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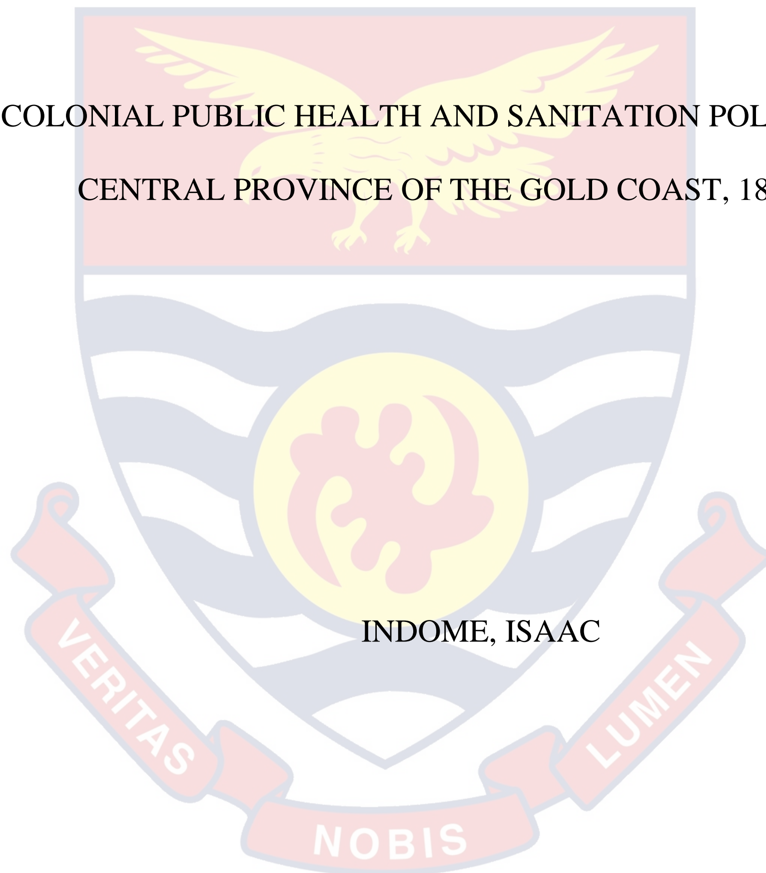

COLONIAL PUBLIC HEALTH AND SANITATION POLICIES IN THE CENTRAL PROVINCE OF THE GOLD COAST, 1874-1957.

INDOME, ISAAC

2019

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COLONIAL PUBLIC HEALTH AND SANITATION POLICIES IN THE CENTRAL PROVINCE OF THE GOLD COAST, 1874-1957.

BY

INDOME, ISAAC

THESIS SUBMITTED TO THE DEPARTMENT OF HISTORY OF THE FACULTY OF ARTS, COLLEGE OF HUMANITIES AND LEGAL STUDIES, UNIVERSITY OF CAPE COAST, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY DEGREE IN HISTORY.

OCTOBER, 2019

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature………………………………… Date ………………

Name: Isaac Indome

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature…………………...……… Date………………

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ABSTRACT

The present Central Region of Ghana was the Central Province of the Gold Coast during the colonial period. Cape Coast was the administrative capital of the British Crown Colony from 24th July, 1874 till 1877 when it was moved to Accra. The transfer was made under the pretext that Cape Coast was insanitary, yet all the remaining coastal towns in the colony were faced with same sanitation challenges, without the exemption of Accra. This raises the question, if Cape Coast was insanitary, which policies then were employed to make it reasonably healthy and sanitary? Thus, the main objective of the study is to examine the British colonial government's public health and sanitation policies in the Central Province of the Gold Coast from 1874 to 1957. The approach to the study is qualitative. The study involved both primary and secondary data. It used a multi-disciplinary approach to demonstrate, describe and narrate the public health and sanitation policies that manifested in the provision and availability of hospital, dispensary and clinic facilities, preventive and curative medicines, vaccination programmes, drainage and sewer systems, public latrines, water supply systems, and well-planned settlements that improved the health and sanitary conditions in the Central Province. The main finding of the study is that the colonial government employed a multi-dimensional and multi-departmental approach in the quest to ensure public health in the Central Province; however, the Gold Coasters financed the cost of the provision of the public health and sanitary facilities. The people of Gold Coast also responded and initiated some of the colonial public health and sanitation policies. Most of the policies that this work reveals are very useful to contemporary health and sanitation policy-makers in their quest to ensure the desired public health.

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DEDICATION

To the Indome and the Nasarah family of Cape Coast and Navrongo respectively.

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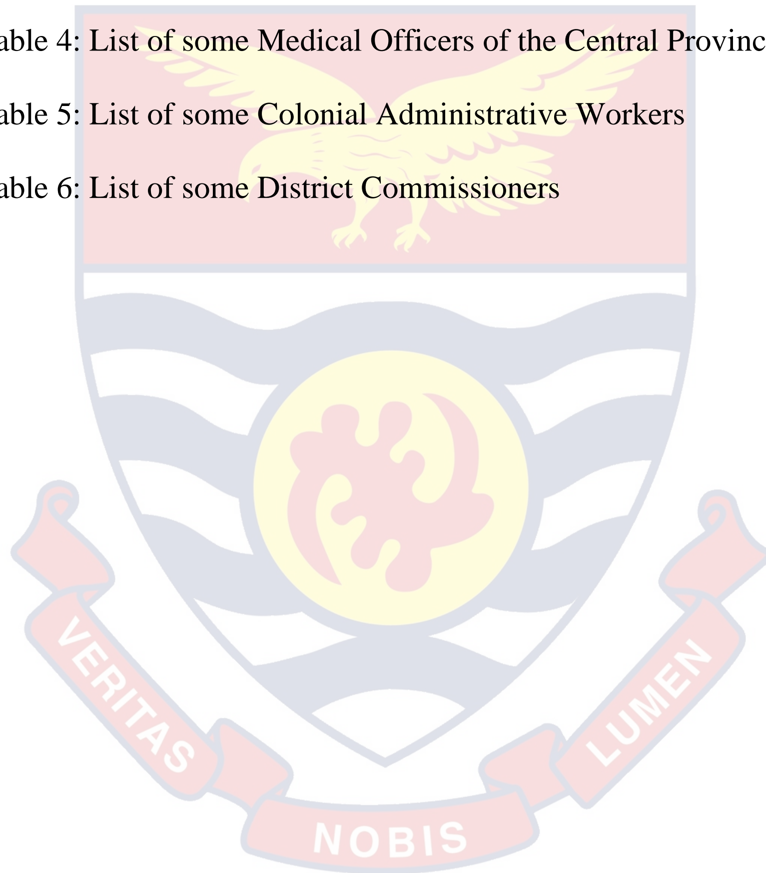

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LIST OF ACRONYMS

AWAM	Association of West African Merchants
BELRA	British Empire Leprosy Relief Association
CHB	Central Health Board
CP	Central Province
DC	District Commissioner
GCBBRCS	Gold Coast Branch of the British Red Cross Society
GCLMCWU	Gold Coast League for Maternal and Child Welfare Unit
IAM	Indigenous African Medicine
MD	Medical Department
MOH	Medical Officer Health
NJO	Native Jurisdiction Ordinance
PRAAD	Public Record and Archives Administration Department
PWD	Public Works Department
SSO	Senior Sanitary Officer
WAMS	West African Medical Service
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

> *Cape Coast [the capital of the Central Province of the Gold Coast] is the troublesome problem. I spent a fortnight of last month going into every dirty hole and corner of it. I should like to clear a lot of it away, but . . . I don't think it could be done.... In the meantime, I propose to adopt various half-measures, which is not very satisfactory.*[1]

Background to the Study

One of the most vital things in life is good health. Strenuous efforts were made to avoid ill-health in all societies in history. Ancient societies explored ways to understand the causes of diseases and how to avoid them. The art and science of medicine, healing and care for the sick obviously has a long tradition dating back to early studied civilizations like Khmet (Ancient Egypt), Mesopotamia, India and China. What is known of the medicine of Khmet comes principally from two fragments of writing, the Ebers papyrus and the Smith papyrus, both discovered in Egypt through archaeological research.[2]

Hippocrates (460-377 B.C.), a Greek believed to be the father of western medicine, described disease symptoms and established that cleanliness, fresh

VERITAS LUMEN NOBIS

[1] Copy of a letter from Governor Nathan Matthew to A. L. Jones, 21 Oct. 1901 after the former had visited Cape Coast, the capital of the Central Province. Cited in Raymond E. Dumett, "The Campaign Against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", *African Historical Studies*, Vol. 1, No. 2 (1968), p. 168. This is used here to point out that the health and sanitation situation of pre-colonial and colonial Cape Coast, the first capital town of the Gold Coast colony, was a poor one. However, nothing much was done to improve the situation.

