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Architecture beyond Europe

21 | 2023
Architecture in the Foreign Aid-Funded Knowledge Economy. Expertise
Dissertation abstracts

Myths and Realities of the Belgian Medical Model Colony: A Genealogy

PhD thesis in Architectural Sciences and Engineering, under the supervision of Prof. Johan Lagae, Luce Beeckmans, and Koenraad Stroeken (UGent), Ghent University, November 2021

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https://doi.org/10.4000/abe.14100

Entrées d'index

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Schlagwortindex: Architekturgeschichte, Kolonial Architektur, Dekolonisation, Krankenhaus, Tropenmedizin, transnationaler Austausch
Parole chiave: storia dell'architettura, architettura coloniale, decolonizzazione, ospedale, medicina tropicale, rete transnazionale
Index géographique : Europe, Europe de l'Ouest, République du Congo (RC), Belgique, Afrique, République démocratique du Congo (RDC)

Texte intégral

This research was part of a broader research project on medical infrastructure in the DR Congo titled "Urban Landscapes of Colonial/Postcolonial Health Care. Towards a Spatial Mapping of the Performance of Hospital Infrastructure in Kinshasa, Mbandaka and Kisangani (DR Congo), from Past to Present (1920–

2014)," financed by the FWO (Fund for Scientific Research), Project No. G045015N and directed by Johan Lagae (Ghent University).

1 "At least the Belgians built hospitals." The phrase is generally heard in defense of Belgium's colonial past, increasingly subject to critiques. In fact, the claim that the Belgian Congo was a "medical model colony" may be the most common argument in today's public debates on Belgium's colonial history. True, the colonial government built a network of hospital infrastructure that was impressive in comparison to many other African colonies. Nevertheless, the argument is rooted in colonial propaganda that essentially sought to legitimize colonial rule by portraying Belgium as a benevolent colonial power bestowing the boons of Western medicine on the denizens of Africa's "Heart of Darkness."[1]

2 The excerpts from *Investir, c'est prospérer*, trumpeting the achievements of a decade of intensive infrastructural investments under the so-called Ten-Year Plan of the 1950s, form a case in point. A distinct chapter on "Public health and medical facilities" highlighted specific architectural success stories, while strategically omitting unfinished paper projects. In addition to vaunting the alleged architectural *quality* of the colony's new medical infrastructure, the booklet emphasized the *quantity* of the Ten-Year Plan's vast hospital network. Lists of localities indicated where new rural hospitals and dispensaries had been constructed (again, omitting gaps in the network), and tables showed the continuously increasing numbers of beds from 1950 until 1959. As a telling example of a much wider tradition of colonial healthcare propaganda, *Investir, c'est prospérer* shows how such publications often distorted the complex reality of colonial hospital infrastructure, in order to paint a flattering image of the Belgian Congo as a "medical model colony."

3 In my PhD dissertation, *Myths and Realities of the Belgian Medical Model Colony: A Genealogy*, I've investigated and nuanced the realities and persistent myths behind this reputation by tracing its "genealogy." In particular, I sought out the untold sides of the story. The structure of my dissertation mirrors the way publications such as *Investir, c'est prospérer* vaunted the various scales at which colonial policymaking resulted in the construction of public health facilities. They ranged from architecturally ambitious landmark hospitals and urban hospital infrastructure to a quantitatively vast, territory-wide network of identical rural healthcare nodes. The various cases I discuss in my PhD are grouped in three categories, according to "scale:" small, medium, and large, corresponding to the hospital, the urban, and the colonial territory as a whole. In a fourth category, simply termed "architecture," I zoom in on an architectural theme that was particularly pertinent to the respective case and its historical timeframe.

