



Medical Orders

Catholic and Protestant Missionary Medicine in the Belgian Congo 1880-1940¹

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The history of religious missions and the provisioning of western medical care in the region that was known as the Congo Free State and later the Belgian Congo reveals the complicated dynamics between competing religious missions vis à vis the Belgian colonial state. This essay highlights divisions between identities and purposes of different religious groups in medical care provisioning, focusing on the divide between the Catholic and Protestant churches. Because most Protestant missions in the Congo were American or British, the medical care provided by the Protestant church was outside of, and sometimes at odds with, the Belgian colonial state until the 1920s. In contrast, the Catholic Church served in an auxiliary role in the colonial state's medical infrastructure. This was not an ideal situation, leading Catholic leaders to attempt to rework the church's role in medical provisioning. Ultimately, mission, medicine, and empire were not always comfortable bedfellows.

Medische Orders: katholieke en protestantse missiegeneeskunde in de Belgische Congo 1880-1940

De geschiedenis van de religieuze missies en het voorzien in westerse medische gezondheidszorg in de Congo Vrijstaat – later de Belgische Congo – onthult de ingewikkelde dynamiek tussen de concurrerende religieuze missies vis à vis de Belgische koloniale staat. Dit artikel belicht verschillende religieuze groepen die medische zorg verleenden in deze regio en hun verdeeldheid inzake identiteiten en doelen. Hierbij wordt vooral gefocust op de tweedracht tussen de katholieke en protestantse kerk. Omdat de meeste protestantse missies die in de Congo gevestigd waren uit Amerika of Engeland kwamen, werd de medische zorg die zij verstrekten vaak buiten de Belgische koloniale staat om geleverd en leefden staat en protestantse kerk tot in de jaren 1920 soms op gespannen voet met elkaar.

Dit staat in sterk contrast tot de katholieke kerk die wat betreft medische infrastructuur juist een ondersteunende rol had in de koloniale staat. Dit was voor de katholieken geen ideale situatie, waardoor de katholieke leiders probeerden om de medische rol van de kerk te veranderen. Het moge duidelijk zijn dat de missies, de geneeskunde en de staat niet altijd even goede bedgenoten waren.

In July 1938 the Baptist Missionary Services celebrated their 25th jubilee in the Belgian Congo. The mission staged a five-part spectacle depicting its history in the region. The first three parts dramatised Stanley's heroic arrival at Stanley Pool, the work of the early pioneer missionaries and the freeing of the slaves by King Leopold II. The last act focused on education of Congolese youth. Our interest is in the fourth act, entitled 'The coming of medicine and the expulsion of the witchdoctor'.² On the stage lies a young, sick boy whereupon a witch doctor enters 'in all his painted and feathery glory, his young assistant carrying just behind him his gruesome accoutrements'. He does a dance, smears white paint on the boy and his friends, and slits open a chicken (which is saved as a 'nice little tit-bit for supper'). The narrator then observes, 'Then came the real ju-ju business. Running both his hands down the boy's arms he drew forth the evil spirit, put his hands to his mouth and blew the spirit away into the river'. Then a missionary doctor comes in, watches for a moment before doing a 'real exam' at which point some native medics 'rush in with real hospital equipment, microscopes [...] [and] the witch doctor becomes sad'. The act ends when, given the signal, 'thirty or forty other of our native protestant infermiers [sic – medics] [...] formed themselves in a long line along the front of the platform; then the witch-doctor [...] came forward trying to effect an entrance to get at the sick folk, but each time he approached one of the infermier [sic] gave him a push along the line'. The witchdoctor eventually disappears off stage, shrieking in rage.³

As this anecdote reveals, medicine is an integral part of the narrative of colonial rule. Very often western medicine is facetly characterised as tool of colonisation, both positively (as above) and negatively: its own 'ju-ju' is little explained by historians.⁴ Those offering this medicine can remain little more than caricatures: they cynically use medicine to garner influence, compliance, productivity and, in the case of religious missions, conversion. What follows attempts to break some of this homogeneity in the depiction of western medicine in the colony. It is a story of religious missions and the provisioning

1 The research for this article was supported by an FWO Pegasus Marie Curie Fellowship.

2 British Missionary Services archive (hereafter BMS), dossier A/103 station reports for Kinshasa (hereafter A/103 Kinshasa), file 1, unsigned letter on the 25th jubilee festivities.

3 Ibidem.

4 Western medicine is used here over other alternatives in recognition that it was a sort of medicine offered by, and seen by its practitioners as belonging to, Europeans and Americans – or Westerners.

of western medical care in the region that was known as the Congo Free State (1885-1907) and later the Belgian Congo (1908-1960). The analysis traces the dynamics between competing religious missions vis à vis the Belgian colonial state in the field of western medicine to World War II. Mission, medicine and empire were not always comfortable bedfellows. It is a well-established and nearly mundane fact that colonialism was exploitative, but colonial subjects were not the only subalterns. In other words, power and authority – including medical authority – was contested among multiple groups beyond the dipole of coloniser and colonised. Authority was contingent on context: the scientists had their lay persons (the ministers and priests) as did the priests (the secular scientists), and indeed, as did colonial – often military – officials (the civilians). While missionary medicine often had strong colonial overtones, it was not simply a subset of colonial medicine, even if we define colonial medicine very broadly as ‘a therapeutic tradition with roots in western scientific rationality, but one that also operated across a rift of political and economic inequality’.⁵ The goals of the religious mission and the colonial state sometimes, but not always, marched hand in hand.⁶

This paper will highlight divisions between identities and purposes of different religious groups in the region providing medical care, focusing on the divide between the Catholic and Protestant churches. As such, the scope of this paper is largely ghettoised to colonial enclaves and Christian missions. In the case of the Belgian Congo, such posts were fewer and more dispersed than those of many other colonies at the time.⁷ Circa 1900 the population of Belgium was around seven million, the population of the Congo was somewhere between 10 and 30 million, and the number of Belgians living in the Congo was miniscule (46 in 1886 and 1.722 in 1908).⁸ However,