[2] Ebers papyrus and Smith papyrus are some of the ancient Egyptian sources of medical practice in Africa. The Ebers text is a compilation from many sources and the Smith text is probably a copy of a text written at about 2500 BC. The impact and contribution of Egyptian medical knowledge is so great. Many of the founders of the ancient Greek schools of medicine owed their learning to Egyptians. See Samuel Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, (Accra: Page links Publishers, 2005), pp. 106-107; Paul Tiyamba Zeleza & Dickson Eyoh (eds.), *Encyclopedia of Twentieth- Century African History,* (London & New York: Routledge, 2003), p. 259 and Kofi Busia, *Fundamentals of Herbal Medicine,* (London: Xlibris Publishers, 2016) pp. 1-5.

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air, good diet and rest promote the natural process of healing.[3] The Romans also endeavoured to understand the cause and prevention of diseases. For example, they linked malaria causation to the location of houses close to marshes and swamps.[4]

In the Middle or Dark Ages (AD 500–1500) knowledge of the causes, prevention and treatment of illness in Europe was basic.[5] The history of modern measures to promote public health and sanitation in Europe began in the mid-nineteenth century.[6] England, passed its first Public Health Act in 1848 to deal with health issues that had worsened due to the Industrial Revolution.[7] C. E. A. Winslow has described public health as:

> the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease and the development of social machinery which will ensure to every individual in the community the maintenance of [good] health.[8]

---

[3] von Julius Springer, *Hippocrates*: *On Airs, Waters and Places*, *Medical Classics (*1938), pp. 19–42*;* George Rasen, *A History of Public Health,* (New York: MD Publications, 1958); Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health,* pp. 106-107; Zeleza & Eyoh (eds.), *Encyclopedia of Twentieth Century African History*, p. 259 and Busia, *Fundamentals of Herbal Medicine,* pp. 1-5.

[4] Springer, *Hippocrates: On Airs, Waters and Places.* pp. 19–42. Lloyd F. Novick & Cynthia B. Morrow, "Defining Public Health: Contemporary Development", July, 2015, pp. 1-34, p. 5. Accessed from https://www.researchgate.net/publication/265118520 on May 2019.

[5] The Middle Ages were marked by two major epidemics of bubonic plague—the Plague of Justinian (543) and the Black Death (1348)—with smaller outbreaks of various diseases in the intervening period, including leprosy, smallpox, tuberculosis, and measles. See Rasen, *A History of Public Health*, p. 6.

[6] John Fry, *General Practice and Primary Health Care, 1940s -1980s,* (London: The Nuffield Provincial Trust, 1988). See also Reference Division, Central Office of Information, *Health Services in Britain,* (London: The Crown Press, 1964), p. 3.

[7] Reference Division, Central Office of Information, *Health Services in Britain*, p. 1. The Industrial Revolution began in Britain from the second half of the eighteenth century and spread to other parts of Europe.

[8] C. E. A. Winslow, *The Untilled Field of Public Health,* (New York: New York County Chapter of the American Red Cross, 1920), p. 34. This definition is also cited in Lloyd F. Novick & Cynthia B. Morrow, "Defining Public Health: Contemporary Development," p. 2 and C. Fraser Brockington & Lord Stopford, *The Health of the Community: Principles of Public Health for Practitioners and Students,* (London: J. & A. Churchill Ltd., 1960), p. xi.

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Thus, the Public Health Act of 1848 attempted to lay down a common minimum standard of sanitary services.[9] The Act also pointed the way for the Public Health Act of 1875 and 1936 and the establishment of the National Health Service in 1948 in England.[10] Did England, under aegis of the British imperial effort, extend its public health policies to the Gold Coast in West Africa? How did the policies manifest at the provincial level in the Gold Coast?

The British, like other European imperial powers, took some measures to ensure and maintain good health for their European nationals in their spheres of influence in Africa. Some local peoples also experienced the tentacles of such measures. This was necessitated by the fact that prior to and during the colonization of Africa, the West African coast was labeled as the "White Man's grave"[11] owing to the fact that tropical diseases like malaria and fevers in this region cost the lives of many European travelers in the region. In fact, the exploitation of the resources in any colony could not have been attained without ensuring the good health of the labour force of the colony or solving the "White Man's grave" issue.

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[9] The Public Health Act aimed at creating a comprehensive public health system to include a sound water supply system, proper sewage, improved drainage and street paving. At the beginning of the implementation of this act, the public health services were placed under the control of local public health authorities. See Fry, *General Practice and Primary Health Care, 1940s -1980s,* p. 3; Novick & Morrow, "Defining Public Health: Contemporary Development", p. 9; Rasen, *A History of Public Health*; R. M. F. Picken, "The Evolution of The Public Health Service (Concluded)", *The British Medical Journal*, Vol. 1, No. 4244 (1942), p. 72.

[10] Fry, *General Practice and Primary Health Care, 1940s -1980s,* p. 3. Amendments were made to the first Public Health Act to meet changing circumstances of the time.

[11] Brodie Cruickshank, *Eighteen Years on the Gold Coast of Africa*, Vol. 1. Second Ed. (London: Frank Cass & Co. Ltd., 1966), p. 5; Philip D. Curtin, "The White Man's Grave:" Image and Reality, 1780-1850", *The Journal of British Studies,* Vol. 1, No. 1 (1961), pp. 94–110; Philip D. Curtin, "The End of the 'White Man's Grave'? Nineteenth-Century Mortality in West Africa", *Journal of Interdisciplinary History* Vol. 21, No.1 (1990), pp. 63- 88; Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, p. 183; Akwasi Kwarteng Amoako-Gyampah, "Inherently Diseased and Insanitary? The Health Status of the Gold Coast (Ghana) from the 18th to the late 19th Century", *Nordic Journal of African Studies* Vol. 27, No. 2 (2018), pp. 1-24, p. 3; Matthew M. Heaton, "Health and Medicine in Colonial Society", Martin S. Shanguhyia & Toyin Falola (eds.), *The Palgrave Handbook of African Colonial and Post-Colonial History,* (New York: Springer Nature Publishers, 2018), p. 304.

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Winslow's view on public health is illuminating when we apply the essential meaning of public health to the practice of public health considered broadly, it can be seen as any measure taken by a group within a defined territory to ensure their collective physical, mental and social well-being for their general progress and development. Public health efforts are aimed at ensuring conditions that promote the health of a community and not merely an individual. In 1948, the World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[12]

Statement of the Problem

The history of medicine and health in Africa is vital, but a neglected field of enquiry in African historiography. Disease and attempts to control endemic and epidemic afflictions have been significant factors of social change throughout the development of African history. Yet historians have rarely paid attention to issues involving human diseases and health, particularly, during the colonial era in Africa. There is some mention of disease in many pre-colonial studies, especially, those of the "trade and politics" variety, but comments are usually directed towards the effects of tropical diseases on Europeans rather than the impact on local and induced diseases on African populations.[13]

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[12] World Health Organization, "General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine, 2000. The United Nations, 'Official Records of the World Health Organization', 2000, p. 100. http://whqlibdoe.whoint/hp2000/WHO-EDM-IRM-2000.pdf. Accessed on 24th February, 2018.

[13] Emmanuel K. Akyeampong, "Disease in West African History", Emmanuel K. Akyeampong (ed.), *Themes in West Africa's History*, (Oxford: James Currey Publishers, 2006), p. 197. Akyeampong explains how quinine helped the European expedition in the Niger in 1854.

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David K. Patterson calls on scholars to pay attention to the study of the medical and health history of Africa in 1974. He remarked:

> It is to be hoped that as the historiography of Africa moves away from its early preoccupation with trade, politics, and the 'origins of nationalism,' and as new archival and other sources become available, scholars will take a greater interest in the role of disease and medicine in the history of the continent.[14]

Patterson's bibliographical essay exposed the fact that the greater volume of African medical history in both the pre-colonial and colonial period are in unwritten form. In the context of the colonial history of Ghana, scholars have devoted much attention to the study of the political and economic history of the country. Scholars have been quite selective in their writing on the colonial experience in the social field. Scholars who wrote on social topics focused much on the spread of Christianity and the introduction of formal Western school education. This is exemplified by scholars like Philip Foster,[15] David Kimble,[16] Adu A. Boahen,[17] Michael Crowder,[18] Francis Agbodeka,[19] F. K. Buah,[20]

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[14] Patterson, "Disease and Medicine in African History: A Bibliographical Essay," p. 141. Patterson calls on historians to study medicine and health history of Africa with the use of archival materials and this is what the present study seeks to do by interrogating the public health and sanitation policies. Patterson also made similar call on historians in his work, David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* (Los Angeles: Crossroad Press, 1981), pp. ix-x.