4 This subdivision of scales and architecture reflects two broader trends in the historiography of colonial architecture. One focuses on what can be termed the "politics" of architecture; i.e. its sociopolitical and power-related aspects. The other emphasizes the autonomy of the field, aside from its political aspects, as a key factor in understanding the colonial built environment. All of my considerations of the three "scales" deal particularly with politics. As Marc Crinson has already stated, "what lies at the heart of colonial architectural history… is power."[2] This strand of architectural history is thriving, and effectively covers a range of different scales. On the one hand, inspired by postcolonial studies that began emerging in the 1980s, architectural historians began focusing on symbolic public buildings as a "highly visible and politicized image of power."[3] On the other hand, more recently, a number of architectural historians have started to question whether these exceptional, symbol-laden edifices are the most accurate lens for the examination of such "politics of architecture." Often inspired by a Foucauldian framework of "governmentality" — of which Marc Crinson was, in fact, rather critical in the aforementioned text — they have argued that the "anonymous" or "grey architecture" of the "neglected ordinary colonial built environment," such as warehouses, medical outposts, or administrative offices, was much more important to everyday colonial statecraft.[4] From the *small*, where I focus on some of the Belgian Congo's most architecturally ambitious hospital projects,

to the *large*, which explores the "anonymous" architectures within the colony-wide healthcare network, and including the *medium*, which bridges both, colonial hospitals form an incredibly rich and varied typology to study the entire spectrum of the "politics of architecture," and to contribute to broader socio-political histories of colonial Congo.

5 I examine three flagship hospitals for Africans in Boma (1885-1921), Léopoldville (1921-1945) and Elisabethville (1945-1959) as illustrations of how colonial authorities explicitly deployed medical architecture to consolidate and legitimize colonial rule. All three complexes were advertised in colonial propaganda as modern, spotlessly clean medical facilities following the latest Western best practices of hospital design. They were indeed well-oiled *machines à guérir* (healing machines), as French philosopher Michel Foucault has termed them, designed to cure and control the indigenous population.[5] In reality, however, these prominent medical centers rarely achieved the steep ambitions of cure and control. The hospital in Boma most explicitly served as an architectural form of window-dressing to counter international critiques of the "red rubber" atrocities occurring in the Congo Free State. Administrators at the highly publicized and symbolic hospital in Léopoldville, the colonial capital, struggled to make ends meet. To face budgetary challenges, the staff often relied on informal collaborations with the families of African patients to ensure simple logistical tasks such as food supply. Lastly, the post-war hospital project in Elisabethville, although designed as an important landmark of the "medical model colony," was never constructed, hampered by strenuous negotiations and political tensions between various branches of the colonial administration.

6 The medium scale investigates how colonial hospital infrastructure was embedded within the broader urban tissue. From the 1920s onwards, especially, colonial town centers were increasingly segregated along racial lines. European parts of town were separated from the African quarters by what was then termed a "cordon sanitaire," or "quarantine area" — a neutral zone that was essentially an empty strip of land. Various historians have mentioned that medical arguments were key in implementing segregation in colonial cities. Africans were pathologized as the main carriers of tropical disease, and thus had to be spatially separated from the European population.[6] Although insightful, this exclusively binary description of the colonial city nevertheless fails to fully grasp the more complex realities of colonial urban environments, as other historians pointed out later. Colonial hospitals offer an interesting perspective from which to join in this academic debate, since they reveal a more detailed history of colonial segregation. With hospitals for Europeans separated from those for Africans, urban hospital infrastructure at first glance reflected segregation. It seems to confirm a straightforward binary reading of the colonial city. Nevertheless, closer analysis of the urban planning of hospital infrastructure in Boma (1885-1921), Léopoldville (1921-1945), and Coquilhatville (1945-1959) brings a more complex history to the surface. In Boma, the small yet cosmopolitan capital of early colonial Congo, medical segregation was never truly considered a priority in the economy-driven urban policies of the municipal authorities. In Léopoldville, segregation was implemented from the end of the 1920s onwards. However, the hospital for Africans was already located on the "wrong side" of the neutral zone — the European side — and was thus considered a threat to the health of the European population. It was never relocated due to budgetary shortages. And whereas the medical department of the colonial administration had been strong proponents of racial segregation during the interbellum, it became an important advocate of unifying hospital infrastructure in the post-war period, even though these progressive policy guidelines were often watered down on the ground, as was the case in Coquilhatville.

