905-1910, and the movement for the “Catholic conquest” of the Congo gained strength in the twenties. This may also have been the case in medical circles.

The contingent of Italian doctors in the Congo was part of a large, active colony in the country during the Free State period. This is also the foreign colony that has been the most closely studied. The many Italians working on the major railroad, civil engineering and

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46 1904: Inauguration, under the name of colonial course, of preparatory sessions for officers and State agents. Colonial courses instituted at the Antwerp Higher Institute of Commerce that same year. Both curricula included classes in tropical hygiene. 1905: decision to build the École mondiale (World School) in Tervuren using money from the Congo. Work started in 1909 but was abandoned in 1910 in a reaction to Leopold II’s sumptuous spending. It should be pointed out that the costs of running the School of Tropical Medicine continued to be borne by the Congo’s budget even when the school became a Belgian state institution after the territory’s annexation by Belgium. In 1907 the Belgian Farm Minister set up a commission to prepare the blueprints for a “school of exotic medicine and hygiene” in Antwerp (Mouvement géographique, March 3 1907, col. 106).

47 “Du rôle de l’enseignement médical dans la préparation à l’expansion économique,” by Dr. C. Firket, in the proceedings of the “Congrès International d’Expansion... Mons, 1905”, op. cit. Dr. Van Campenhout was the first director of the School of Tropical Medicine (*Biographie belge d’Outre-Mer*, ARSOM, Vol. V, cols. 167-171).


49 For “colonial Belgium,” see the classic biographical instruments, especially *Biographie coloniale belge* (renamed *Biographie belge d'Outre-Mer*). For Italy, see P. DIANA (1961), *Lavoratori italiani nel Congo belga*. Elenco biografico, Rome, Istituto Italiano per l’Africa. For the Scandinavian countries see H. JENSSEN-TUSCH (1903-1905), *Skandinaver i Congo*, Copenhagen.
urban construction sites remind us how much Italy contributed to all fronts of European expansion in the world at this time, well beyond the simple confines of her more or less successful political undertakings. She supplied a large number of highly-qualified immigrants to the Congo: judges, army officers (between 1903 and 1908), and doctors. In the thirties a nationalist historiography even attributed the major successes of colonial medicine in the Congo to the Italians. In these pages we shall merely mention the role of these doctors, often graduates from the medical schools of Lombardy, Tuscany and Emiglia, who included a strong contingent of military doctors. With the exception of the stir created by Dr. Baccari’s report, Italy’s testimony about the period of the construction of the Colonial State has attracted little notice.

Medical activities in the Congo Free State, as so far described, were scattered, and lacked both resources and personnel. However signs of a new concept were beginning to appear, pointing the way to a more ambitious type of medicine which, backed by the administrative powers, would play an active role in the country’s development. This modern colonial or tropical medicine was born in response to challenges: those of tackling the epidemics that were becoming a permanent threat, of pursuing the many scientific conquests already made in tropical medicine, and of organizing the major railroads and mining concerns. Medicine in the Belgian Congo from the twenties and thirties onwards owed still a great deal to these first projects of medical coverage.

2. The lessons of the endemic diseases and the beginnings of a new medical project

We have described the obstacles which the tropical environment placed in the way of long-term implantation by industrial companies from temperate zones. The situation of the West Coast of Africa was probably especially conclusive but was not unique. Yellow fever was endemic in Havana and Rio. In 1902 it was estimated that half of Egypt’s population had schistosomiasis. In fact the so-called “tropical” endemic diseases were known in temperate regions too. Malaria control measures in Italy and yellow fever control work in the southern United States served as laboratories for intensive State action in the field of public health. In fact there were two lines of development that were not always well combined. The late 19th century was decisive in terms of research and scientific breakthroughs as a result of the marked progress made in America, Italy and England in identifying the vectors of yellow fever and malaria. Discovery followed discovery, and information was spread quickly by a few specialized journals. Another, quite separate, line of development was that of the application of these discoveries. Attacking the root of the evil by controlling the vectors of tropical diseases required political will and administrative means. These were found in a few large-scale undertakings of the time, namely Italy’s very successful 1902-1908 antimalarial programme and the still legendary campaign of William Gorgas and the American army to eradicate yellow fever from Havana and later Panama. Thus practical American skill overcame the obstacles plaguing such major tropical engineering projects as the Panama Canal. The example was followed quickly, wherever warranted by the available means or by the stakes involved, for example in Rio and the Transvaal (and thence, in Katanga).

Without effective tropical medicine, industrial capitalism and its production methods could not become established. A new concept emerged: it was no longer a case of adapting gradually to the tropical environment and accepting a vague geographical determinism, but rather of tackling – and conquering – it systematically. In 1907, for example, a German public health specialist stated clearly, “the mastery of hygiene in Africa will be the Europeans’ most effective means of political and social conquest.”

While this voluntarist project was taking shape in various parts of the world, the Congo remained dominated by a regime of trading economy. There was as yet no plan to remodel African societies completely. Within the Free State there were some sharp contrasts.


European medicine in the Congo free state

Despite the strong influence of European scientific circles, and active research in Africa and in European laboratories, the application of knowledge in this part of the world remained rudimentary for many years. Under King Leopold's rule, the lack of impetus at the highest echelons of the State, combined with administrative inertia, explain the delays in environmental control programs, by comparison with the progress made in the American tropics and the Mediterranean Basin. Africa as a whole, however, presented a less favourable situation, and the Congo was no exception when compared with the least developed African colonies at the time. This relative delay did not extend to science itself, to which the State certainly contributed albeit without undertaking the initiative. It came, as we have seen, from Belgian scientific circles backed by private companies not necessarily interested in colonial undertakings.