[15] Philip Foster, *Education and Social Change in Ghana,* (London: Compton Printing Ltd., 1965).

[16] David Kimble, *A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1928*, (Oxford: Clarendon Press, 1963), p. vii.

[17] Adu A. Boahen, *African Perspectives on Colonialism*, (Maryland: John Hopkins University Press, 1989); Adu A. Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century,* (London: Longman Group Ltd., 2000) and Adu A. Boahen, J. F. Ade Ajayi & Michael Tidy, *Topics in West African History*, (London: Longman Group Ltd., 1986).

[18] Michael Crowder, *West Africa Under Colonial Rule* (London: Hutchinson & Co. Publishers Ltd., 1968).

[19] Francis Agbodeka, *Ghana in the Twentieth Century*, (Accra: Ghana University Press, 1972).

[20] F. K. Buah, *A History of Ghana*, (Malaysia: Macmillan Publishers Ltd., 1980), pp. 132-143.

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Elizabeth Isichei,[21] S. K. Odamitten,[22] and, M. Ralph Wiltgen.[23] Kimble devoted chapters one to three of his work, *A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1928,* to the study of "the Economic Background of the Gold Coast," "Education and African Leadership" and "Social Change"[24] respectively. In his discussion of the latter, he focused on Christianity, churches and nationalism without any major reference to health and sanitation as a catalyst of social change during the colonial era.

Following David Kimble, Michael Crowder discussed, among other topics, the political administration of the imperial powers in West Africa, the colonial economy and social change in parts three, five and six of his work, *West Africa Under Colonial Rule*.[25] On the theme of social change, he discussed five issues which did not include health and sanitation but rather featured the spread of Islam, Christianity and Western education.[26] Thus, other equally vital social experiences under colonialism like health and sanitation policies are either absent or mentioned in passing in most historical works on colonialism in the Gold Coast.

The far-reaching effect of the absence of colonial public health and sanitation policies in the study of colonial West Africa and Ghana in particular

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[21] Elizabeth Isichei, *History of West Africa since 1800,* (London: MacMillan Publishers, 1977).
[22] S. K. Odamitten, *The Missionary Factor in Ghana's Development up to 1880s,* (Accra: Waterville Publication House, 1978).
[23] Ralph M. Wiltgen, *Gold Coast Mission History, 1471-1880*, (New York: Divine Word Publications, 1956).
[24] Kimble, *A Political History of Ghana*, p. vii.
[25] Crowder, *West Africa Under Colonial Rule*, pp. viii-x.
[26] *Ibid.,* pp. viii-x. See also Isichei, *History of West Africa since 1800*, p. iv. She also repeated the same themes in her discussion on the colonial experience, but only added a colonial balance sheet as a new theme in her work. See Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century.* He devoted chapter ten of his work to discuss the Christian missions in Gold Coast in the nineteenth and twentieth centuries. He also discussed social developments in the nineteenth and twentieth centuries without any major mention of colonial public health and sanitation programmes in the Gold Coast.

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is that very little has been known about colonial public health and sanitation policies of the Gold Coast. There is, therefore, an incomplete knowledge of health and sanitation policies of the Gold Coast in general and the Central Province in particular. The study of the colonial history of Ghana will be incomplete without the health and sanitation policies. Consequently, there is the need for a study that investigates the colonial public health and sanitation policies that were formulated, pursued and implemented in the Gold Coast using the Central Province as a case study. This thesis examines colonial public health and sanitation policies in the Central Province of the Gold Coast, 1874-1957.

Review of Related Literature

One of the flourishing debates among historians of African history concerns the role and influence of science and technology in aiding European expansion, imperialism and administration of colonial Africa.[27] Until quite recently, historians shared the contemporary view that medicine was a straightforward element of colonial administration. With the advent of colonialism and the germ theory, western medical science was viewed as unquestionably beneficial and progressive.[28] Indeed, western medicine was perceived as perhaps the only indisputably facet of European imperialism.[29]

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[27] Sandra M. Tomkins, "Colonial Administration in British Africa during the Influenza Epidemic of 1918-19", *Canadian Journal of African Studies / Revue Canadienne des Études Africaines,* Vol. 28, No. 1 (1994), pp. 60-83.

[28] The germ theory began to take root in Europe and America from 1870s. David Arnold, (eds.), *Imperial Medicine and Indigenous Societies,* (Manchester: Manchester University Press, 1988), pp. 12-18. See also Stephen Addae, *History of Western Medicine in Ghana, 1880-1960,* (Edinburgh: Durham Academic Press, 1997), p. 19 and Juanita De Barros & Sean Stilwell "Introduction: Public Health and the Imperial Project", *Colonialism and Health in the Tropics,* Vol. 49, No. 4 (2003), p. 3.

[29] Arnold (ed.) *Imperial Medicine and Indigenous Societies*, pp. 3-16 and R. V. Kubicek, "Science and Empire", *The Administration of Imperialism,* (Chapel Hill: Duke University Press, 1967).

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Recent scholarship has challenged this schema. Far from being a neutral and value-free tool, medicine is now recognized as a cultural artifact carrying its own assumptions and prejudices.[30] Instead of their former emphasis on medicine's assumed neutrality, historians have argued that medicine was instrumental in maintaining European authority and superiority in Africa. As a unique area of cultural contact, medicine is now identified as a potentially rich source of insights regarding the principles and practice of imperialism in Africa.[31]

One of the central arguments that Daniel R. Headrick makes in his work, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century* is that the advancement in transportation and communication technology, military weaponry and, most importantly, improvement in medicine served as enabling tools that aided the European imperialist's invasion of Africa.[32] He explains how the perfection of steamers and gunboats during the 1830s enabled England to establish its supremacy over India, the Near East and Africa. He made a case that quinine prophylaxis, which was discovered in the 1840s and was improved upon throughout the nineteenth century made European imperial powers successful in their penetration into the interior of

[30] Tomkins, "Colonial Administration in British Africa during the Influenza Epidemic of 1918-19", pp. 60-83.
[31] *Ibid.* See Anis Alam, "Science and Imperialism." *Race and Class*, Vol. 19 (1978.), pp. 239-51; Arnold, (ed.) *Imperial Medicine and Indigenous Societies*; Daniel R. Headrick "The Tools of Imperialism: Technology and the Expansion of European Colonial Empires in the Nineteenth Century", *The Journal of Modern History,* Vol. 5, No. 1 (1979), pp. 231-63; Daniel R. Headrick, *Tools of Empire: Technology and European Imperialism in the Nineteenth Century,* (New York: Oxford University Press, 198I); Daniel R. Headrick, *The Tentacles of Progress: Technology Transfer in the Age of Imperialism I850-1940,* (New York: Oxford University Press, 1988).
[32] Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*. Also, see Roy Macleod & Lewis M., (eds.), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experiences of European Invasion,* (New York: Routledge, 1988).

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Africa.[33] Although Headrick presented very sound arguments on the enabling factors for the European invasion of Africa, he failed to articulate further how "the tools of the empire" that he mentioned, particularly, the improvement in medicine, was used by European imperialist to maintain their stay in their spheres of influence. The point here is that Headrick stopped at how Africa was colonized and not how "the tools of the empire" were used throughout the colonial period. In fact, it must be pointed out here that it was not only malaria that impeded European occupation of tropical Africa and so the discovery and improvement in malaria drugs alone could not have guaranteed European settlement in Africa throughout the whole colonial period. Other tropical diseases that were obstacles to the European occupation of Africa included trypanosomiasis, all types of fevers and small pox.[34] Hence, there is the need for scholarly investigation into the health and sanitation policies that were adopted by the imperial powers to enable their stay in Africa.