- 5 Richard C. Keller, ‘Geographies of Power, Legacies of Mistrust: Colonial Medicine in the Global Present’, *Historical Geography* 34 (2006) 26-48, 26. See also Andrew Porter, *Religion Versus Empire?: British Protestant Missionaries and Overseas Expansion, 1700-1914* (Manchester 2004); David Simmons, ‘Religion and Medicine at the Crossroads: A Re-Examination of the Southern Rhodesian Influenza Epidemic of 1918’, *Journal of Southern African Studies* 35:1 (2009) 29-44.
- 6 See Ryan Dunch, ‘Beyond Cultural Imperialism: Cultural Theory, Christian Missions, and Global Modernity’, *History and Theory* 2002, 301-325 DOI 10.1111/1468-2303.00208; Michael Jennings, ‘“Healing of Bodies, Salvation of Souls”’: Missionary Medicine in Colonial Tanganyika, 1870s-1939’, *Journal of Religion in Africa* 38:1 (2008) 27-56; Ryan Johnson, ‘Colonial Mission and Imperial Tropical Medicine: Livingstone College, London, 1893-1914’, *Social History of Medicine* 23:3 (2010) 549-566 DOI 10.1093/shm/hkq044; Simmons, ‘Religion and Medicine’.
- 7 Britain in Nigeria had a lesser colonial presence per capita than the Belgian Congo, although a greater colonial presence by territory. A.H.M. Kirk-Greene, ‘The Thin White Line: The Size of the British Colonial Service in Africa’, *African Affairs* 79:314 (1980) 25-44, 38.
- 8 Estimated population in the Congo varies widely, see Jean-Luc Vellut, *La mémoire du Congo: le temps colonial* (Ghent 2008), 8; Kirk-Greene, ‘The Thin White Line’, 38. Matthew G. Stanard, ‘Belgium, the Congo, and Imperial

interestingly for our story, by 1908 the majority of Westerners were and continued to be Belgian Catholic missionaries. Unique to the Congo, most were also colonial functionaries.⁹ By 1940, the Belgian population in the Congo was still hovering under 15,000 among millions in a territory 76 times larger than Belgium.¹⁰ Because most Protestant missions in the Congo were English or British, the medical care provided by the Protestant church was outside of, and sometimes at odds with, the Belgian colonial state until the 1920s. It treated fellow Protestants, and potential converts. However, it also used its medical capabilities to extract financial support from the Belgian administration.

In contrast, the Catholic Church, especially its women, served in an auxiliary role in the colonial state's medical infrastructure. This was not an ideal situation, neither for the religious project of saving souls nor for the political power of the church, leading Catholic leaders to attempt to rework the church's role in the provision of medical services. An individual providing western medicine in the Belgian Congo could assume several roles – the patriot, using medicine to treat his Belgian subjects and prove the worth of the colonial state as master; the professional doctor, under the obligation of healing the physical suffering of his patients; or the saint, who would put himself in danger to rescue both the body and the immortal soul of his ministry. Along with this there could also be the more practical and cynical mandates of social control, exploitation and extraction of resources. Spiritual care, medical care and citizen formation were goals that could either synchronise or conflict.

Setting

Our story occurs between 1880 and 1940, a dynamic period in the history of the colony, missions and medicine. These dates bracket the first major push to introduce western medicine in the region. In the late nineteenth century, religious institutions or colonial/military administration provided western medical services in most colonies. State medical care was usually limited to colonial enclaves, with the exception of vaccination campaigns. In the late nineteenth century most indigenous populations in Africa, including those in the Belgian Congo, had little experience with western medicine other than through their encounters with missionary medicine. At

Immobility: A Singular Empire and the Historiography of the Single Analytic Field', *French Colonial History* 15:1 (2014) 87-109, 91
DOI 10.14321/frencolohist.15.2014.0087.

9 Marvin D. Markowitz, *Cross and Sword: The Political Role of Christian Missions in the Belgian Congo, 1908-1960* (Stanford 1973) 25-26.

10 Stanard, 'Belgium, the Congo, and Imperial Immobility', 91.

the turn of the twentieth century colonies around the world saw increased attempts by imperial powers to extend western state medicine to native populations, largely impelled by the trends of public health as a field aligned with missionary and colonial aspirations.¹¹ Around the turn of the century the British, French, Dutch and Belgians all created or greatly expanded services dedicated to *civilian* indigenous populations.¹² In the early twentieth century this sometimes led to the use of religious missionaries in state medical institutions and agreements between religious organisations and the colonial state for missionary control of lazarets and isolation camps.¹³ By the interwar period, mirroring trends in the metropole, colonial states began to marginalise religious assistance in state medical care in favour of professionally trained medical staff.¹⁴ Accredited nurses replaced nuns at state hospitals, licensed doctors performed technical medical procedures, and trained dispensary assistants or pharmacists dispensed drugs.¹⁵ The major exceptions to this were certain types of palliative care and in particular

- 11 Further reading, see David Arnold, *Imperial Medicine and Indigenous Societies* (Manchester 1988) 12-20; Pratik Chakrabarti, *Medicine and Empire: 1600-1960* (New York 2013) 73-100.
- 12 Notably, most non-white populations with access to western medical care before this period were part of the military forces. Peter Boomgaard, 'The Development of Colonial Health Care in Java; An Exploratory Introduction', *Bijdragen Tot de Taal-, Land-En Volkenkunde* 149:1 (1993) 77-93, 87 DOI 10.1163/22134379-90003137; Juanita De Barros, "'Spreading Sanitary Enlightenment": Race, Identity, and the Emergence of a Creole Medical Profession in British Guiana', *The Journal of British Studies* 42:4 (2003) 483-504, 486-487 DOI 10.1086/376463; Cristiana Bastos, 'Medical Hybridisms and Social Boundaries: Aspects of Portuguese Colonialism in Africa and India in the Nineteenth Century', *Journal of Southern African Studies* 33:4 (2007) 767-782 DOI 10.1080/03057070701646878; Sokhieng Au, *Mixed Medicines: Health and Culture in French Colonial Cambodia* (Chicago 2011), 26 DOI 10.7208/chicago/9780226031651.001.0001; Lenore Manderson, *Sickness and the State: Health and Illness in Colonial Malaya, 1870-1940* (Hong Kong 1996).
- 13 Jean-Marie Bouron, 'Le paradigme médical en milieu catholique: offre sanitaire missionnaire et demande de santé en Haute-Volta (actuel Burkina Faso)', *Histoire, monde et cultures religieuses* 21:1 (2012) 103 DOI 10.3917/hmc.021.0103; Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford 1991) 55-76.
- 14 Pierre Guillaume, *Médecins, église et foi, XIXe-XXe siècles* (Alençon 1990); Jacques Léonard, *La médecine entre les pouvoirs et les savoirs* (Paris 1981); Rita Schepers, 'Towards Unity and Autonomy: The Belgian Medical Profession in the Nineteenth Century', *Medical History* 38:3 (1994) 237-254.
- 15 Ruramaisi Charumbira, 'Administering Medicine Without a License: Missionary Women in Rhodesia's Nursing History, 1890-1901', *Historian* 68:2 (2006) 241-266 DOI 10.1111/j.1540-6563.2006.00142.x; Philip J. Havik, 'Reconsidering Indigenous Health, Medical Services and Colonial Rule in Portuguese West Africa', *O Colonialismo Português: Novos Rumos Para a Historiografia Dos PALOP* (2013) 233-266, 240; Sheryl Nestel, '(Ad)ministering Angels: Colonial Nursing and the Extension of Empire in Africa', *Journal of Medical Humanities* 19:4 (1998) 257-277.