In the Congo as elsewhere in colonial Africa malaria control would play a major role in the expansion of the State's services and medical surveillance of the population, at least in the most accessible population centres and regions. Later, sleeping sickness would be the stimulus for medical teams to seek out the patients in their homes, the most out-of-the-way villages, thereby bringing them in contact with the lifestyles most deeply rooted in tradition and custom.

While this was not yet the case in the Congo under King Leopold's rule, one epidemic – smallpox – was tackled successfully by the Free State's administration. As we have seen, this disease had been known for a long time in Central Africa. The fact that it took on epidemic proportions at the beginning of the colonization was attributed to increased population movements which caused the destruction of barriers protecting immununized communities. The practice among the Arabs and Swahilis of inoculating the natives against the disease by variolation as they extended their trade networks into the interior was characteristic.

There was an urgent need to control smallpox in the Congo, especially along the major waterways. In fact the first two native hospitals – in Boma and Leopoldville – were built to house smallpox patients. However, the bulk of the efforts were concentrated on prevention, and the smallpox vaccination program must be considered the first offensive conducted by the Free State against a major epidemic. In the beginning vaccines were ordered from Europe, but this was so unsuccessful that, from 1895, the State created its own vaccine production centers. Finally, it had eight centres covering the major travel routes from Boma to the Lualaba and Tanganyika. The procedure was very modern and the campaign was a resounding success, especially in protecting those working on the Great Lakes railroad. The example is all the more worthy of mention as historians of Western European medicine generally consider smallpox vaccination to be a decisive stage in the spread of medical care to the entire population rather than just the upper classes.

Measures to control sleeping sickness had to be on a much larger scale. As this was an ecological disease, the environment in the vicinity of human settlements, fishing areas, hunting grounds etc., had to be properly managed. Control measures included the monitoring of population movements, widespread availability of costly Atovyl treatments, and close medical and administrative coverage. These are all factors that delayed effective control of sleeping sickness in French Equatorial Africa until after World War II, when the Jamot method was implemented.

The medical services in the Belgian Congo had reached similar conclusions at about this time and were working in the same direction. As a result a similar

54 For a comparative study see W.B. COHEN, op. cit., and R.E. DUMMETT (1968), The Campaign against Malaria and the Expansion of Scientific, Medical and Sanitary Services in British West Africa, 1898-1910, - African Historical Studies, 1, 2, pp. 153-197.
55 Rapport de la Commission d'Enquête au secrétaire d'Etat de l'EIC, Bruxelles, 30 octobre 1905 (Commission of Inquiry's Report to the Secretary of State of the Congo Free State, Brussels, October 30, 1905). Bulletin Officiel (Bruxelles), p. 239. The smallpox epidemic decimated the population west of Lake Leopold II, among others (ibid.). Tragic description of the introduction of smallpox in Sankuru by "the Stanley," a steamer on board of which the epidemic broke out at the end of 1892. The patients disembarked as the vessel steamed up the river and, carrying trading goods to buy their food supplies, communicated the contagion, which led to 10,000 deaths in one year. Sankuru's population attacked the Stanley two years later, as they considered it responsible for the epidemic. De pokken aan boord. Doed van tientallen neger in C. DE DEKEN, Twee Jaren in Congo, Antwerp, De Vlijt, undated 1952, pp. 87-91.
56 Assistance médicale aux Indigènes..., op. cit.
57 It was not until the 1880s that vaccination campaigns in Europe relied more and more on animal vaccines. Vaccination became mandatory in Germany in 1874. See C. HUERKAMP (1985), The History of Smallpox Vaccination in Germany. A First Step in the Medicalization of the General Public, Journal of Contemporary History, 20, pp. 617-635.
58 The Jamot method was generated by the experience acquired in Ubangi-Chari and Cameroon during World War I. It was based on mobile units that not only "went out to the patient" but also practiced prevention and screening. The "Jamot system" required a general, medical and administrative supervisory framework. It was applied in FEA first, then in West Africa. (M. BBEY-EYIDI (1950), Le vainqueur de la maladie du sommeil. Le Dr. Eugène Jamot (1879-1937), Paris, Edition of l'A. See also P.G. JANSSENS, A propos du livre de L. Lapeyssonie, Moi, Jamot, Bull. des Sciences ARSOM, 34, 3 (1988), pp. 497-504.

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method was finally adopted. Since it consisted of systematic screening, it supposed the creation of quasi-military public health services. Indeed, public opinion was occasionally scandalized by the brutality of the means employed. During the epidemic itself the Free State confined itself to the cheapest administrative measures: roads and waterways were closed and patients seized at control points were placed in lazarets, but very little in the way of treatment or prevention was taken, except for the State personnel. The cultural shock also played a part. The 1907-1908 report from Leopoldville laboratory concluded that prophylaxis was out of the question in the villages, given the “apathetic, carefree population, refractory to our European medication”.