In his article on "Disease in West African History," Emmanuel Kwaku Akyeampong traced the history of diseases in West Africa from the pre-colonial period through to the post-independence era.[35] He identified some of the major diseases of the Atlantic Trade and epidemiology in West Africa. He also went further to discuss the themes, "Colonial rule, 'colonial diseases' and Western biomedicine."[36] Akyeampong seemed to agree with Daniel Headrick that the breakthrough in western allopathic medicine and the Industrial Revolution

[33] *Ibid.,* p. 74. See also Akyeampong, "Disease in West African History", p. 197. Akyeampong explains how quinine helped the European expedition on the Niger in 1854.
[34] John Ford, *The Role of Trypanosomiasis in African Ecology: A study of the Tsetse fly Problem* (Oxford: Clarendon Press, 1971) and Helen Tilley, "Ecologies of Complexity: Tropical Environment, African Trypanosomiasis and the Science of Disease Control in British Control Africa, 1900-1940", *Landscapes of Exposure: Knowledge and Illness in Modern Environment,* Second Series, Vol. 19, pp. 21-38.
[35] Akyeampong, "Disease in West African History", pp. 186-207.
[36] *Ibid.*

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aided Europeans in the colonization of Africa when he concluded that "Indeed, the colonization of Africa might well have been impossible without the industrial and medical revolution of the nineteenth century."[37] However, unlike Headrick, Akyeampong, went further to talk about how European medicine, coupled with some health policies like residential segregation, were employed as a measure to prevent the spread of malaria and yellow fever among the Europeans in West Africa.[38] By this, Akyeampong gave some ideas about the health policies that European imperial powers used to consolidate their gains in West Africa. Residential segregation, as Akyeampong pointed out, was a health policy that was adopted to protect European nationals and not the African population from tropical diseases like malaria and fevers. The question then is: which health policies, both clinical and environmental, were pursued by the European imperialist administrations to ensure a proper sense of public health for the general population in their spheres of influence? Akyeampong's work does not answer this question.

Although, Akyeampong's work is very informative on the subject of disease history in West Africa, the work is generally a survey and so it is not detailed enough to spell out the chronology in the development of the health history of the various colonies in West Africa. Regardless of this shortcoming, Akyeampong's article is useful to the present study. Its usefulness is that Akyeampong discussed, though briefly, the outbreak of bubonic plague epidemic, influenza pandemic and flu pandemic among others in the Gold Coast which is very useful as it will serve as the bases for further studies into the role

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[37] *Ibid.,* p. 196.
[38] *Ibid*., pp. 197-199. European medicine like Quinine and atoxyl were used for the treatment of malaria and trypanosomiasis.

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of epidemics and pandemics in the formulation and the pursuit of colonial public health policies. Also, his discussion of segregation as a health policy in the Gold Coast, offers leads and hints about the history of colonial public health and sanitation policies in the Central Province of the Gold Coast, even though segregation was not the only health policy that was pursued by the British.

In his study of the social impact of colonialism on Africa, A. Adu Boahen pointed out that the population of Africans increased by 37 per cent during the colonial period.[39] He attributed the increase to some of the policies and activities of the colonial administrators. Among other things Adu Boahen mentioned the campaign launched against epidemic diseases like sleeping sickness, bubonic plague, yellow fever and yaws and the provision of some medical facilities as a measure to promote public health during the colonial period.[40] Nevertheless, Adu Boahen did not articulate the exact health policies which were formulated and implemented by European imperialists in the campaign against those diseases. The institutions or agencies that the colonial government established to launch the supposed campaign against diseases were not mentioned by Adu Boahen. He also did not spell out the extent to which an imperial power strove to improve upon the health conditions of people in its sphere of influence.

In a bibliographical essay on disease and medicine in African history, David K. Patterson, claimed that it was the ineffectiveness of indigenous African medicine and medical system that had led to poor health conditions in

[39] Boahen, *African Perspectives on Colonialism*, p. 103. He mentioned one Caldwell who estimated that the increase was 37 percent. See also Isichei, *History of West Africa since 1800,* p. 230. She agrees with other historians on the said increase in West African population.
[40] *Ibid.*

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Africa.[41] He seems to suggest that it was European medicine and other health systems that improved African health conditions during the colonial period.[42] Patterson was Eurocentric in outlook and neglected the fact that, African therapies saved Africans long before the European imperial conquest and the institutionalization of western medicine in colonial Africa. The point here is that since time immemorial, Africa has been more prone to diseases than any other continent in the world due to the nature of its ecology.[43] Hence, African communities frequently experienced diseases and, therefore, it is erroneous to conclude that African therapies were ineffective. If indeed African therapies were that ineffective, perhaps, European imperialists would not have found a single African on the continent at the time of their contact with Africans.

Several works provide contrasting positions with what Patterson intimated about African medicine and medical systems. For instance, William Bosman, who explored the West African coast in the seventeenth century provided good testimony about how effective the African *materia medica* was in curing several diseases and dangerous wounds in the Gold Coast.[44] Similarly, T. E. Bowdich, also reported the efficacy of Asante *material medica* to the British colonial government in the late nineteenth century.[45] Patterson

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[41] David K. Patterson, "Disease and Medicine in African History: A Bibliographical Essay", *History in Africa*, (1974), p. 142.
[42] *Ibid.*
[43] William McNeill H., *Plague and Peoples*, (New York: Anchor Doubleday, 1997[1976]), pp. 47-67. See also Akyeampong, "Disease in West African History," pp. 186-187.
[44] William Bosman, *A New and Accurate Description of the Coast of Guinea Divided into the Gold, the Slave, and the Ivory Coasts,* (London: The Ballantyne Press, 1907), p. 225. Bosman pointed out that the *materia medica* of the Gold Coasters was very effective when compared with what the European surgeons administered to the Europeans on the coast.
[45] See also T. E. Bowdich, *Mission from Cape Coast Castle to Ashantee,* (London: Frank Cass Publishers, 1966 [1819]), pp. 371-377. See also PRAAD- ACCRA ADM 5/3/1 (1817) Bowdich's Report and Correspondent on his Mission to Ashanti. Some of the diseases introduced into the Gold Coast by contact with Europeans were also taken care of by indigenous African medicine as in the case of Asante. The work of Bowdich proved that concoction made from bark of trees, which have medical components, and herbs forms the bulk of the biomedical materials among the Asante.

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overlooked the fact that due to the so-called European "civilization mission in Africa," European imperialists deliberately tagged indigenous things as bad or outmoded, hence, they did not tolerate nor incorporate indigenous African medicine and medical systems into their clinical and environmental public health policies.[46] Although Patterson's work registers some shortcomings, it is useful to the present study since he articulated some of the health care practices that were introduced by Europeans to resolve some of the health issues in colonial Africa. However, the present study investigates the agency of Gold Coast Africans in initiating and formulating health and sanitation policies in the Gold Coast.

In *Topics in West African History,* Adu A. Boahen maintain that colonial rule stimulated an increase in the population of West Africa especially from 1910 onwards. Adu Boahen and his colleagues attribute the increase to the establishment of hospitals, the provision of good drinking water, improvement in sanitary conditions and the launching of campaign against epidemic diseases.[47] The inference that one can make from this argument is that there were public health and sanitation policies that the European colonizers of West Africa pursued that promoted the good health of the people living in their spheres of influence. However, Adu Boahen and his colleagues failed to articulate the specific health policies that were pursued which resulted in the increased in the population of West Africans with the colonial period. Thus, the

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[46] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses.
[47] Adu A. Boahen, J. F. Ade Ajayi & Michael Tidy, *Topics in West African History,* Second Edition, (London: Longman Group Ltd., 1986), p. 132. See also Isichei, *History of West Africa since 1800,* p. 230. She agrees with other historians that there was a general population growth in West Africa during colonial time due to improvement in health services.

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scholars spoke about the outcome of colonial health policy without clarifying the nature of the policy and the process of implementation.

In his study of colonial Ghana, Adu A. Boahen again argues that there was increase in the population of Gold Coast in the early twentieth century. He attributed the increase to, among other things, the steady positive increase in health and living standards of the people.[48] He makes the case that in the first half of the twentieth century there was the provision of pipe-borne water supply, hospitals, dispensaries and health services in the Gold Coast. His discussion of the health policies that facilitated the increase in the population was very brief and not detailed to represent a true picture of the health policies that the British employed in the Gold Coast.[49] It must be noted here that Adu Boahen did not mention the establishment of the Town Council system. This Council was introduced in 1894 for the purpose of executing the public health and sanitation policies in major towns in the Gold Coast. British colonial health policies in the Gold Coast preceded the enactment of the Town Council Ordinance of 1894. However, it was in 1894 that an established administrative system, the Town Council, was introduced to help in the implementation of health and sanitation policies in the Gold Coast.

David Kimble,[50] D. E. K. Amenumey,[51] F. K. Buah,[52] Roger S. Gocking,[53] and Stephen Addae[54] argue that the British colonial government established the Town Council system under the 1894 Town Council Ordinance.