7 In the large scale, I explore three consecutive construction plans implemented throughout the colonial period: the *Plan Renkin*, launched in 1910, the *Plan Franck*, followed during the 1920s, and the *Plan Décennal*, dating from 1950 to the end of the colonial period. Each of these plans included extensive campaigns to build an increasingly dense rural network of hospital infrastructure across the colonial territory. While genuine ambitions to improve the health of the African population underpinned

all three building campaigns, they were driven by other political motives as well. Hospital building campaigns sought to parry external critiques and legitimize colonial rule, ensure a healthy and economically productive African workforce, and extend state presence and control across the colonial territory. All three vast and politically crucial infrastructural programs included the construction of multiple, comparable medical centers. In order to build them efficiently, colonial authorities repeatedly relied on the use of standardized type-plans that were developed by the central departments and then distributed to the various provincial and local administrative branches. The top-down implementation of these infrastructural plans suggests that the Belgian colonial government functioned like a well-oiled, omnipotent, and strongly centralized state apparatus. This was a reputation that the Belgian Congo already had during colonial times, and that was later theorized by historian Crawford Young.[7] He utilized the metaphor of the omnipotent "Bula Matari" — or "Breaker of Rocks," the nickname the Congolese populations had given to the Belgian colonial government — to argue that colonial governance, with Belgian Congo as the prime example, was quintessentially characterized by strong, monolithic, and autocratic government administrations. Nevertheless, a close examination of the administrative processes behind these infrastructural plans, and mappings of their actual realization, raise questions about the Belgian colonial administration as a top-down, monolithic "Bula Matari." Instead, I argue throughout these three cases that the everyday *modus operandi* of the colonial apparatus was often messy, characterized by ad-hoc improvisations to make do with the numerous budgetary problems, issues of manpower, and logistical challenges that continuously plagued the colonial administration.

8 Throughout these scales, I mainly zoom in on the sociopolitical dimensions of colonial hospital infrastructure. Overemphasizing the politics of architecture, however, raises a crucial issue particularly pertinent to the colonial context. Architectural historian Sibel Bozdogan asked the question in 1999: "How does one talk about the politics of architecture without reducing architecture to politics?"[8] Although it is undeniable that colonial architecture served the state's ambitions of power, politics, and economy, the autonomy of architecture as a profession and of the architects themselves still needs to be acknowledged. Johan Lagae has made a similar argument, warning that by "reducing the role of architecture and planning to that of a mere instrument of power," architectural historians risk "erasing the degree of disciplinary autonomy through which designers always respond to political, social, economic and cultural conditions."[9] In architecture, I aim to complement the political analysis explained above with more balanced "accounts of buildings that do not privilege either the politics of architecture or the autonomy of the architectural object."[10] I do so by charting how transnational flows of architectural knowhow on hospital construction circulated to and within the colonial world, and how local building practices translated this architectural expertise to the local context. The cases explore diverse architectural themes, ranging from how the materiality of colonial hospitals was shaped by local Congolese building practices (1885-1921), or how Western hospital typologies were translated to the tropical and colonial context (1921-1945), to how postwar hospital plans, designed for Western patients, were adapted to African users (1945-1959). Together, these cases make it possible to highlight not only the *longue durée* of transnational knowledge exchange on hospital construction, but also the importance of intercolonial and transimperial networks that go beyond those bilateral connections between *métropole* and colony that have remained the main focus of many architectural historians.[11]

9 Through these various scales and architectural themes, my dissertation explores the complexities that characterized the colonial Congo's healthcare system. It is a contribution not only to the already vast academic scholarship on Belgium's colonial past through the lens of colonial hospital infrastructure, and to the various strands in architectural histories of the colonial built environment. I I have also aimed to add further detail to current debates on Belgium's colonial history, in which the myth of the "medical model colony," deeply rooted in colonial propaganda, continues to be reiterated in an often reductive and simplified way.