Nor should the lazarets deceive us. While the name was associated with a charitable organization, the reality in this context was bitter. Patients were treated like prisoners and social problems arose constantly. For example no accommodation was available for the families who traditionally accompanied the patients, and the lazarets did not receive supplies regularly. There is no shortage of descriptions of these horrifying places, into which patients were crammed to await death. At the time, however medicine was powerless against the disease’s effects on the patient’s nervous system. Take the example of Prince Albert’s visit to a lazaret at Vieux-Kasongo, in 1909:

“The patients with sleeping sickness are relegated to a small, isolated building. Nothing is as distressing as the sight of these African lazarets, true living charnel houses in which the negroes are locked up to die, miserable, resigning to their approaching end. No one comforts or cares for them. One wonders if death in the bush, being left to die in the thick of the forest, would not be better than these awful prisons where a little food and shelter prolong their suffering for a few months.”

The epidemic and the system of isolation and Cordon sanitaire posed a number of moral questions. Was it acceptable to isolate the patients by force, whereas in Europe tubercular patients were free to roam at will? Could one tackle the disease without taking into account the more general living conditions of the population? In the short term such considerations led to improved living conditions in some lazarets, while in the longer term they produced a more comprehensive view of the disease and its context and a broader understanding of medicine. At the time, however, during those years under Leopold’s authority, one could not look to the State to implement a project of social medicine.

Does this mean that the Congo contained no trace of the aforementioned Promethean view, whereby the tropical environment was to be mastered so as to make it receptive to the great capitalist undertaking?

59 The experiment attempted by Dr. Lejeune in Kiambi in 1911 (in Katanga at the time) was considered a forerunner of this. Lejeune organized a systematic census of the population, outpatient treatment by “native nurses,” and a network of village dispensaries. (J. BURKE, Historique de la lutte contre la maladie du sommeil au Congo, Ann Soc. Belg. Méd. Trop., 51, pp. 465-482 (p. 468).) Jamot willingly acknowledged the parallels between his work and that of Dr. Lejeune.


61 In Europe a lazaret was traditionally a place of quarantine run by monks or nuns. Lazarets existed in the Middle East in the 19th century. Built at the instigation of the European powers, these lazarets were attempts to check the spread of epidemics. Hence the re-opening of the lazaret on the Farsan Islands in 1895-1896 in which all pilgrims going north to Jeddah had to spend a period in isolation. Some dozen doctors, including several Italians, examined about 40,000 people a year in this lazaret. (D. CAVALLINI (1909), Il lazaretto di Kamuran, Annuali di Medicina Navale e Coloniale, xv, 2, pp. 453-460.) The first lazarets in the Congo seem to have been intended for smallpox patients. The Compagnie du Chemin de Fer, for instance, established a lazaret near its “hospital for Blacks” above Matadi. The set-up was rudimentary: “cabins of wooden planks, sheets of zinc and thatch, arranged to house one smallpox patient per cabin. In the event of an epidemic a soldier stood guard in the area and prevented the patients from walking off. Victuals were kept in a special place where the cook who served as a nurse would fetch them.” (O. JULLIEN, Le service médical de la Compagnie du Chemin de fer au Congo (1893-1895), in Mouvement géographique, 11, Oct 1896, cols. 495-498 (col. 496).


63 We cite here as examples, of some of the comments by U. Zerbini, one of the State doctors responsible for controlling the epidemic. He was worried, but he was not the only one, about the lack of sensitivity that often betrayed the struggle against a disease when the administration was implementing control measures. Zerbini’s comments are given by M. LYONS (1987), The colonial disease: sleeping sickness in the social history of northern Zaire, 1903-1920, Ph.D. thesis, University of California, Los Angeles, pp. 245-246, 259. See also M. LYONS, From ‘Death Camps’ to Cordon Sanitaire..., op. cit. In quoting Zerbini we are not relying on the isolated case of an outsider. Zerbini was one of the most important Italian doctors in the history of the young colony. He had reached one of the highest positions in the medical administration by the end of his official career in the Congo in 1914. He went on to practice in Belgium, then returned to Katanga – which was something of a novelty at the time. Article on “Zerbini, Umberto” in P. DIANA, Lavoratori italiani nel Congo belga..., op. cit., and entry in Biographie coloniale belge, V, Brussels, ARSC, 1958, col. 899.
The plan, we should remember, was simple: first conquer the environment, then open the door to its development. This is undoubtedly an oversimplification. In practice, the tropical environment was conquered only after a long and painful process made of failures and successes, that preceded rather than resulted from its conquest. Nowhere was the challenge of applying the laboratories' scientific discoveries systematically and on a large scale more evident than in the vast civil engineering projects in the tropics. The Leopoldian State, which focused on the commodities trade and military adventures, did little to provide the country with an infrastructure, except for the railroads built first in the Bas-Congo and then in the Stanleyville-Luaba region. These works were nevertheless modest precursors of the intensive programs of medical coverage that would characterize the vast mining undertakings and, in the fifties, the entire Belgian Congo.

In the 1890s these ambitious programs were still far off. The Compagnie du Chemin de fer du Congo, however, was the first to organize complete medical services for its workforce. While the capital and general administration were Belgian, the workforce was a real mosaic of ethnic groups. As on other railroad construction sites in late 19th-century Africa, from Senegal to the Transvaal, Italian crews played a major role. With the help of West-African foremen (head-men), the Italian crews supervised the manual labourers, also predominantly West African. At first only porters for the food supply caravans and baggage trains were recruited from among the Congolese population. The company employed some 300 Europeans and no more than 9,000 Africans. This labour was expensive, and absences due to illness had to be kept to a minimum. This was the job of the almost military health service that the company set up.