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[48] Boahen, *Ghana: Evolution and Change in Nineteenth and the Twentieth Century*, pp. 102-127.
[49] *Ibid.*
[50] Kimble, *A Political History of Ghana,* pp. 423-426.
[51] Amenumey, *Ghana: A Concise History*, pp. 164-166.
[52] Buah, *A History of Ghana*, pp. 104-105.
[53] Gocking, *The History of Ghana,* pp. 51-54. The Town Council of 1894 was for Accra, Cape Coast and Sekondi, the Eastern, Central and Western Provinces respectively.
[54] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 119.

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These scholars agree that the Town Council was established under the local government system of administration and that the Town Councils were charged with the responsibility of ensuring public health and sanitation within the Provincial and district levels where the ordinance was applied. They also confirm that Cape Coast, the capital of the Central Province, vehemently opposed the Town Council Ordinance because of the 5 per cent rate that the people were to pay and also because the council was a British prototype.[55] It can be inferred from the second reason that was given for the rejection of the Town Council Ordinance by the people that the council to ensure the implementation of the health and sanitation policies was a semblance of what was in metropolitan Britain.

D. E. K. Amenumey maintains that it was not until 1908 that Cape Coast accepted the functioning of the Town Council Ordinance in its territory after the colonial government had made a few modifications to the ordinance.[56] Roger S. Gocking agrees with Amenumey on the year of the commencement of the ordinance in Cape Coast. However, Gocking went further to postulate that it was the outcome of the outbreak of a plague in 1908 and yellow-fever epidemic of 1910 in the Gold Coast which claimed the lives of ten Europeans and two Africans that compelled Cape Coast to accept the ordinance.[57] What Gocking did not make clear was whether the number of the recorded deaths he mentioned were for the whole of the Gold Coast or Cape Coast alone. Contrary to the

[55] *Ibid.* The people of Accra also opposed the Ordinance on the same grounds.
[56] Amenumey, *Ghana: A Concise History,* p. 165.
[57] Gocking, *The History of Ghana,* p. 53. By 10th April, 1908, the Central Province had recorded just over 100 cases of the plague while Accra had almost 200. See David Scott, *Epidemic Disease in Ghana, 1901-1960*, (London: Oxford University Press, 1965), p. 6.

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number of recorded deaths given by Gocking, Emmanuel Kwaku Akyeampong puts the number at 288 deaths. He wrote:

> The 1908 outbreak started in Accra and spread quickly to other towns along the coast line, causing 288 deaths in 336 official reported cases. The second Gold Coast plague epidemic started at another port town, Sekondi.[58]

It is possible that the number of deaths given by Gocking were those recorded in Cape Coast or the Central Province as a whole. It can be inferred from the account given by Kimble, Amenumey, Buah, Addae and Gocking about the Town Council Ordinance that the British colonial health policies began in the Gold Coast colony before it spread to Asante and the Northern Territories. In fact, it was not until 1943 that the Kumasi Board of Public Health was established in Asante and tasked to ensure a reasonably good health of the people in that territory.[59] The coastal line of the Gold Coast became the abode of most Europeans and so most of the early health facilities provided by the colonial government from the late nineteenth century were confined to the southern Gold Coast. Throwing light on this situation, that is, the concentration of health facilities in the southern Gold Coast, Amenumey writes:

> The government also built a number of hospitals and dispensaries. But they were rather few. The lucky towns were mostly coastal ones like Keta, Saltpond, Cape Coast, Elmina and Sekondi-Takoradi. Later, others were built in Kumasi, Sunyani

[58] Akyeampong, *Disease in West African History,* p. 199. It must be pointed out here that Akyeampong took the number of the death from archival source. PRAAD, Accra, ADM 5/1/85. Report of the Medical and sanitation Department. For the 1908 outbreak of plague in the Gold Coast see Scott, *Epidemic Disease in Ghana, 1901-1960*, pp. 1-25. Accra was the hotspot for the plague in the Gold Coast.

[59] Gocking, *The History of Ghana,* p. 78. See also Buah, *A History of Ghana*, p. 105 and Kimble, *A Political History of Ghana,* p. 145.

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> and Obuasi. As a rule, the hospitals were built in the big towns where there were large numbers of Europeans.[60]

The mention of three towns in the Central Province as beneficiaries of the few hospitals that were built by the colonial government means that the province had experienced the colonial health policies for a long time or was one of the focus of the colonial government. It could also be that importance was given to the health needs of the numerous Europeans in the Central Province and not necessary the Gold Coast Africans of the province. Hence, this province needs to be studied to ascertain what made it an epicenter of colonial hospitals. A reading of Amenumey does not lead one to understand the reasons why the Central Province received most of the health-promoting facilities during the early colonial period. This thesis focuses on the factors that made the Central Province the central focus of the British in the provision of health facilities in the Gold Coast.

Until this study was undertaken, few works exist on the health history of the Gold Coast. The two works of David K. Patterson, *Health in Colonial Ghana: Diseases, Medicine and Socio-Economic Change, 1900-1955,*[61] and "The Influenza Epidemic of 1918-1919 in the Gold Coast"[62] are part of the works that attempt to tell the health history of the Gold Coast. Another notable work on the medical history of Ghana is David Scott's *Epidemic Disease in Ghana, 1901-1960.*[63] It deals with nothing else but a history of epidemic disease

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[60] Amenumey, *Ghana: A Concise History,* p. 181.

[61] David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* (Los Angeles: Crossroad Press, 1981). In this work he focused on infectious diseases and the changes in the epidemiological environment which confronted the Gold Coast in the period that the work covers.

[62] David K. Patterson, "The Influenza Epidemic of 1918-1919 in the Gold Coast", *Journal of African History* Cambridge, Vol. 24, No. 4 (1983); pp. 485-502.

[63] David Scott, *Epidemic Disease in Ghana, 1901-1960,* (London: Oxford University Press, 1965). David Scott, an epidemiologist, whose work surveys outbreak of plagues, fever, small

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on the Gold Coast. This work is useful to the present study since it concerns aspect of the public health history of Ghana.

Also, Raymond E. Dumett's work, "The Campaign Against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910"[64] deals with malaria and the epidemiological measures taken by the colonial government to eradicate it in British West Africa. A more recent work on the medical history of Ghana is the work of Stephen Addae titled, *Medical Histories from Primitive to Modern Medicine, 1850-2000.*[65] Addae systematically presents the history of "modern medical services" in the Gold Coast and also during the immediate post-independence years of Ghana. The work is very detailed and informative on the health history of colonial Ghana. Some aspects of colonial public health and sanitation measures executed by the colonial government are dispersed throughout the work. However, Stephen Addae's work does not discuss the various health policies that were promulgated and their mode of implementation at the provincial and district levels.

The Public Records and Archives Administration Department in Cape Coast has abundance of documents on the subject of colonial health and sanitation policies. For instance, there are documents whose contents deal with issues such as residential segregation,[66] water supply,[67] medical officers of

pox, cerebrospinal meningitis, relapsing fever, trypanosomiasis and influenza describes medical countermeasures in Ghana.

[64] Raymond E. Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", *African Historical Studies*, Vol. 1, No. 2 (1968), pp. 153-197.

[65] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 3.

[66] PRAAD, Cape Coast, ADM 23/ 1/ 276 (1916-47) Segregation Area- Saltpond.

[67] PRAAD, Cape Coast, ADM 23/ 1/ 2232 (1922-24), Water supply. Also, see PRAAD, Cape Coast, ADM 23/ 1/ 2284 (1924-25) Water Supply; PRAAD, Cape Coast, ADM 23/ 1/ 2361 (1926-31) Cape Coast Water Works.

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health,[68] construction of hospitals and dispensaries,[69] local health practitioners,[70] drilling of wells,[71] leprosy,[72] yellow fever,[73] trypanosomiasis,[74] small pox,[75] and malaria.[76] These and many more of the documents in the archives have been harvested for the present study.