leprosy, because of its peculiarly close links to Christian theology and missionary work.¹⁶

Despite these trends, professionalisation – the byword of nineteenth century medical reform in Europe – came to the colonies in fits and starts. In many parts of Africa, particularly in remote areas, missionary medicine remained the only form of western medicine available to indigenous populations until World War II and sometime after.¹⁷ In these contexts, missionary medicine had little competition or coordination with state medicine in the provisioning of western health care. While missionary medicine was also the predominant form of western medicine in rural parts of Belgian Congo, one peculiarity of the Congo was the heavy reliance of the colonial state on *formal arrangements* with Catholic and (at a later period and to a lesser extent) Protestant missionaries to provide care *under state auspices* throughout the colonial era. Religious men and women were contracted to staff colonial hospitals, provide general medical services, screen for sleeping sickness and run lazarets. Catholic nuns and priests were actively recruited to work for state medicine and their role in all aspects of colonial governance was such that historian Crawford Young wrote of the ‘triple alliance’ of state, church and big business in the Belgian Congo as ‘not only [...] a virtually seamless web, but each component, in its area of activity was without peer in tropical Africa in the magnitude of its impact’.¹⁸ While Young exaggerated with his assertion of a *seamless* web between church, industry, and the colonial state, he was largely accurate in the *extent* of involvement of church and industry in colonial governance.

The involvement of religious institutions in colonial affairs existed since the inception of the Congo Free State (CFS), the vast territory in Central Africa ‘claimed’ by Belgian King Leopold II in 1885. How these relations evolved was to impact significantly the shape that state medical care would take in the early twentieth century. In short, Protestants were first welcomed

16 Sokhieng Au, ‘The King with Hansen’s Disease: Tales of the Leper in Colonial Cambodia’, in: Ann Ruth Hansen and Judith Ledgerwood (eds.), *Songs at the Edge of the Forest: Essays in Honor of David Chandler* (Ithaca 2008) 121-136; Sanjiv Kakar, ‘Leprosy in British India, 1860-1940: Colonial Politics and Missionary Medicine’, *Medical History* 40 (1996) 215-230 DOI 10.1017/S0025727300061019; Michael Worboys, ‘The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940’, *Osiris, Nature and Empire: Science and the Colonial Enterprise* 15 (2000) 207-218 DOI 10.1086/649327.

17 Vaughan, *Curing Their Ills*.

18 This particular assertion is so bold as to have been quoted in both of the following articles: Patrick M. Boyle, ‘School Wars: Church, State, and the Death of the Congo’, *The Journal of Modern African Studies* 33:3 (1995) 451-468, 451 DOI 10.1017/S0022278X00021200; David Northrup, ‘A Church in Search of a State: Catholic Missions in Eastern Zaire, 1879-1930’, *Journal of Church and State* 30:2 (1988) 309-319, 311 DOI 10.1093/jcs/30.2.309. They both quote Young to present a straw man in their arguments on the conflicts in education, religion, and politics between the Catholic Church and the Belgian colonial administration.

as allies by the colonial state and later marginalised in all aspects of colonial governance in favour of the more 'loyal' Catholic Church. Missionaries were among the first explorers and white settlers of the region. They became embroiled in the politics of the region from the initial scheming of Leopold to lay claim to the territory. Leopold and his agent on the ground, Henry Morton Stanley, initially tolerated and indeed encouraged Protestant missionaries in Congo, believing that their support would bolster their claims to certain territories. However, even in this early period, this toleration had a price. Dr. Aaron Sims of the American Baptist Mission observed in 1883 of the very affable Mr. Stanley:

Above all things Mr. Stanley desires the members of our Mission to mind their own business, both in conversations, in letters, and magazines [...] because certain missionaries out here and certain publications have caused trouble [...] in Africa & with the managers at home, without mentioning peoples' reputation & peace of mind.¹⁹

Protestant missions were largely American and British; by gaining missionary support, Leopold intended to obtain some leverage in their home countries for support of his claims to the territory, formally recognised as the Congo Free State (CFS) in the 1885 Berlin Act. In contrast, the King had the French Catholic order of the Holy Ghost Fathers expelled from the eastern Congo in 1886, as he believed its archbishop was collaborating too closely with French-backed explorer Savorgnan de Brazza.²⁰ During this same period, he tried to persuade reluctant Belgian Catholic missionaries to found missions in the Congo.²¹ He had little direct success and turned to Rome to pressure recalcitrant orders. With Papal encouragement, Catholic missionaries began to arrive in the Congo towards the last decade of the nineteenth century.²² Formal agreements were made between Rome and the King for the Catholic presence in the Congo, the most notable being the Concordat of 1906, which laid the groundwork for a close collaboration between the CFS and Rome.

19 The archives of the American Baptist Historical Society (hereafter: ABHS), papers of Aaron Sims.

20 Reuben Loffman, 'In the Shadow of the Tree Sultans: African Elites and the Shaping of Early Colonial Politics on the Katangan Frontier, 1906-17', *Journal of Eastern African Studies* 5:3 (2011) 535-552, 540 DOI 10.1080/17531055.2011.611668. The Holy Ghost Fathers returned to aid the Flemish Scheutists in 1907.

21 The Jesuits were asked repeatedly by Leopold II to create missions in the CFS, before finally acquiescing in 1892. The Scheutists also refused

numerous requests to 1887. Fernand Allard, *Journal du Congo, 1905-1907: Un apprentissage missionnaire* (Bruxelles 2001) 31; Guy Vanthemsche, *Belgium and the Congo: 1885-1980* (Cambridge 2012) 66.

22 Vanthemsche, *Belgium and the Congo*. It has been argued that this indifference to the Congo was widespread among the Belgian population. Martin Ewans, 'Belgium and the Colonial Experience', *Journal of Contemporary European Studies* 11:2 (2003) 167-180 DOI 10.1080/1460846032000164609.