On their arrival in the Congo all workers were examined and vaccinated. Those who failed in the selection were sent back at the recruiter’s expense. The company’s head medical office was set up in Matadi, with a hospital for Europeans nearby at Kinkanda. There was also a hospital for Africans, run by black nurses whose job was to provide beds for the sick and wounded before sending them home. There was a doctor for every 80-100 km of track being laid. Other doctors were assigned to the departments of road-building, track-laying and earthworks. At the height of the construction work, in 1893-1895, the company’s medical department employed an average of five doctors, one pharmacist, and some African nurses. These figures should be compared with the ten or so doctors employed by the Free State at the same time to cover its entire territory.

We shall return later to the first Congolese nuns employed by the railroad company’s hospital at Kinkanda. Let us just mention here that each company doctor could rely on the assistance of one or two nurses who were described vaguely as Wolof or from Sierra Leone, depending on whether they came from the French or English parts of the coast. “To be truthful, we must recognize that they carried out their work with an intelligence, accuracy, devotion and gentleness that many of their European colleagues unfortunately did not possess.”

Medical achievements on the construction site cannot be assessed precisely. It is interesting, in this context, to read the commentary of the official historian of the Compagnie du Chemin de Fer du Congo:

“When, on June 19, 1898, the missionaries commemo rated...the funeral services for all the men who had lost their lives on Congolese soil in the Company’s service, the names of 132 Europeans were cited...1,800 Black and Chinese workers lie in the cemeteries that line the track, and these figures do not include all the sick who were evacuated and went off to die anywhere...”

64 See, notably, the programme described by H. ZIEMAN (1907), op. cit.
65 L. TROUET, “Le Chemin de fer du Congo,” excerpted from Annales des Travaux publics de Belgique, August 1898, 101 pp. (p. 96). These nurses were trained in Africa. Their role is also mentioned by E. Willems, a former company doctor who was interviewed later by A. DUBOIS (La médecine au Congo belge en la fin du XIXe siècle, op. cit., pp. 355-357). The medical department’s painstaking organization is described by O. JULIEN, Le service médical de la Compagnie du chemin de fer du Congo (1893-1895), Revue Géographique, Oct. 11, 1896, cols. 495-498, and Oct. 18, 1896, cols. 510-512.
66 R.J. CORNET (1958), La bataille du rail. La construction du chemin de fer de Matadi au Stanley Pool, Brussels, Ed. L. Cuypers, p. 377. It should be noted that the roll-call addressed the Europeans only (83 Belgians, 31 Italians, 9 Frenchmen, etc.). The total number of victims is unknown, as the African sick and wounded were repatriated after a spell in Matadi. Cornet mentions the high cost in human lives of the great projects of the time. If he is to be believed, true necrotomies took place. Cornet gives the figure of 450 deaths in the construction of the Saint-Gothard pass and “thousands of Egyptian corpses” littering the construction of the Suez-Cairo section of the railroad track. He adds, rather curiously, “building Antwerp’s forts took a greater toll of the Belgian army’s engineering corps than the Franco-German war (of 1870) took of the two armies engaged.” (Ibid., pp. 377-378.) Around 1908 an old construction hand in southern Africa mentioned a conversation with a Belgian known as Poli-poli (“very softly” in Swahili), a former surveyor on the Matadi-Leopoldville line. He described the losses in human lives along the caravan trail: “the deaths on that road were even surpassed in numbers by the awful loss of life amongst the labourers constructing the railway. According to Poli-poli, the natives just died “et on ne pouvait rien faire” (nothing could be done).” In a remark typical of the rifts and rivalries that divided the Europeans in the Congo at the time, the author adds, “An Englishman would have found some way out.” (J.B. THORNHILL (1915), Adventures in Africa Under the British, Belgian and Portuguese Flags, London, John Murray, p. 236.)
Nevertheless, it seems that the bulk of the losses occurred at the start of the undertaking, when workers were crushed together along the first kilometres of the line, at which time dysentery was responsible for many deaths. The health care system set up by the Matadi railroad, with its successes and failures, was a pioneer in the field of social medicine. A few years later it would be the turn of the mining concerns in Kasai and Katanga to give final shape to the plan for complete medical supervision of the company’s personnel. However, this exceeds the limits of this introduction, and interested readers should consult the chapter Occupational Health (p. 788).

By definition, the major companies took an interest in the salaried employees. The villages were their concerns only to the extent that they were pools of labour. Special incentives were necessary to generate interest in the bush beyond these purely utilitarian considerations. Such motivations were not lacking at the time, but had to be sought in directions other than the rationality of the enterprises. During an argument in 1894 that ended in the courts, the Compagnie du Chemin de Fer du Congo had been denounced as a Judeo-Masonic enterprise. The roots of a health plan giving priority to the rural population belong to a non-capitalist tradition, that of the Catholic and Protestant missions.