This thesis, "Colonial Public Health and Sanitation Policies in the Central Province of the Gold Coast, 1874-1957" will, thus, fill some of the glaring gaps created by some unanswered questions in the literature on the health and medical history of the Gold Coast in general and the Central Province in particular. This thesis, interrogates the matter of public health and sanitation in a colonial setting. The concept of public health and sanitation policies, as used in this work, refers to all forms of frameworks, philosophical ideas, plans, orders, directions, strategies, enacted laws and bye-laws and their mode of implementation to ensure reasonably good health of the people by considering the clinical, social and environmental dimensions of health. In addition to being interested in these forms of practices and ways to ensure a reasonably good health of the people, the thesis also looks at the clinical dimension of health promotion. The clinical aspect of public health policy concerns the provision

[68] PRAAD, Cape Coast, ADM 23/ 1/275 (1916-37) Medical Officers as District Commissioners- Appointed.
[69] PRAAD, Cape Coast, ADM 23/ 1/ 1093 (22/7/1943- 23/12/ 1943) Hospitals- Central Province. Also see PRAAD, Cape Coast, ADM 23/ 1/ 1619 (1927-49) African Hospitals; PRAAD, Cape Coast, ADM 23/ 1/ 2059 (1914-15) Hospital- Cape Coast Native Hospital and Dispensary Dresses Quarters.
[70] PRAAD, Cape Coast, ADM 23/ 1/411 (1922-47) Native Medicine- Practitioners and Licenses. Native Doctors.
[71] PRAAD, Cape Coast, ADM 23/ 1/ 2179 (12/3/1919- 30/10/ 19) Tanks and Wells, also see ADM 23/ 1/ 2225 (13/12/1921- 14/06/1922) Tanks and Wells and Air Motors.
[72] PRAAD, Cape Coast, ADM 23/ 1/ 2993 (12/3/1919- 30/10/1919) Leprosy Control, Ankaful. Also see PRAAD, Cape Coast, ADM 23/ 1/ 4068 (1925-29) Leprosy.
[73] PRAAD, Cape Coast, ADM 23/ 1/ 632 (1926- 45) Yellow Fever Outbreak.
[74] PRAAD, Cape Coast, ADM 23/ 1/ 1805 (21/7/1952- 30/7/52) Trypanosomiasis.
[75] PRAAD, Cape Coast, ADM 23/ 1/ 3785 (1955-56) Small Pox; PRAAD, Cape Coast, ADM 23/ 1/ 176 (1909- 45) Small Pox Infectious Diseases.
[76] PRAAD, Cape Coast, ADM 23/ 1/ 2716 (1945-48) Anti-Malaria Drainage and Control Scheme.

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and availability of health-promoting infrastructure, health officers, medicine for both preventive and curative purposes and vaccination programmes all constitute the clinical aspect of health. The use of the term "sanitation" comprises all forms of programmes for improving the environment and health.[77] The sanitary dimension of public health looks at the environmental aspect of health promotion among the people in the Province.[78] Attention has been given to the provision of drainage and sewer systems, public latrines, markets, water supply systems, specifications on the layout of settlements and the environmental aspect of prevention of transmissible diseases. Health education programmes that also aimed at sensitizing the people on personal and environmental hygiene as part of the colonial public health policies are also discussed in this work.

Objectives of the study

This thesis, "Colonial Public Health and Sanitation Policies in the Central Province of the Gold Coast, 1874 -1957," sets out to fulfill certain research objectives. First, analyzes indigenous African medical practices during the pre-colonial period. Second, it systematically examines the underlining reasons for the transfer of the colonial administrative capital of the Gold Coast from Cape Coast to Accra. Third, it examines the influence of the two world wars on the colonial government's health policy direction and implementation. Fourth, it traces the general pattern, features and nature of the colonial public

[77] Lily Pritam Telu Ram, *Environmental Health and Hygiene*, Second Ed. (New Delhi: Vikas Publishing House PVT Ltd., 1993), p. 35.
[78] The environment exerts influence on health conditions in all human societies. The physical, biological, and socio-cultural milieu effects the physiological conditions and behaviour of man, his parasites, and the animal vectors which transmit many infectious diseases. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 1.

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health and sanitation policies that were formulated, pursued and implemented in the Central Province. Last, it highlights the Gold Coast Africans' initiatives and responses to the colonial public health and sanitation policies. Consequently, this thesis offers a rich and textured analysis of the ideas, plans and implementation of laws promulgated with a view to ensuring public health and sanitary environment in the Central Province.

Research Questions

The writing of this thesis was guided by the following research questions:

i. What was the nature of indigenous African medical practices in the pre-colonial period?

ii. What were the underlining reasons for the transfer of the colonial administrative capital of the Gold Coast from Cape Coast to Accra?

iii. To what extent did the two World Wars influence the colonial government's health policy direction and implementation?

iv. What were the general features, pattern and nature of the colonial public health and sanitation policies that were formulated, pursued and implemented in the Central Province of the Gold Coast?

v. What were the Gold Coast Africans' initiatives and responses to the colonial public health and sanitation policies from1874 to 1957?

Methodology and Sources

The thesis benefited from the qualitative method of historical research. Qualitative method is used here to mean an inquiry process of understanding based on distinct methodological traditions of inquiry that explores a social or

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human problem. The approach allows the researcher to build a complex holistic picture, analyses words, reports, detailed views of informants and conducts the study in a natural way.[79] Thus, data relevant to the study was collected, critically examined and analyzed, interpretations and conclusions presented in a descriptive and narrative approach in a historical context.

The study utilized documents from the Public Records and Archives Administration Department (PRAAD) of Ghana from Accra, Cape Coast, Sekondi-Takoradi and Kumasi. In Cape Coast, archival data were collected from files, such as ADM 23, whose contents are related to public health and sanitation issues. In Accra, information was derived from relevant files such as those on the annual *Medical Reports, Sanitation and Medical Facilities in the Gold Coast* and *Government of Gold Coast Annual Departmental Reports*. Useful information under ADM 5 and CSO files were used. In Kumasi, archival data were sourced from files on Health Week- Kumasi, *Quinine Distribution Scheme and Plague at Cape Coast Appearance in Kumasi*. Useful information under ARG 1 was used. In Sekondi-Takoradi information on Red Cross Society from the WRG 8 file was used. Most of the archival materials were from the diaries of the Provincial and District Commissioners, the correspondence of the Provincial and District Medical Officers of Health in the Central Province as well as the monthly and annual reports, especially, those that centered on health and sanitation.

Another primary source used in this study is newspaper reports. References were made to the *Gold Coast Independence, Gold Coast Leader* and

[79] For further reading on qualitative method see Hinneh Kusi, *Doing Qualitative Research: A Guide for Researchers* (Accra: Emmong Press, 2012), p. 1.

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Gold Coast News. Some of the publications in these newspapers deal with issues of public health and some sanitation in the Central Province in particular and the Gold Coast in general.

In order to obtain information on indigenous medicine and medical practices, oral interviews were conducted between the months of December, 2017 and February, 2018. Some of the interviews were done on phone. The people interviewed included herbal practitioners, bone setters, dealers in indigenous and traditional medicine. The sampling procedure was done randomly.

There were some challenges that were faced in the quest for oral information on the study. For instance, some of the informants declined to be interviewed. Other respondents provided a lot of information but very little of that information was relevant to the study. These oral interviews, together with information that were collected from the archives, were critically analyzed and used for the study. This enabled the researcher to straighten out some facts and eliminate some distortions, inaccuracies in chronology and exaggerations which are some of the shortcomings associated with oral tradition.

Secondary sources were also employed in the writing of this thesis on public health and sanitation policies in the Central Province of the Gold Coast. Important secondary sources were utilized in order to analyze the views and conclusions of other studies related to the study. The account of the early European writers on Gold Coast especially those on towns that constituted the Central Province were consulted. In addition, important and germane documented anthropological and ethnographic investigations about the Central Province were used in this study. These materials are deposited in major

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libraries that include the Balme Library of the University of Ghana, Institute of African Studies Library of the University of Ghana, the Sam Jonah Library of University of Cape Coast and the Medical School Library of the University of Cape Coast.

The study also used internet sources. Different search engines were used to assess websites that gave relevant and useful data related to the study. Unpublished thesis from libraries at the University of Cape Coast and Ghana were used.

Significance of the Study

The study complements the already existing literature on the Gold Coast by introducing a new dimension to the study of colonialism in the country. This thesis is a source of information on the history of colonial public health and sanitation policies that were formulated and implemented in the Gold Coast especially in the Central Province.

The thesis can be consulted by policy makers, especially, the Public Health Unit of the Ministry of Health, to adopt some of the practical past policies that this study underscores so to help in the formulation and implementation of new policies that will help solve some of the prevailing health and sanitation problems in Ghana. Policy-makers should also note that global events can have direct impact on government's public health and sanitation policies.

Students of diverse academic fields, such as Indigenous Medicine, Population and Health, Water and Sanitation, Public Health and History may also find this thesis as a useful reference material.