The CFS was to promote the spread of Catholicism in the colony by making grants of land to missions, pay salaries of resident priests and distribute other favourable grants.²³

The scandal of Leopold II's 'régime foncier', instituted in 1891, would fundamentally affect the colony's relationship with Catholic and Protestant missions into the next century. Under this system, Leopold's agents ruthlessly exploited native populations to extract rubber and other materials in the Congo, turning life in certain regions into what one observer called 'hard slavery'.²⁴ Torture, mutilation, kidnapping and arbitrary murder by state agents became widespread in sections of the CFS. Protestant missionaries were some of the earliest and most vocal in demanding an international accounting for the atrocities being committed under this system. The Catholic orders were largely silent, a troubling passivity hotly disputed at the time, and still being discussed today.²⁵ Prominent Belgian historian Jean-Luc Vellut was to note that, while uncertain that the atrocities in the region were different from those in other regions in Africa, he was certain that the region was exceptional in having vocal Protestant missionaries.²⁶ Ultimately, the fall of the CFS in large part was driven by the agitation of Protestants in the region. Leopold was forced to cede his vast personal territory to the control of the Belgian nation in 1908, and it became the Belgian Congo. One could say it was unjust, but yet accurate, for the incoming colonial state to view the Protestant orders as a 'problem'.

Leopold's agreements with Rome and the continuation of pro-Catholic policies in the new Belgian Congo impacted the medical services provided by each denomination. Protestant medical missions relied on private donations and concrete demonstration of medical works to church donors to ensure continuing funds; correspondence home was largely about keeping up public interest in their works. After the CFS was transferred to Belgium in 1908, the

- 23 Markowitz, *Cross and the Sword*, 7; Northrup, 'A church in search of a state', 12.
- 24 Félicien Cattier, *Étude sur la situation de l'État Indépendant du Congo*, second edition (Brussels 1906) 130.
- 25 See Cattier, *Étude sur la situation*; Northrup, 'A church in search of a state'; Vanthemsche, *Belgium and the Congo*; Arthur Vermeersch, *La question congolaise* (Bruxelles 1906); Robert G. Weisbord, 'The King, the Cardinal and the Pope: Leopold II's Genocide in the Congo and the Vatican', *Journal of Genocide Research* 5:1 (2003) 35-45.
- 26 Introduction to Roger Casement, *Le rapport Casement: rapport de R. Casement, consul*

britannique, sur son voyage dans le Haut-Congo (1903) (Louvain-la-Neuve 1985). This sort of academic equivocation is not new, and even existed during the scandal itself. See Cattier, *Étude sur la situation* 142-173; Kevin Grant, *A Civilised Savagery: Britain and the New Slaveries in Africa, 1884-1926* (New York 2014) DOI 10.4324/9780203955505; Aldwin Roes, 'Towards a History of Mass Violence in the Etat Indépendant Du Congo, 1885-1908', *South African Historical Journal* 62:4 (2010) 634-670 DOI 10.1080/02582473.2010.519937.



Figure 1:

Catholic nun among yaws patients in Inongo
(Congo) in 1930.

Archives Africaines, Belgian Ministry of Foreign
Affairs.

Belgian administration continued to view Protestant missionary activity with suspicion, and showed a distinct favouritism to Catholics in the form of continued subsidies for various activities including medical care, as well as generous land grants and tax breaks.²⁷ National and Catholic became synonymous. The English Catholic Mill Hill mission, for example, was quickly granted land and tax concessions in the Congo.²⁸ In contrast, Protestants found themselves fighting for fair treatment, frequently resorting to legal action and evoking the Berlin Act.

Hierarchies of body and soul

In the Catholic Church care of the body is subordinate to care of the soul. Historically a priest was discouraged from being a doctor, because of the fear that ministrations of the soul would be neglected for those to the body. Very early examples of this antagonism include the famous papal edicts of the medieval period forbidding Catholic clergy to practice medicine.²⁹ By the late nineteenth century, with the successful professionalisation of medicine and decreased political power of the Catholic Church in France, the power dynamic between priest and doctor had changed dramatically. In Belgium the Catholic Church was more successful in holding on to its political power, but it too would face similar changes in the twentieth century.³⁰ The priesthood in many ways was on the defensive and the Church led new social movements to push back against the erosion of its power. The Medical Society of Saint Luc, created in France in 1884 with a Belgian unit in 1922, like the later *Action Catholique*, attempted to marshal practicing lay Catholics into fraternities or unions that propagated and defended the Catholic faith against the increased laicisation of all aspects of life.³¹ This move would also affect Catholic missionary medicine in the colony, as we shall see.

Debate was also common in the Protestant churches on the appropriateness of targeting precious resources to healing the body rather than saving the soul. Importantly, the Protestant churches never

27 The Archives Africaines (further: AA) of the Belgian Ministry of Foreign Affairs holds a majority of the state archives on the Congo. See AA, collections M, files 591, 594, 608, 631, 642, 644 and 687.

28 Mill Hill was in 1907 given an exemption from taxes, as having a 'public utility'. AA, M, 594.

29 Guillaume, *Médecins, église et foi*, 18.

30 This is a gross simplification of a long and complicated process. For more, see Jacques Léonard, *La médecine entre les pouvoirs et les savoirs*; George Weisz, *The Medical*

Mandarins: The French Academy of Medicine in the Nineteenth and Early Twentieth Centuries (New York 1995).

31 Anthony Favier, 'Les Mouvements de laïcs en France jusqu'à la définition romaine de l'Action catholique', Oct 2011, Lyon, France; Hervé Guillemain, 'Les débuts de la médecine catholique en France: La Société médicale Saint-Luc, Saint-Côme et Saint-Damien (1884-1914)', *Revue d'histoire du XIXe siècle* (2003) 227-258 DOI 10.4000/rh19.747.

institutionalised a prohibition on ordained medical doctors. One Catholic observer noted that, because Protestant missions began much later than Catholic ones, from their beginning they were organised with medical and scientific works in mind.³² As a historian of missiology observed, in contrast to Protestant missionaries where technical skills and spiritual works were not in explicit conflict, the work of Catholic missions ‘had to confront modernity rather than embrace it. Catholic engagement in medical relief work [...] presented genuine theological difficulties by often dissociating physical and spiritual work’.³³ Ultimately, Protestant missions embraced medicine sooner and with much more vigour than the Catholics. The first Protestant priest with a medical license was an American who was sent to China in 1834, while his first British counterpart was sent to Macao in 1839.³⁴ By the 1870s ministers with medical training were preferred for missionary work abroad.³⁵ Something similar does not occur in Catholic missiological trends until nearly fifty years later, and even then, to a lesser degree. However, this is not to say that Catholic missions always neglected and Protestant missions always embraced medicine. Across colonial Africa attitudes could vary widely; one could identify Catholic orders that were more medically-oriented than Protestant denominations and vice versa.³⁶