3. Christian missions and health projects

When writing a review of a biography of Dr. Schweitzer, Graham Greene remembered him in the Belgian Congo of the fifties. During a visit to a leprosarium Dr. Schweitzer had spoken to Greene of the contrast between the sentimental leprosariums and those that claimed to be scientific. The sentimental hospital, the doctor explained, offered something to suffering mankind or mankind in despair, something that the scientific hospital was unable to provide. It was only too easy, Graham Greene added, to perceive the passivity of a sentimental African hospital. Here he mentioned the dispensary he had visited on the banks of the Ruki River, the miserable conditions of which had left him with a feeling of anguish the years had not dispelled. And yet he, too, had felt during this visit that the sentimental hospital could boast of a psychological quality that was also essential for the patient.

We do not intend to discuss here the application of the term sentimental to the missionaries’ medical care; but it is true that in dealing with this subject we shall describe a project that was seen less as the application of scientific knowledge and practice and more as a way of reaching hearts and souls, especially at the outset. Scientific concerns gradually acquired a certain prevalence, notably under the impetus of the epidemics linked to the European settlements, but this was not the main intention in the beginning.

The status of medical care in the Christian missions has been described repeatedly by those involved, by contemporary observers or in recent studies. At the risk of oversimplifying, we can pick out three major motivations behind the work of the missionaries belonging to the different branches of Christianity, for no marked differences appear between Catholics and Protestants in this field (these motivations are not ranked in order of importance, as each had a role to play).

- First there was the religious motivation: in caring for the sick, Christ had pointed out the path to follow.
- Next we must take the charitable and humanitarian tradition of the Church in European society into account.
- Finally, the motivation of a spiritual struggle must be included, for the missions tried to counterbalance the power of the healers, sorcerers, witch-doctors, etc.

The missionaries were aware that one of the effects of medicine should be to free the Africans of their fear of the unknown. According to the doctrine of personal salvation, it should develop the individual’s sense of personal responsibility for his or her physical health as well as spiritual salvation. According to the attitude of the time, the spiritual combat waged by the missionaries was also seen by the scientists as a sign of the clash between the natives and civilization. To their thinking, the missionary doctors were carrying out a positive task. One of the leading medical journals of the time welcomed, “the progress made by these devoted men in elevating the local benighted population to the standard of the West”.

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67 Le Congo belge aux Juifs, published by Drumont’s La Libre Parole in Paris January 22, 1894, and a lawsuit brought by A. Thys a few months later. (R.J. CORNET, op. cit., pp. 258-269.)
69 R. SLADE (1959), English-Speaking Missions in the Congo Independent State (1878-1908), AISC Mém., p. 198, quotes missionaries of the period: “...the witch doctor became afraid to state that every death that occurred was the result of witchcraft. The mother began to understand that it was her own responsibility, not that of the spirit world, if her six month’s old baby had stomach ache after eating peanuts and maize.”
70 “The work of medical missionaries,” Medical Record (New York), Nov. 4, 1903, p. 605.
Things were not so simple in the field, and the coming of the missionaries was often experienced as a clash between two worlds. The ravages of the major epidemics contributed a great deal to this. A Jesuit from the Kwango Mission explained with a certain amount of candor the inextricable links that developed between politics and religion under such conditions: "We relied greatly on the help of the State. Without this help, we were powerless (...Natives would not dare too rapidly attack the white man with open force, but would they have any compunction about trying to poison them, about striking and killing Christians? In my humble opinion, they have poisoned quite a few catechists in ten years (...) What the natives are demanding above all is complete freedom, as before, to kill the ndoki (the spell-casters, that is to say, those who are accused of evil spells). They imagine that, since they are forbidden to kill each other on grounds of claimed evil spells, the death rate has risen; that to be able to live and multiply they must faithfully kill all the ndoki. It is true here that since the white man's arrival they have been ravaged by smallpox and sleeping sickness, but other regions in which there are no whites have suffered from the same afflictions. All in all, we should see this rather as the action of the Dark Angel (who) is spreading his lies to destroy God's work (...). Because we are trying to save souls, he is spreading the stupid belief that white men eat souls (...). For most of these vulgar heathens, the missionary is a terrible monster, the white ghost of Europe that prows everywhere, with terrifying greed and a constantly growing appetite, eating people (...)."

Some authors wanted to show that the medical action of the Christian missions was a total failure, in terms of both scientific and spiritual achievements. This conclusion does not reflect the data culled from documents that show sufficiently the contradictions of a history marked by uncertainty. Some souls were won, others were lost. European science and medicine proved sometimes powerless, sometimes effective. Indeed, the best-argued analyses were sensitive to the contrasting dimensions of this page of history, in which religious spirit and humanitarian concern were intertwined with exploitation of the issues to political and colonial ends.

The major orientations of the Christian missions in the Congo belonged to the more generous currents that we have just briefly outlined. Thus the Baptist Missionary Society (BMS) had more than thirty years of experience in the Gulf of Guinea when it entered the Congo region, several years before the proclamation of the Congo Free State. It came to the area with a threefold vision of the missionary's task, namely, to preach to and teach the schoolchildren, provide care, and act as a universal entrepreneur and craftsman. At the time, however, the missionaries saw medical action as part of their struggle to gain legitimacy vis-à-vis the African healers and to protect Christians from evil.