Figure 1: *Investir, c'est prospérer*, page 87.

L'HYGIÈNE ET LES INSTALLATIONS MÉDICALES

SERVICE MEDICAL

Les établissements de médecine générale en 1950 étaient au nombre de 989 et comportaient 27.546 lits.

Le Plan Décennal a permis de porter, au 31 décembre 1959, le nombre des formations à 2.108 et celui des lits à 58.058.

La capacité hospitalière a donc doublé en neuf ans, ainsi que le montre le tableau comparatif ci-après :

Désignations	1950		1959	
	Nombre établissements	Nombre lits	Nombre établissements	Nombre lits
Etablissements de médecine générale :				
Hôpitaux et maternités de l'Etat	117	9.729	190	25.388
Hôpitaux et maternités autres subsidiés par l'Etat	59	5.056	174	15.223
Dispensaires ruraux de l'Etat.	514	4.677	1.273	9.029
Dispensaires ruraux autres subsidiés par l'Etat	299	8.084	471	8.418
	989	27.546	2.108	58.058

Un aspect du nouvel hôpital en construction dans la commune africaine de Kadutu, à Bukavu, chef-lieu de la province du Kivu.

Les bâtiments abritant le laboratoire médical de Luluabourg, chef-lieu de la province du Kasai.

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Chapter on public health. A prime example of how the colonial government mobilized medical architecture to legitimize colonial rule, portraying the Belgian Congo as a philanthropic endeavor.

Source: MINISTÈRE DES COLONIES, *Investir c'est prospérer : le plan décennal pour le développement économique et social du Congo belge 1950-1959*, 1960, p.87.

Figure 2: *Investir, c'est prospérer*, page 88.

NOMENCLATURE
DES REALISATIONS

Dans les grands centres :

Ont été aménagés et agrandis :

11 hôpitaux généraux à Matadi, Kikwit, Thysville, Coquilhatville, Stanleyville, Bunia, Paulis, Bukavu, Elisabethville, Luebo et Lusambo.

11 hôpitaux pour classes aisées à Boma, Léopoldville (en cours), Coquilhatville, Stanleyville, Buta, Bukavu, Elisabethville, Albertville (en cours), Luebo, Lusambo et Luisa.

Ont été construits :

5 nouveaux hôpitaux à : Léopoldville-Ouest, Luluabourg, Elisabethville, Bukavu et Stanleyville rive gauche.

15 laboratoires médicaux,
17 dispensaires,
1 grand sanatorium à Makala (Léo),
1 institut de pneumologie à Luluabourg.

Dans les zones rurales :

581 pavillons de Centres Médico-Chirurgicaux (C.M.C.) ont été réalisés, ainsi que 102 dispensaires.

Simultanément ont été construits les logements pour le personnel de ces formations rurales, soit 113 et 630 maisons respectivement pour membres du personnel de catégories supérieures et inférieures.

Les Centres Médico-Chirurgicaux sont répartis comme suit :

Province de Léopoldville :

Bagata, Bulungu, Feshi, Gombe-Matadi, Gungu, Idiofa, Kahemba, Kasongo-Lunda, Kenge, Kimvula, Kiri, Kutu, Lukula, Luozi, Maluku, Masimanimba, Moanda, Mushie, Seke Banza.

Province de l'Equateur :

Banzyville, Basankusu, Befale, Bikoro, Bokote, Bokungu, Bolomba, Bomboma, Bomongo, Bongandanga, Bosobolo, Budjala, Businga, Djolu, Monkoto, Lisala, Gemena.

Province Orientale :

Aba, Ango, Aru, Bafwasende, Banalia, Bondo, Dungu, Doruma, Ganga, Gombari, Mombasa, Opala, Poko, Ponthierville, Yabaondo, Yahuma.