Practicalities of care provision

The Catholic Church in the Congo was bureaucratically intertwined with the colonial state. Initially the missions had no doctors of their own. Not professionally trained in medicine, Catholic fathers ran lazarets or other palliative care centres while nuns became the main providers of nursing care in the state and industrial hospitals (Figure 1). The Red Cross opened the first

- 32 Dr Arlette Butavand, *Les Femmes Médecins-Missionnaires* (Louvain 1933).
- 33 Bertrand Taithe, ‘Pyrrhic Victories? French Catholic Missionaries, Modern Expertise, and Secularizing Technologies’, in: Michael Barnett and Janice Gross (eds.) *Sacred Aid: Faith and Humanitarianism*, (Oxford 2012) 166-85, 166 DOI 10.1093/acprof:oso/9780199916023.003.0007.
- 34 Dr. John Scudder, sent to India in 1818, is sometimes called the first ‘medical missionary’, but his dual role was somewhat unintentional and ill-defined. Christoffer Grundmann, ‘The Role of Medical Missions in the Missionary Enterprise: A Historical and Missiological Survey’, *Mission Studies* 2:1 (1985) 39-48

DOI 10.1163/157338385x00223; Porter, *Religion versus Empire*, 200.

- 35 Porter, *Religion versus Empire*, 311.
- 36 Bouron, ‘Le paradigme médical’; Felix K. Ekechi, ‘The Holy Ghost Fathers in Eastern Nigeria, 1885-1920: Observations on Missionary Strategy’, *African Studies Review* 15:2 (1972) 217-239 DOI 10.2307/523920; Claire Fredj, ‘“Et il les envoya prêcher le royaume de Dieu et guérir les malades...” (Luc, ix, 2). Soigner les populations au Sahara: l’hôpital mixte de Ghardaïa (1895-1910)’, *Histoire, monde et cultures religieuses* 22:2 (2012) 55 DOI 10.3917/hmc.022.0055; Vaughan, *Curing their Ills*.

parastatal hospitals in Boma (1889) and later Leopoldville (1897) with the support of the CFS. After the 1906 Concordat was signed, the Red Cross and the CFS recruited several Franciscan sisters to work at these two hospitals and the sanatorium of Banana. Arriving in 1907, the sisters soon found their roles in flux as this was also the moment when the Congo Free State was making the transition to the Belgian Congo. Furthermore, at the same moment this Red Cross unit was forced to disband. With the dissolution of the CFS and the Red Cross, the colonial state assumed the responsibility for these hospitals, as well as the work contracts of the six Franciscan sisters.³⁷

The sisters at Leopoldville were soon at odds with the new colonial doctor, as competence, priority and hierarchy had to be established. As the district commissioner noted to the Governor General, ‘Problems and conflicts arise frequently. I even received a complaint from the Reverend Mother Superior because the doctor had forbidden the reverend sister nurse [*Révérènde Soeur Infirmière*] from entering the pharmacy’.³⁸ Within a few years such disputes became rarer as work contracts explicitly spelled out the domains of the doctor and the sister-nurses.³⁹ Conflicts in hierarchy between lay and religious colonial staff were not confined to the medical sphere. In 1910, the Minister of Colonies circulated a list of priority ranking of all colonial functionaries and religious personages by administrative category to clarify the issue, particularly for ceremonial functions where religious persons were always to have first rank.⁴⁰

The hostility of some doctors to these sister-nurses would flare up on occasion, as some doctors were anti-clerical, others jealous of their priority and still others frustrated by the lack of professional knowledge of these women. Sisters in some orders refused to participate in certain practices – obstetrics, attending births or bandaging of certain parts of men.⁴¹ While called sister-nurses, most did not have a nursing degree, although by the 1920s all were required to complete a brief course in tropical medicine at the *Ecole de Médecine Tropicale* (EMT) in Brussels.⁴² In fact, the personnel rank of ‘colonial nurse’ was not created until June 1927. This new personnel category, the colonial nurse, was required to have a nursing degree, along with the EMT training and a practical training period in a colonial laboratory.⁴³ The creation of this category did not bar the sister-nurses from working in hospitals; it only provided a clearer mechanism for hiring additional lay nurses for colonial hospitals. Despite occasional friction between medical staff and the sisters, the colonial government continued to show a marked enthusiasm for exploiting this convenient source of labour. The Church, at times, protested

37 AA, collection for Hygiene (hereafter: H), dossier 4390.

38 *Ibidem*, 4393.

39 *Ibidem*, 4390 and 4392.

40 AA, M 594.

41 *Ibidem*, H 4392 and 4393.

42 *Ibidem*, 4392.

43 *Ibidem*, 4555 bis.

this recklessness. Shortly after the Sisters of the Charity of Moorslede were installed in the new hospital of Basankusu, the medical services asked them to take over the running of the hospital entirely in 1933 so that the doctor could be reposted elsewhere. The order refused, with the Reverend Mother writing, 'It would be too reckless to impose the heavy responsibility of all medical care to the sisters, a responsibility that depends on the competence of a good doctor'.⁴⁴

The Catholic fathers had a somewhat different role than the sisters. They ran lazarets, and dispensed medicines from missions and in state-provisioned dispensaries. Also, as most indigenous primary school education was confided to the Catholic orders, their schools served as the suppliers of the government-run indigenous medical assistant training institutions.⁴⁵ As with the women, these men were encouraged by the colonial medical service to complete a course at the EMT. Their work often went unsupervised, but not always, as various conflicts arose between state doctors and Catholic fathers over medical works. For example, in 1921 the Jesuit father Pierpont had instructed one of his *boys* incorrectly on administering a dose of emetic to two sleeping sickness patients, who then died. The priest had his own *boy* arrested for murder, but the colonial doctor Schwetz then had the youth released. The Governor General threw his support behind the doctor; a little later the Minister of Colonies, perhaps more attuned to the political consequences, downplayed the entire event. He wryly commented in 1921, 'One can [...] reconstitute the origin of the dispute. Scientists in general, and medical doctors especially, are quite jealous of their scientific authority [...]'.⁴⁶ The Jesuits had abandoned their sleeping sickness work in the region of Kikwit as a result of this controversy, claiming that the colonial medical services, or at least Schwetz as its representative, wanted them to stop all medical works.⁴⁷ Thus, it was in the state's interest to smooth things over, as the missionaries provided the bulk of palliative care for this disease in the region. The perceived crisis of depopulation and the growing panic over sleeping sickness in the region threatened to erode the legitimacy of the Belgian colonial state.⁴⁸

In contrast, in the same period Protestant medical missions had licensed medical doctors and hospitals. They were initially largely autonomous of the colonial state. Most of the money to build and run these hospitals came from donations from Protestant communities abroad. In the first two decades of the twentieth century the presence or influence of either Belgians or Catholics in these hospitals was nominal. Thus, medicine here was

44 Ibidem, 4391.

45 There were also several important Protestant training initiatives for medical assistants, which, due to space constraints, cannot be discussed here.