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This thesis will serve as a reference guide to students who will like to study the impact of colonialism on health and sanitation in the Central Province in particular and the Gold Coast in general. Also, the impact of colonialism on indigenous medicine and medical system in Ghana.

Finally, future researchers can use the models used in writing this work to study how colonial public health and sanitation policies were formulated, pursued and implemented in other provinces and territories in the Gold Coast.

Organization of the work

This thesis is divided into seven main chapters. Chapter one is the introductory section. It covers the background to the study, statement of the problem, literature review, objectives of the study, research questions, methodology and sources, significance of the study and the organization of the thesis.

Chapter two examines and highlights indigenous African conceptions about the causes of ill-health and diseases, medicine, healing cosmologies and practices as well as the training of indigenous medical practitioners in Africa. Thus, this chapter provides an understanding of indigenous African medicinal practices before colonization.

Chapter three discusses colonial public health and sanitation policies in the Gold Coast between 1874 and 1918. The chapter deals with themes like the health status of the Gold Coast colony at the time of colonial rule and the agencies and institutions that were established to enforce the health and sanitation policies during the early years of colonial rule.

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Chapter four examines the colonial public health and sanitation policies that were pursued during the inter-war period, that is, 1919 to 1939. It discusses the form of health education that was employed in the creation of awareness about diseases and how to prevent them. The chapter underscores Gold Coasters' initiatives and responses to the colonial public health and sanitation policies.

Chapter five interrogates the colonial public health and sanitation policies between 1939 and 1957. The chapter highlights the war time health and sanitation policies. Also, the systematic education and training programmes that the colonial government rolled out for the people of the Gold Coast to prepare them to take up the management of their own health and sanitation issues after independence are examined in this chapter. The public health and sanitation policies that were pursued under the leadership of Kwame Nkrumah from 1951 to 1957 are also discussed in this chapter.

Chapter six evaluates the public health and sanitation policies for the whole colonial period by offering a survey of the general pattern and features of public health and sanitation policies to prove how efficient the policies were. It also analyses the colonial policies that drew the people of the Gold Coast towards their indigenous medical systems. The chapter also shows how public health and sanitation programmes were financed. This chapter further discusses some of the factors that hindered the implementation of the public health and sanitation policies.

Chapter seven is the conclusion of the study. This chapter summarizes the findings of the thesis. The recommendations of the work also fall within this chapter.

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CHAPTER TWO

INDIGENOUS AFRICAN MEDICAL PRACTICES IN THE PRE-COLONIAL PERIOD

As the nest so is the bird and as the ideally one so is his environment.[1]

Introduction

Throughout history, human beings have endeavoured to find ways to combat diseases as well as create antidote to death. Death is an inevitable part of life and so no individual or a community as a whole embraced it. Aside natural disasters that may cause mass destructions of lives and properties, ill-health, in most cases, produces death. Societies and cultures all over the world attempted to seek solutions or developed answers to crucial health care issues and questions. The practice and methods adopted to deal with health care issues emanate from specific cultural setting, prevailing endogenous conditions and historical experiences of each society.[2] This means that knowledge about medicine and health care needs of a particular group of people evolved within the people's culture and their "indigenous knowledge systems."[3] Since medicine and health care needs are culturally based, the sickness, 'dis-ease' and malady that a person suffers, and the kind of health care system that a people

[1] An Akan proverb which means that all things being equal, everything in life is determined by one's environment. And that one cannot give out what is absent of one's environment.

[2] De-Valera N. Y. M. Botchway, "Note on the Ethnomedical Universe of the Asante, an Indigenous People of Ghana", Effie Gemi-Iordanou, Stephen Gordon et. al. (eds.), *Medicine, Healing and Performance*, (New York: Oxbow Books, 2014), pp. 160-176.

[3] The term Indigenous Knowledge System is the complex set of knowledge, skills and technologies existing and developed around specific conditions of populations and communities indigenous to a particular geographical area. For further readings on indigenous knowledge systems. See D.D. Kuupole & De-Valera N.Y.M. Botchway (eds.) *Polishing the Pearls of Ancient Wisdom: Exploring the Relevance of Endogenous African Knowledge Systems for Sustainable Development in Postcolonial Africa,* (Cape Coast: University of Cape Coast Press, 2010), pp. 4-6 and Isaac Sindiga, Nyaigotti-Chacha Chacha & Mary Peter Kanunah, (eds.), *Traditional Medicine in Africa*, (Nairobi: East African Educational Publishers Ltd., 1995), p. 17.

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would resort to, depend upon socio-cultural, psychological, and biological factors.[4]

Indigenous African medical systems were operating long before African contact with European and Arab cultural imperialism. However, the experience of colonization, political, economic and socio-cultural factors, coupled with existing epistemological and ontological differences, have influenced the present difference between indigenous African medical systems and western medicine in Africa.[5] The increasing use of western scientific medicine and health care in postcolonial Africa is eroding the history, origin and the use of indigenous African medicines.

Ideas and practices relating to health, sickness and healing across the African continent have evolved over millennia in many local, regional and broader constellations.[6] In fact, what is commonly known of pre-colonial indigenous African medicine and medical systems comes from Khmetic (Ancient Egypt) sources.[7] The art and science of medicine, healing and care for

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[4] Botchway, "Note on the Ethnomedical Universe of the Asante," p. 160.

[5] The use of western medicine or the so-called 'modern medicine' and indigenous medicine in reference to European and indigenous African medicine respectively in this work does not purport that the so-called indigenous medicine is not modern or it is static. The fact is that all medicine is modern despite the setting in time, place and culture. The usage of the term is only to distinguish between purely indigenous African medicine and exotic ones. Melvin, O. Agunbiade, "Spirituality in Knowledge and the Practice of Traditional Herbal Medicine among the Yoruba People in Southwest Nigeria", Effie Gemi-Iordanou, Stephen Gordon et. al. (eds.), *Medicine, Healing and Performance*, (New York: Oxbow Books, 2014), pp. 177-191, p. 176. See also, K. Konadu, *Indigenous Medicine and Knowledge in African Society*, (New York: Routledge Publishers, 2007), p. 11.

[6] John Middleton & Joseph C. Miller, *New Encyclopedia of Africa.* Vol. 1, (New York: Charles Scribner's Sons, 2008), p. 523.

[7] Ebers papyrus and Smith papyrus are some of the ancient Egyptian source of medical practice in African. Both were assembled around 1600 BC. The Ebers text is a compilation from many sources and the Smith text is probably a copy of a text written about 2500 BC. The impact and contribution of Egyptian medical knowledge is so great. Many of the founders of the ancient Greek schools of medicine owned their learning to the Egyptians. Even Hippocrates, the so-called Western Father of Medicine, whose writings mentioned over 250 medical plants, known to Egyptian medicine, is said to have benefited from the ideas and knowledge of Egyptian priest-doctors. See Samuel Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health,* (Accra: Page links Publishers, 2005), pp. 106-107; Paul Tiyamba Zeleza & Dickson Eyoh (eds.), *Encyclopedia of Twentieth- Century African History,* (London

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the sick obviously has a long tradition dating back to early studied civilizations like Khmet, Mesopotamia, India and China. What is known of the medicine of Khmet comes principally from two fragments of writing, the Ebers papyrus and the Smith papyrus, both discovered in Egypt through archaeological research.[8]

However, there was a dearth of information on indigenous African medical systems which were, and are, commonly practiced among other Africans in the pre-colonial era until very recently. It is against this background that this chapter seeks to discuss indigenous African medicine and health care practices in the Gold Coast in the pre-colonial era. To attain this objective, the chapter would be developed around four themes namely African philosophy on the causes of ill-health, indigenous African medicine and methods of healing, a call to social services: a training of African medical practitioners and, lastly, indigenous African medicine on the eve of colonization, with the Gold Coast as the case study.

African Philosophy on the Causes of Ill-Health and Diseases

With the advent of the western "germ theory" in the late nineteenth century came the "growing conviction" of the unique rationality and supposed superior efficacy of western medicine.[9] This does not mean until the nineteenth century, nowhere in the world had people conceived the causes of diseases.

& New York: Routledge of Tylor & Francis group, 2003), p. 259 and Busia Kofi, *Fundamentals of Herbal Medicine* (London: Xlibris Publishers, 2016), pp. 1-5.

[8] Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, pp. 105-107.

[9] The germ theory began to take root in Europe and America from 1870s. David Arnold, (eds.), *Imperial Medicine and Indigenous Societies,* (Manchester: Manchester University Press, 1988), pp. 12-18. See also Stephen Addae, *History of Western Medicine in Ghana, 1880-1960,* (Edinburgh: Durham Academic Press, 1997), p. 19 and Juanita De Barros & Sean Stilwell "Introduction: Public Health and the Imperial Project", *Colonialism and Health in the Tropics,* Vol. 49, No. 4 (Caribbean Quarterly: Taylor & Francis, Ltd., 2003), pp. 1-11, p. 3.