Province du Kivu :

Baraka, Beni, Fizi, Goma, Kabambare, Kabare, Kasongo-Kibombo, Kirotshe, Lokandu, Lubero, Lubutu, Lusangi, Mwenga, Pangi, Rutshuru, Shabunda, Uvira, Walikale.

L'hôpital de l'Institut médical évangélique à Kimpese, dans le Bas-Congo.

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Chapter on public health. A prime example of how the colonial government mobilized medical architecture to legitimize colonial rule, portraying the Belgian Congo as a philanthropic endeavor.

Source: MINISTÈRE DES COLONIES, *Investir c'est prospérer : le plan décennal pour le développement économique et social du Congo belge 1950-1959*, 1960, p.88.

Notes

1 As Joseph Conrad famously described the region in his 1899 novel.

2 Mark CRINSON, "The Powers That Be: Architectural potency and spatialized power," *ABE Journal*, no.. 4, 2013. URL: https://journals.openedition.org/abe/3389 ; DOI: 10.4000/abe.3389.

3 Jiat-Hwee CHANG, *A Genealogy of Tropical Architecture: Colonial Networks, Nature and Technoscience*, London; New York, NY: Routledge, 2016 (The Architext Series), p. 10.

4 G. A. BREMNER, Johan LAGAE and Mercedes VOLAIT, "Intersecting Interests: Developments in Networks and Flows of Information and Expertise in Architectural History," *Fabrications*, vol. 26, no. 2, 2016, p. 236. DOI: 10.1080/10331867.2016.1173167 ; Johan LAGAE and Bernard TOULIER, "De l'outre-mer au transnational: glissement de perspectives dans l'historiographie de l'architecture coloniale et post-coloniale," *Revue de l'Art*, vol. 186, no. 4,2014, p. 48 ; Jiat-Hwee CHANG, *A Genealogy of Tropical Architecture*, *op. cit.* (note 3), p. 11.

5 Michel FOUCAULT, Anne THALAMY and Blandine BARRET-KRIEGEL, *Les machines à guérir : aux origines de l'hôpital moderne*, Brussels: Mardaga, 1979 (Architecture + Archives).

6 See e.g. Luce BEECKMANS and Johan LAGAE, "Kinshasa's syndrome-planning in historical perspective: from Belgian colonial capital to self-constructed megalopolis," *in* Carlos NUNES

Silva (ed.), *Urban planning in sub-Saharan Africa: Colonial and post-colonial planning cultures*, New York, NY: Routledge, 2015, p. 201-224.

7 Crawford Young, *The African Colonial State in Comparative Perspective*, New Haven, CT; London: Yale University Press, 1994.

8 Sibel Bozdoğan, "Architectural History in Professional Education: Reflections on Postcolonial Challenges to the Modern Survey," *Journal of Architectural Education*, vol. 52, no. 4, May 1999, p. 207.

9 Johan Lagae, "Momo in the 'heart of darkness': challenges to the documentation and conservation of modern Heritage in Central Africa," *in* Maristella Casciato and Emilie d'Orgeix (eds.), *Modern architectures : the rise of a heritage*, Liège: Mardaga, 2012, p. 216.

10 Sibel Bozdoğan, "Architectural History in Professional Education: Reflections on Postcolonial Challenges to the Modern Survey," *op. cit.* (note 8), p. 212.

11 For an extended historiographic account that explores how bilateral connections, as well as English- and French-speaking networks, have been overprivileged in architectural histories, see e.g. G. A. Bremner, Johan Lagae and Mercedes Volait, "Intersecting Interests: Developments in Networks and Flows of Information and Expertise in Architectural History," *op. cit.* (note 5).

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Pour citer cet article

Référence électronique
Simon De Nys-Ketels, « Myths and Realities of the Belgian Medical Model Colony: A Genealogy », *ABE Journal* [En ligne], 21 | 2023, mis en ligne le 07 juillet 2023, consulté le 12 juillet 2023. URL : http://journals.openedition.org/abe/14100 ; DOI : https://doi.org/10.4000/abe.14100

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