This combat was waged largely by individuals without special medical training. Only exceptionally were doctors or trained nurses found in the Protestant missions that set up in the Lower Congo region and then along the Congo river and in Kasai. In 1907, for example, Dr. R.J. Dye, who was stationed at the American mission at Bolenge, was the only missionary doctor in the entire Upper Congo region. The first Protestant hospital was built in Bolobo in 1912. Previously the few doctors in the Protestant missions had the most rudimentary working conditions. Thereafter, however, the mission's medical work gradually

71 The account continues, revealing that, according to popular belief, "each missionary has his central cemetery, just as he has his central chapel". Letters from the Kwango mission, Missions belges de la Compagnie de Jésus (1906), pp. 108-109. See a similar episode at the Lukulu mission (Urwa): "Some Baluba came several times to ask us if our cloth had been woven by our dead." This is followed by an account of the Europeans' offerings to the dead and the cloth that the dead wove and gave to the white men (Chronique de la Société des Missionsnaires d'Afrique (Pères Blancs, 1908, p. 202). Concerning the opposition between rival health systems see M. SINGLETON, Du salut à la santé: demandes et offres d'Églises, Actes du Colloque "Églises et Santé dans le Tiers-Monde hier et aujourd'hui", Louvain-la-Neuve, October 19-21, 1989 (proceedings in course of publication).

72 In speaking of the work of the Universities Mission in Central Africa, in Massai (southeast Tanzania), a known historian recently concluded with the following hasty judgment: "(of) the justification and expectation of mission medical work, up to 1945 at any rate, none were fulfilled." (T.O. RANGER (1981), "Godly medicine: the ambiguities of medical mission in Southeast Tanzania, 1900-1945," Social Science and Medicine, 15 B (1981), pp. 261-277 (p. 262). This particularly opportunistic article illustrates in exemplary fashion the reductionist spirit of varied sources characterized by one-way conclusions that have been decided upon beforehand. It is definitely not easy to have to deplore the absence and ineffectiveness of European medicine for the bulk of the population and, in the same breath, attribute to Western-trained doctors the leading roles in a vast, long-term picture of deteriorating food and health conditions in Africa.

73 For example, and to confine ourselves to the more recent works, see the balanced discussion of "the mission via medicine" (Mission durch Medizin) in H. GRUNDER (1982), Christliche Mission und deutscher Imperialismus, 1884-1914, Paderborn, Ferdinand Schöning, pp. 350-352 (and passim).

74 Comber, Ngombe mission (1887), quoted by R. SLADE, English Speaking Missions (...) op.cit. p. 136

75 Station of the Disciples of Christ Congo Mission, in the Congo since 1897.
became a responsibility in its own right, not just an addendum to its religious activity.

It is in this context of greater attention being paid to scientific endeavours that medical auxiliaries were given specialized training, although the first medical schools were not opened by the Protestant missions until the twenties and thirties. Native auxiliaries had long taken an active part in dispensing care to the sick. Some of them have been saved from anonymity. Take Vingadio Timorio, a catechist and teacher from Mbanza Manteko, in Lower Zaire, whose life – which was exemplary on more than one score – is known to us through the writings of various missionaries. Immediately after his conversion by an African catechist from the Mbanza Manteko mission, in an atmosphere of both attraction and fear, Vingadio enrolled for teacher’s training at the mission. However his first assignment was Kimpese’s dispensary, where he was noticed by Dr. Catherine Louise Mabie who took him on as an assistant at Kimpese Institute. In 1917 Vingadio became the Institute’s first African staff member.77

Although preponderant in the first years of colonization, Protestant missions were soon outnumbered and outreached by the Catholic establishments. This should be seen as a result of the powerful missionary movement that developed in Belgium and made the Congo a colony which was exceptionally strongly influenced by the Catholic Church. This missionary spirit first had to overcome a phase of Catholic mistrust towards the King’s undertaking in the Congo, as he was suspected of being under the influence of anti-clerical circles. It took the intervention of members of the clergy in Liège, Ghent, and Louvain as well as Leopold II’s overtures to the Vatican to overcome this reluctance on the part of a Catholic society that had originally been poorly disposed towards Christian emigration to far-off lands.78 Indeed it is significant that some of the first priests in the Congo were sent to minister to the European workers on the Matadi-Leopoldville railroad. These priests were soon followed by the first Sisters of Charity, who provided nursing care in the company’s European hospital. They nursed 288 white patients in 1892-1895, in addition to providing occasional care for local people.

These European activities were not always clearly explained to the faithful, who were increasingly solicited on behalf of an apostolic project aimed at the African population. In 1888, for example, Cardinal Lavigerie launched an antislavery charity, (l’oeuvre antiesclavagiste) which did a lot to popularize the Congolese cause in Belgium and to encourage the birth of a missionary movement aimed at Central Africa. In 1891 the Catholic Congress gave its support to a campaign to mobilize the clergy and young people in favor of this charity, asserting “...the African question must be spread among young people above all... The oeuvre antiesclavagiste is an initiation to the great movement that is carrying Europe towards the Dark Continent – let each young man spread its message.”79

An analysis of the methods by which the Belgian missionaries established themselves in the Congo is beyond the scope of this discussion. It is important, however, to observe that the French orders had preceded the Belgian congregations in Central Africa. This was the case with the White Fathers in eastern Central Africa. Their methods were devised by Lavigerie himself, based notably on Comboni’s projects, which were also aimed at the heart of Africa but starting from the Nile Valley. Medical assistance played a key role in the work of the White Fathers. Each mission was to be backed up by an African doctor-catechist. This project, which dates back to 1876, was part of a vision of the evangelization of Africa by Africans, especially by African doctors, whose “profession was the best suited to exert influence in their country”. The experiment was continued between 1881 and 1896 and affected more than twenty young Africans – most of whom had been slaves “bought” in Sudan – who attended courses given at the Faculty of Medicine of the University of Malta.