46 AA, M, 631.

47 Ibidem.

48 Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge 1992).

clearly not a direct tool of the colonial state. Whereas the impetus for colonial hospitals (where Catholic sisters worked) came from the importance of the colonial enclave (usually represented by the number of white settlers or black workers in colonial concerns), Protestant hospitals came into being under more heterogeneous impulses. Some hospitals sprang up where conversion was very successful and the mission population grew rapidly, while at the other end of the spectrum, some were placed where few converts existed and much need was perceived. Sometimes hospitals could be the result of the crusade of individual missionaries working in the region.

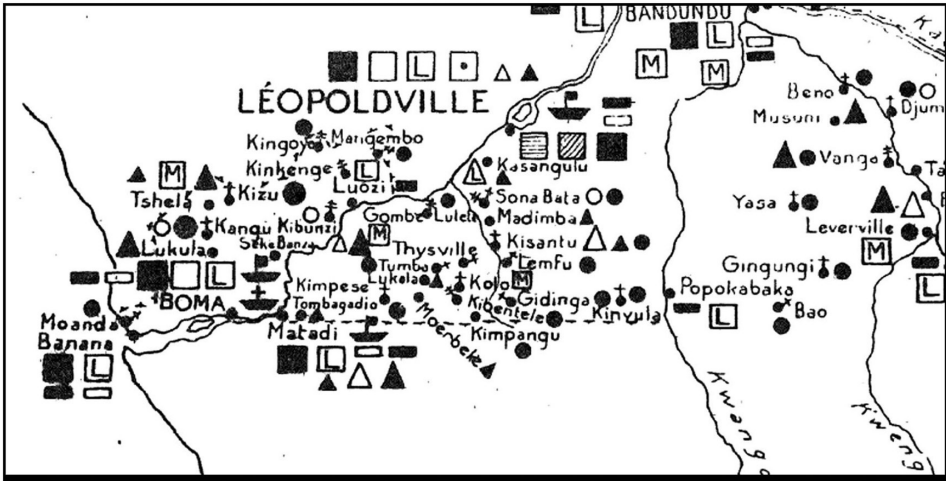
An example of such a Protestant hospital is the Tremont hospital in Ntondo, in the Equateur Province. The hospital was largely the result of the efforts of missionary doctor Hjalmar Ostrom, from Minnesota. Ostrom arrived in Ntondo (Ikoko) for the American Baptist Foreign Mission Society (ABFMS) in 1911 with a handful of other missionaries. He performed his first major operation, an emergency, in 1912. After this successful surgery he observed that, 'I have had scores of applications for operations since but have had to refuse them because of lack of proper accommodation'.⁴⁹ He started lobbying vigorously for funds to build a proper hospital, but as of 1920 he and his assistants were still working in three wattle and daub huts. When Ostrom went on furlough to Minnesota in 1922, other mission staff in Ntondo made serious accusations of abuse by Ostrom and his wife to the ABFMS board. In response, Ostrom argued that the 'stupidity' of certain patients demanded a raised voice or the occasional slap as, in particular, obstinate parents put their children in danger by disregarding his advice. Disturbingly, he defended himself in part by noting that, unlike some of his colleagues, 'I have never, thank God, punished anyone so severely that he has lost consciousness [...]'. In my medical work, I had always a great number of patients in spite of my alleged cruelties [...]'. He noted that his skills were in great demand, he had always been shown 'great love by the natives' and thus the charges by his colleagues were engineered.⁵⁰ It was clear that it was not only the natives but also – or perhaps predominantly – the staff that did not want him back. For its part, the ABFMS board was keen to keep him in the field but attempted to repost him to another Congo mission. Ostrom refused and at the end of 1922 the ABFMS and Ostrom arrived at an impasse; the doctor asked to remain a member of the Society with his salary stopped.⁵¹

Despite Ostrom's ill health over the next few years, discussions continued between the two parties. By April 1924 Ostrom had obtained further substantial donations from the Minnesota community for a new hospital and doctor's residence in Ntondo, which he probably used as leverage in his discussions with the ABFMS board. By February 1925 the Ostros were back in Ntondo building Tremont hospital. Despite his failing health, Ostrom

49 ABHS, Ostrom papers.

51 *Ibidem*.

50 *Ibidem*.



LÉGENDE VERKLARING

| ÉTAT | | STAAT | | MISSIONS | | ZENDINGEN | |
|--------------------------|---|----------------------------|---|----------------------|-----|-------------------------|-----|
| Hôpital : Européens. | □ | Hospitaal : Europeanen | □ | Hôpital : Europ. | ○ | Hospitaal : Europeanen. | ○ |
| " : Noirs. | ■ | " : Negers. | ■ | " : Noirs. | ● | " : Negers. | ● |
| Maternité. | ◻ | Moederhuis | ◻ | Dispens.: Europ. | ○ | Dispens.: Europ. | ○ |
| Dispensaire: Européens. | ◻ | Dispensarium: Europeanen | ◻ | " : Noirs. | ● | " : Negers. | ● |
| " : Noirs. | ■ | " : Negers. | ■ | Sommeilleux | ⊙ | Slaapzieken | ⊙ |
| Sommeilleux { Mission. | M | Zending { Slaapzieken. | M | Miss. Catholique | + | Katholieke Zending. | + |
| Lazaret. | L | Lazaret | L | " Protestante. | + | Protestantsche Zending. | + |
| Tuberculeux. | ▨ | Teringlijders. | ▨ | Bateau | ⊕ | Hospitaal boot. | ⊕ |
| Lépreux. | ▩ | Melaatschen. | ▩ | Hôpital. | + | Zec lazaret. | + |
| | | | | Lazaret maritime | + | Ontsmettingsboot | + |
| | | | | Bateau désinfecteur. | + | | |
| | | | | Limite de Province. | --- | Province grenz. | --- |
| PRIVÉ | | PRIVAAT | | | | | |
| Hôpital : Européens. | △ | Hospitaal : Europeanen. | △ | | | | |
| " : Noirs. | ▲ | " : Negers. | ▲ | | | | |
| Maternité | ◻ | Moederhuis. | ◻ | | | | |
| Dispensaire : Européens. | △ | Dispensarium : Europeanen. | △ | | | | |
| " : Noirs. | ▲ | " : Negers. | ▲ | | | | |
| Sommeilleux { Mission | △ | Zending { Slaapzieken. | △ | | | | |
| Lazaret | ▲ | Lazaret | ▲ | | | | |
| Tuberculeux. | ▨ | Teringlijders | ▨ | | | | |
| Lépreux. | ▩ | Melaatschen: | ▩ | | | | |