The three medical assistants who laid the foundations of a medical service in the area of Lake

76 Here we find once again the myth of the European body-snatcher. According to rumors, the founder of the Mbanza Manteko mission, Henry Richards, expiated a crime by sending to Europe the heads of corpses that he dug up at night.

77 SERUFURI Hakiza (1984), Les auxiliaires autochtones des missions protestantes au Congo, 1878-1960. Etude de cinq sociétés missionnaires. Ph.D. thesis in history, mimeo, Louvain-la-Neuve, pp. 460-461. The biographical sketch given by the author is chronologically inaccurate, but Vingadio’s birth can be situated around the 1890s at the very latest. The world of the medical auxiliaries of both Catholic and Protestant missions in the Congo deserves further study.

78 “We can repeat what was said at our Congress three years ago: Emigration should not be advised. We should even advise against it. As a rule, those who leave their country run the risk of losing their faith. This same degree of danger would not have existed for them if they had remained in their fatherland.” The conclusion was that they should be sent priests who spoke their language. Mgr. Rutten, speaking at the Third Session of the Congress of Social Works in Liège in September 1890. (Actes de la IIIe session du Congrès des oeuvres sociales, Liège, 7-10 septembre 1890, Ed. Demarre, 1890, pp. 105-106.)

Tanganyika, some 15 years before the German health services began operating on the eastern shore and the services of the Free State and Comité spécial du Katanga began working on the western shore, came from this group. Upon reaching Mpala in 1889 two of them would have long careers in the region: Adrien Atiman was soon reassigned to Karema, on the eastern bank, where he was still practising in 1955, while Carolo Faragi joined the civil service at Baudouinville after twenty years at the mission. Giuseppe Gatchi, the third assistant, may be included among the doctors mentioned earlier who occasionally performed military functions, as he was in charge of a state post at the southern tip of Lake Tanganyika for a spell in 1894. This pioneer Hausa doctor was one of the victims of the sleeping sickness epidemic that ravaged Lake Tanganyika in 1904.80

The shock of the epidemics gave unforeseen urgency to the medical aspect of the missionaries’ work. In the first decade of the 20th century, when the epidemics were spreading, the missions were already better established and the problem concerned them more directly than in the early years of their first settlements. Just to mention the leading congregations: the Congregation of Fathers of Scheut was established along the Congo River and was growing in Kasai; the Jesuits had received part of the Scheutist territory and were building a Christianized network in the Lower Congo; and the White Fathers were extending their territory in the Upper Congo, and in the Tanganyika-Lualaba region.

The epidemics showed up the basic confrontation between rival health care systems. The White Fathers in Urula left a particularly vivid picture of the situation in 1903:

“… the patients who were previously hidden in the woods and tall grasses for fear that the missionaries would baptize them are now summoning the Fathers themselves and asking to be baptized. The children who attend the schools will form a Christian generation that will dare to break with what is called Kilouba here, which is the local customs and superstitions, in favour of Kiyungu – Christian habits.”

While the healers subjected suspects to trial by poison or the sick were abandoned far from the villages, the missionaries initially were not much better armed against the unknown epidemics. Of course for smallpox the White Fathers performed elementary inoculations, variation using procedures already familiar locally, but when sleeping sickness struck, they had to resort temporarily to isolating the sick and conducting ceremonies in honor of Our Lady of Perpetual Succour. Until then the mission had considered health work to be no more than “a way to reach the soul”.

Moreover it is typical that around 1900, in the vicinity of Baudouinville missionaries and catechists sought out smallpox patients to be baptized. However, given the urgency of the situation and the colonial authorities’ indifference, they had to change their policies and pay special attention to medical care. Thus in 1906 a White Father working in the mission on the shores of Lake Tanganyika, J. Kindt, bought a microscope and went to the Pasteur Institute in Paris for training before courses in tropical medicine were instituted in Brussels. In 1906 he was already starting to give some Atoxyl® injections, but these were still experiments initially restricted to adults.81 In speaking of Atoxyl®, moreover, we must bear in mind the high cost of this drug, which was produced in the laboratories of industrial countries and was thus out of reach for patients in poor countries. This reminds us how decisive a role economics played when the discoveries of modern tropical medicine were to be applied in the field. This problem is known to be worsening today; and at the start of the century it was already severe. Let us take the example of French Ubangi, a region very close to the Free State with very similar material conditions. Missionary reports revealed that sleeping sickness was


81 This paragraph is based on the brochure by V. ROELENS & J. KINDT, Les Missionnaires d’Afrique (Pères Blancs) et la Maladie du Sonneil, Antwerp, undated (1912). Was also used V. Roelen’s handwritten report from Mpala dated January 25, 1908, Archivio, Missionari d’Africa (Rome), 283.4. - Smallpox inoculations by J. Gatchi at Saint-Louis du Munnbi in 1893 and Baudouinville in 1900, Chronique de la Société des Missionnaires d’Afrique (Pères Blancs), limited edition, Maison-Carrée, Algiers, 1900, p. 326. Kilouba vs Kiyungu: Ibid., p. 303. Example of the trial by poison for a smallpox epidemic in Luba territory (Urula-Saint-Lambert), Ibid., p. 358. Sleeping sickness, pilgrimage to Our Lady of Perpetual Help, Mpala, Ibid., 1908, p. 905. (“All the Christians are present, but the assembly is sparse, ‘Where are the great celebrations and large crowds of yore?’) Child with sleeping sickness chased out of a village with blows from a stick, left in the bush with his legs bound. A catechist finds him and brings him to the mission.” Archivio, Missionari d’Africa (Rome), Diario de Kasongo, entry of November 1907, p. 23.
wreaking havoc in the area at the turn of the century, “decimating our Christians as well as the natives”. In 1905 the mission estimated that, “in some places”, the epidemic had carried off three-quarters of the population. Atroxyl® was developed soon thereafter. In 1907, the annual report observed laconically that this product was “recommended by the Pasteur Institute but it costs 700 francs and we cannot afford it”. The total expenditure of Ubangi’s French mission for the year, it is true, was only 93,565 francs.83

Kwango’s Jesuit mission was also hit hard by the trypanosomiasis epidemic. Here, too, it is possible to follow some of the main stages of the mission’s response: children’s lazarets first, then preliminary training for the missionaries in the rudiments of diagnosis limited at first to the staff and children of the mission, then the first, often disappointing, attempts at treatment with Atroxyl® (1907-1908). The efforts of two missionaries, H. Vanderyst and G. Greggio, will remain forever associated with efforts to control sleeping sickness around Kisantu.84

An assessment of the medical activities of the different missions has yet to be made. We can see that it was the medical teams connected to the missions which were in contact with the greatest number of patients. In 1907-1908 the Upper Congo vicariate of the White Fathers reported having cared for 171,651 patients in Baudouinville, Mpala, Vieux-Kasongo, etc. During the same year 33,000 communions had been given.85 This showed that medical care was beginning to supplant the missionaries’ purely religious tasks.

4. Provisional assessment

Studies of the history of colonial medicine in the former Belgian Congo have often been dominated by a sense of calm superiority.85 This may be explained by the implementation of intensive medicalization programmes in Belgium’s African colonies, especially after World War II. At first these projects were developed by the large companies for their workers and dependents; and only much later, in the fifties, did the towns and villages benefit from close medical supervision. The Ten-Year Plan was expected to play a decisive role in this direction.

A self-satisfied attitude characterizes many Belgian colonial writings of the fifties and sixties. This took shape during this period of material optimism. To understand it, one must also recognize the desire to make up for the troubled events marking the first years of the Congo’s colonial history. The memory of the campaigns of accusation against King Leopold’s regime remained strong. These critics, who were particularly active in Great Britain and the United States, triggered a chauvinistic nationalistic response in Belgium.

All of this helps us to understand why the successes of the colonization of the fifties were all too often projected on the more distant past, that is 1880 to 1910, as if the period of colonization had for better or for worse, been an indivisible whole. Such a perspective is anachronistic, as the history of the organization of public health in the Congo turned out to be successful. The Congo Free State, like other colonial regimes of the period, never considered its mission to be purely philanthropic despite the king’s claims. The State was not responsible for promoting what would now be called development or social welfare schemes. We consequently should not be surprised that private initiatives were at the root of scientific research programmes and the first medical assistance for the entire population (not just State employees). The term private also covers the medical projects of Christian communities that were often supported by complete private fund-raising networks in Europe. Finally, private companies were the ones that set up the first complete medical services designed to safeguard the health of their workers. This was utilitarian medicine, but it was also an instrument of progress in view of the desire to organize and implement. The ambitions of State medicine during this period were limited by the priority given to short-term yields. Thus, under King Leopold, the State of the Congo never employed more than 30 doctors at a time. Here a little modesty is in order. Is our era really so much more altruistic? After thirty years of independence, Zaire devotes a smaller share of its revenue to public health than King Leopold II’s State did a century ago. Is the industrialized world more generous? A demonstration of farmers on the Champs-Élysées recently swallowed up a sum equivalent to the combined budgets of all France’s agricultural development projects in the Maghreb.

83 This information is drawn from the Annual Reports of the Apostolic Curacy of Ubangi, 1903-1907 (Rapports annuels du Vicariat apostolique de l'Oubangui, 1903-1907, Archives des Oeuvres Pontificales Missionnaires, Lyon, G 105). The financial data cannot be taken at face value, as they come from reports that were drafted for the very purpose of justifying a request for an increase in the mission’s subsidies. Moreover, the phrase “Atroxyl® costs 700 francs” is not clear. Nevertheless, the high cost of the drug definitely restricted its use in many of the missions of the time.
84 Chronique, op. cit., March 1906.
Awareness of the present, but also lucidity as regards the past, is to be able to distinguish clearly between periods, which is important when we tackle the history of public health in the Congo (Zaire). It is true that the scientific foundations were laid under King Leopold, but real progress in their implementation was made under the Belgian regime. This new policy was presaged by Prince Albert’s trip to the Congo in 1909. History will remember him and Queen Elisabeth as the indefatigable craftsmen of an “ethical colonization,” in which social medicine would play the leading role. This conviction is strengthened by that of Lyautey, who believed that medicine should justify colonization.

Medicine came to the Congo and triumphed over the ruins left by the epidemics and wars of the Free State. Once again, it is history that will decide whether the modern, technological medicine transplanted to the Congo was not too alien, in the African cultural context, for it to have a chance to put down deep roots.

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