▲
 Figure 2:
 One detail of a medical services 'repartitions' map for all of the Belgian Congo produced by the Colonial Medical Services in December 1930. Archives of the Institute of Tropical Medicine, Antwerp.

was commended in the annual Belgian colonial medical report as doing 'remarkable work', a rare compliment by the state of a Protestant doctor in an official report.⁵²

The funding for Tremont hospital reveals that private donations could be linked to both specific causes and specific individuals. Ostrom's story hints at the complicated internal dynamics of these missions. Politics were both local and diffuse. Mistreatment of Congolese alone did not seem to merit a larger complaint, if one extrapolates from Ostrom's comments in his own defence. Troublesome missionaries were those who displeased their colleagues, not those who abused their flock. Missions were often excruciatingly small and tight-knit communities, particularly those in remote regions; Ntondo was one of these more remote missions. Conflicting personalities could affect the entire mission. Money also played an important role. Fund-raising was a central concern to these Protestant missions, to a much greater extent than the state-supported Catholic missions (although they too raised funds from their constituents).

Largely for such financial reasons, Protestants lobbied hard to obtain a share of the medical subsidies that flowed much more generously to their Catholic counterparts, as well as some alleviation from what they perceived as unfair taxation.⁵³ For example, while Catholic missions providing medical services easily obtained waivers on personnel and land tax as institutions of 'public utility' in the early years of the Belgian Congo, Protestant medical missions during the same period were lodging complaints as head taxes on their mission workers steadily increased.⁵⁴ In 1920 as the Government General attempted to improve collaboration on medical services with charitable organisations, it created the *Assistance Médicale Indigène Bénévole* (AMIB). To be recognised as a part of the AMIB, staff in these charitable organisations had to complete the EMT course and one month of laboratory training. As recompense, they would be supplied with free microscopes and medications.⁵⁵ The state also agreed to subsidise Protestant missions for medical services rendered at its request. Protestant accord with such agreements could be motivated by more than financial gain; competition with the Catholics, as usual, was a serious concern. As the Baptist Missionary Service doctor noted in 1925, 'We have been forced somewhat to take on medical work for the State, so as to keep the Catholics from certain sections of our district, and this means that one of the missionaries on the field ought to have the Brussels' [EMT] diploma'.⁵⁶ After the creation of the AMIB, support to the Protestant medical services improved somewhat. Nevertheless, complaints

52 AA, H, 102 and 1926 Equateur report.

53 Ibidem, M, 608 and 644; BMS, A/41/4, papers of Clement C. Chesterman.

54 AA, M, 594 and 608.

55 Ibidem, Rapports Annuels/Médicale (RA/MED) 1.

56 BMS, A/48, letter from Dr. Wilson in Yalembe to home correspondent Wilson.

about unfair treatment continued into the 30s.⁵⁷ Gradually, Protestants received more state subsidies in recognition of their service to the colonial state, although in the mid-30s this would lead to some grumbling about time wasted in ‘collecting data and statistics for the Colonial Medical Machinery’.⁵⁸ State support, it was discovering, was linked to state co-optation of its medical capacities.

Although favoured as medical auxiliaries, the Catholic Church still aspired to a more central role in medical care. Part of this might have originated from the metropole (both France and later Belgium) and the erosion of the power of the Church, but, in the context of the Congo, the search for doctors aligned with Catholicism was more a competitive response to Protestant gains in indigenous conversion through its medical works. Recognising that medical care could often be the first step towards religious conversion, the Catholic missions sought the means to incorporate qualified medical staff, even as the state continued to seek fathers and sisters as auxiliary staff for its medical services (Figure 2). As the Apostolic Prefect observed of Kimpese in 1923:

The Protestants are going to build an enormous hospital there; thus we need to get ahead of them because it will be difficult to draw our populations from them once they know the way to this hospital; [...] [T]hese uncivilized [farouche] heretics [...] would heal the body completely but steal away the souls of our unwary Christians.⁵⁹

Offers of free medical care brought Congolese into the Protestant missions, where patients along with their attending family and friends were usually pressured to attend prayer services during their stays. Catholic Church leaders were aware that their participation in medicine was often confined to state hospitals and lazarets, which limited both the populations they could reach and the methods they could use to gain converts. In 1925 prominent Belgian Catholic leaders began the movement *l'Aide Médicale aux Missions* with the purpose of recruiting medical staff for Catholic missions in the Congo. This was probably influenced by the Papal declaration in the same year proclaiming that Catholic missionary medicine was not antithetical to spiritual conversion.⁶⁰ *L'Aide Médicale* was launched with an accompanying journal, whose introductory issue proclaimed of the doctors in the Congo,

57 Ibidem, A/41/4 papers of Clement C. Chesterman; AA H 4440. See also Markowitz, *The Cross and the Sword*, 46–51.

58 ABHS, papers of Judson King, letter to foreign secretary Lorrigo in 1933.

59 Documentation and Research Centre for Religion, Culture, and Society, Leuven (KADOC), file 82 of

archives of Chanoinesses Missionnaires de St. Augustin (Zusters van de jacht).

60 Ugo Bertini, *Pie xi et la médecine au service des missions* (Paris 1929); Taithe, ‘Pyrrhic victories?’, 174.

'Among these doctors the greatest part are foreigners or Protestants [...]. Every patriotic Belgian Christian cannot but be painfully struck by the great difficulty such a situation represents, from either a national or religious perspective'.⁶¹ Although there is a significant Protestant population in Belgium, the Catholic Church clearly framed a national identity as uniquely Catholic.

Whereas Catholic missionary medicine had consisted of nuns and fathers working as 'aids' to the colonial medical service, *l'Aide Médicale* inverted this relationship. Accredited medical doctors would work as 'médecins aide-missionnaires' at missions.⁶² A 1931 brochure described such a doctor: 'His motto should be: do good for the soul in doing good for the body [...]. He should effectively contribute to the goal of the Mission: the conquest of immortal souls'.⁶³ The doctors were hired and paid by the missions, and technically were mission staff, not colonial staff.⁶⁴ None were ordained priests and licensed doctors; they were (ideally) devoutly Catholic doctors assisting priests.

The *Fondation Médicale de l'Université de Louvain au Congo* (FOMULAC) was another medically-oriented Catholic institution created around the same time (1926) as *L'Aide Médicale*. In partnership of the Jesuits of Kisantu and the Catholic University of Leuven, it soon built three hospitals staffed with accredited doctors.⁶⁵ Despite such efforts, in 1930 the Belgian Congo still had only eight Catholic mission doctors and the three FOMULAC doctors. As *L'Aide Médicale* observed, the 30 Protestant mission doctors still vastly outnumbered them.⁶⁶ By 1939 there remained only three doctors working in Catholic missions, although at this time the number of Protestant doctors had a proportionally more drastic decline, to five.⁶⁷ The lack of doctors might have had little to do with religious demands, as the colonial service itself lacked qualified *Belgian* doctors, although it often turned away foreign doctors by claiming that it had too many candidates for its service.⁶⁸ The scarcity

61 Comité de l'Aide Médicale aux Missions, 'Appel aux étudiants et futurs étudiants en médecine', *L'Aide Médicale Aux Missions* 1:2 (1929) 19-21, 19.

62 KADOC, file 10.513-10.515 of archives of Jesuits, 1929 pamphlet entitled *Aide Médicale aux Missions: Appel aux Médecins Catholique et aux Etudiants en Médecine*, 4.

63 *Aide Médicale aux Missions*, 1931 pamphlet, 30.

64 KADOC, file 2759.

65 Annual Hygiene Report of the Belgian Congo, 1928. Most of the doctors recruited by *l'Aide Médicale aux Missions* came from Louvain.

66 AA, H, 4390; KADOC Jesuit collections, file 10.515.

67 MAE/AA, Rapports Annuels du Congo Belge (hereafter RACB), 252.

68 See AA, H, 4444; *Ibidem*, RACB, 122; Institute of Tropical Medicine, Antwerp (hereafter ITM), Rodhain papers 4.1.2, which all discuss how to meet the needs of the medical services in the Congo while encouraging Belgian doctors rather than foreign doctors. Rodhain informs several foreign doctors that they are eligible to get the EMT degree but would be unlikely to be hired in the Belgian Congo as the state had enough Belgian doctors for its needs. These exchanges occur simultaneously with internal debates on the reasons for the paucity of eligible Belgian doctors in the Congo!

of doctors across all missions by the end of 1939 was likely a product of the economic downturn and the approaching war.

Conclusions

Historians of medicine in European colonies under whatever label (imperial medicine, colonial medicine, global history, etc) have argued its relevance to the history of science generally, and indeed the rich results to be found from interdisciplinarity for history as a field.⁶⁹ Western medical technology, in common with many goods exchanged at what Mary Louise Pratt famously called ‘cultural contact zones’⁷⁰ was not homogeneously conceived or exploited by Americans and Europeans in the Belgian Congo. Catholics and Protestants, the two main missionary religious expressions in the Congo, engaged quite differently with medicine, due to both their histories and their religious stance in regard to providing medical services. Their positions regarding medicine must also be analysed while taking seriously the fact that western medicine consisted of a range of practices, material objects and knowledge, over which no single institution or organisation practiced hegemony.

The narrative above, focusing as it does largely on colonial missionary medicine, excludes most of medicine practiced in the Belgian Congo (i.e. indigenous medicine). Rather it speaks to the relationship between missions, western medicine and politics among a few select enclaves in Belgian Congo. Western medical know-how was intimately linked to both political power within the colonial machinery and influence over the indigenous populations, two disparate things. In many colonised regions of the world, western medicine had (and in some instances continues to have) little presence or impact. This is not a health care vacuum, as western medicine was always being introduced as a complement to or in competition with existing medical systems. However, and perhaps largely because of the way that the Belgian Congo came into being – with the constant threat of take-over from stronger states and the inclusion of the religious tolerance act in the grudging recognition of Leopold’s claims by the UK – it did create a competitive situation between the Catholic and Protestant missions in the provision of western medical care. The fact that American and British Protestants were so ubiquitous in western medical practices facilitates an analysis of these

69 Waltraud Ernst, ‘Beyond East and West. From the History of Colonial Medicine to a Social History of Medicine(s) in South Asia’, *Social History of Medicine* 20:3 (2007) 505-524 DOI 10.1093/shm/hkm077; Shula Marks, ‘What Is Colonial about Colonial Medicine? And What Has Happened to Imperialism and Health?’, *Social History*

of Medicine 10:2 (1997) 205-219 DOI 10.1093/shm/10.2.205; Sujit Sivasundaram, ‘Sciences and the Global: On Methods, Questions, and Theory’, *Isis* 101:1 (2010) 146-158 DOI 10.1086/652694.

70 Mary Louise Pratt, *Imperial Eyes: Travel Writing and Transculturation* (London 1992) DOI 10.4324/9780203106358.

medical structures within what has been called the ‘British world system,’⁷¹ particularly considering that these individuals were often deliberately excluded by the Belgian colonial state. On the other hand, Catholics would become strongly implicated in the state medical system. In other words, the Catholic Church had a political advantage but was constrained by its subordinate role in the medical system and its lack of technical expertise; the Protestant denominations had greater independence and medically-oriented resources, but were handicapped by partial political disenfranchisement with the ruling state. This created a lopsided political dynamic that has been little explored in histories of missiology or colonialism, and provides another analytical lens to examine the rich literature on the relationship between science and religion.⁷² Further, the divisions were not only among Catholics or Protestants, but among nations, relative orientation towards science or language, as disagreements could be found between Flemish and Walloon Catholics, more or less science-oriented Catholic orders such as Jesuits or Benedictines, or the Protestant missions of American Baptists, British Pentecostals or Swedish Mission Forbundet.

The distinct attitude of the colonial state to the different religious groups problematises standard narratives of agency and exploitation in histories of medicine in the colony. From the perspective of the state, one could argue that the Catholic sisters were exploited as cheap medical labour; Protestants were excluded from this system which was for them both a political gain and a financial loss, while the Catholic fathers negotiated a middle path. From the perspective of these individual men and women, their motivations for providing care could range from the instrumentalist to the deeply ethical.

While the constitution of western medicine was strongly influenced by the Catholic Church’s cultural and political interconnections with the colonial state, the Protestant example clearly illustrates that medical care allocation was not always tied to the political and economic structures of colonial rule. In contrast, the Catholics working within the medical structures of the colonial state also prove those practicing western medicine were not always wielding it as their tool. Medicine was an example of Christian work deserving financial support from the devout at home, bait to bring Congolese to sermons and masses and a source of information in the form of research and statistical collecting. However, medicine was also a humanitarian good and a Christian charity provided to people who were perceived as suffering and having little other recourse. While this might not have been the reality (imperial

71 Stanard, *Belgium, the Congo, and Imperial Immobility*, 101.

72 The tension between Flemish and Walloon Catholics is also another relatively unexplored topic.

perceptions frequently were not), such perceptions also drove the ambitions of missionaries on the ground.



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