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People all over the world had and, still have, their own world view on the causes of ill-health. The knowledge and understanding about the causes of diseases and ill-health in the Gold Coast, where various ethnic groups lived, were culturally defined, and hence, depended on the medical system of the people. A medical system is the patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention and the treatment of sickness.[10] Medical systems may be viewed as the indigenous practices and beliefs related to diseases of a people. Therefore, each medical system has its own unique features and attributes and often tells the world view of the people and society that has it. There are some commonalities and universal attributes among the diverse medical systems in the world. A medical system, therefore, includes but not limited to concept of disease causation, nosology, prophylaxis, therapy-seeking and therapy-selecting behaviour, therapy management and choice, range of practitioners, practitioner and specializations. Also, how a social setting makes it possible and available for the sick and ill-health person to see the practitioners and vice versa. Furthermore, diagnoses of health problems and therapy procedures and drugs or other pharmacopeia also forms part of the medical system of a people.[11]

The medical system of a people reflects on the culture, social pattern and experiences of the community that has it. Each society's idea of illness is to be understood within the context of its beliefs and culture.[12] To the African, health behaviour involves not only single individuals but persons interacting with one another and with the environment. Although the climatic pattern plays a major

[10] Sindiga et al. (eds.), *Traditional Medicine in Africa,* p. 17.
[11] *Ibid.*
[12] P. A Twumasi., *Social Foundations of the Interplay between Traditional and Modern Medical Systems,* (Accra: Ghana University Press, 1988), p. 2.

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role in determining the ecology and habitat of disease vectors in Africa,[13] indigenous African societies did not pay much attention to the climatic and geographical aspect of the causation of ill-health and diseases.[14] According to E. Evans-Anfom, Africans attributed the causes of diseases to mainly natural and supernatural factors. The believe in the physical and supernatural role in disease causation is a common thought among Africans. He explained that diseases were commonly attributed to factors such as,

> [a]ngry deities who punish wrongdoers, e.g. those who violate taboos; ancestors and other ghosts who feel they have been too soon forgotten or otherwise not recognized; sorcerers and witches, working for hire or for personal reasons; loss of the soul following a bad fright that jars it loose from the body or as the consequence of the work of a sorcerer or supernatural spirit; spirit possession, or the intrusion of an object into the body; loss of the basic body equilibrium usually because of the entry of excessive heat or cold into the body and the evil eye.[15]

From Evans-Anfom's observation, it is evident, as John Mbiti has also confirmed, that the ill-will or ill-action of one person against another, normally through the agency of witchcraft, sorcery, "evil eye" or "bad words" (curses) and magic, also caused disease.[16] Disease is not just a physical condition,

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[13] For one of the earliest works on climatic factors as causes of diseases in West Africa see James A. B. Horton, *Physical and Medical Climate and Meteorology of the West Coast of Africa,* (Edinburgh: Frank Cass Publishers, 1867). In this work, he described diseases associated with harmattan or cold season. He also described the climatic symptoms of haemoglobinopathy. See also William Bosman, *A New and Accurate Description of the Coast of Guinea Divided into the Gold, the Slave, and the Ivory Coasts,* (London: The Ballantyne Press, 1907), p. 108.

[14] Temperature, rainfall and humidity determine the geographical distribution of vectors and diseases. See John Middleton & Joseph C. Miller, *New Encyclopedia of Africa*, p. 106.

[15] E. Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects,* (Accra: Academy of Art and Sciences, 1986), pp. 14-15.

[16]John S. Mbiti, *African Religions and Philosophy*, Second Edition, (New York: Heinemann Educational Publishers, 1989), p. 165. For further readings on the role of mystical power, magic, witchcraft and sorcery in causing ill-health see pp. 189-198. There are two categories of magical beliefs, practices and functions. They are good and bad magic. It is when used maliciously that this mystical power is condemned as bad magic, "evil magic" or "sorcery." It must be pointed out here that there is the belief among various African communities that the lesser gods could cause diseases and calamities to befall a community. For supernatural causes of diseases perceived by Africans see Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems*

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according to African interpretation and experience. It is also a religious matter and, therefore, to deal with diseases and ill-health, people revert to religious practices which is the inexplicit part of medicine.[17] The practice of medicine is closely associated with the practice of religion in Africa. The practice of medicine is considered a divine gift of the Supreme Being and is dispensed through the agency of the divinities.[18] Thus, within the context of indigenous African worldview, diseases and misfortunes are seen as spiritual experiences and they require a spiritual approach to deal with them.[19] Thus, the universal principle among Africans that whatever evils afflict men are produced by supernatural means, and can only be counteracted or removed by supernatural agency.[20] The physiological interpretation and treatment of disease also existed in Africa. Although to the disciple of the western scientific tradition, or the positivist, this relationship between the causes and the effect may not be logical, spiritual remedies were employed to resolve such diseases.

and Prospects, pp. 14-15; John Beecham, *Ashanti and the Gold Coast,* (London: Photolithography Unwin Brothers Ltd., 1968 [1841]), p. 198-99; Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, p. 185; Kofi Asare Opoku, *West African Traditional Religion,* (Accra: FEP International Private Ltd., 1978), pp. 140-141; T.N.O. Quarcoopome, *West African Traditional Religion*, (Ibadan: African University Press, 1987); E. G. Parrinder, *West African Religion*, (London: SPCK, 1962) and Forshaw Roger, "Before Hippocrates: Healing Practices in Ancient Egypt", Effie Gemi-Iordanou, Stephen Gordon et. al. (eds.), *Medicine, Healing and Performance,* (New York: Oxbow Books, 2014), pp. 25-41, p. 26.

[17]This is why communal health rituals are carried out when there is an epidemic. Interview with Sofomaame Efua Comfort Eshun, Traditional priest and herbalist, aged 61 years, on 12th February, 2018 at, house number A36/4 Idan, Cape Coast. Also see Mbiti, *Introduction to African Religion*, p. 135 and Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, pp. 14-15.

[18] Interview with Sofomaame Efua Comfort Eshun, aged 61 years. See also Opoku, *West African Traditional Religion*, p. 149.

[19] Mbiti, *African Religions and Philosophy*, p. 165 and p. 195. For further readings on the characteristics of witches and wizards and their role in causing ill-health, see Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, pp. 36-39 and E.E. Evans-Pritchard, *Witchcraft, Oracle and Magic among the Azande,* (Oxford: Oxford University Press, 1937).

[20] Beecham, *Ashanti and the Gold Coast,* p. 190.

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Members of African families, understood their intricate interdependence on their fellow relatives. Therefore, a breach of their relations threatened almost the very survival of the social unit, so health and illness became the means for detecting threats to the social unity of the group and for reestablishing the harmony of the group.[21] There existed the view that the external and internal (the ancestral and physical respectively) worlds of a human being shared the same principles and good health required for equilibrium of the physical and spiritual realms. Thus, good health as well as ill-health were concerns of both the individual and the community. Thus, within such environment was the individual conscious of himself or herself emanated from a social philosophy that said "I am because we are, and since we are, therefore I am."[22]

The idea that there must be complete harmony between the physical and spiritual part of the human being is basic to African thought. Africans believed that either part, when damaged, will have some effect on the other. In cases of illness, for example, attention is not paid exclusively to the physiological aspects but to the spiritual dimensions as well. Hence, good health and well-being can only be attained when both the body and spirit are taken care of and are in harmony.[23] It is worth mentioning here that the African knew and could distinguished between the physiological and spiritual aspects of diseases and therefore employed physical or spiritual remedies or both to treat ill-health. On the physiological courses of diseases perceived by Africans, a critical look at

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[21] In Africa, a person's membership of a community is emphasized more than his or her individuality. Therefore, to be human is to belong to the whole community. For instance, among the Akan of Ghana, disease is viewed as a social phenomenon attacking the whole community and its cure requires a communal effort. See Kassahun Checole, "Man Cures, God Heals", pp. 126-139; Twumasi, *Medical System in Ghana: A Study in Medical Sociology*, p. 40 and Opoku, *West African Traditional Religion*, p. 11.
[22] Mbiti, *African Religions and Philosophy*, p. 209.
[23] Opoku, *West African Traditional Religion*, p. 91.

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some of the plants used to treat diseases seems to suggest that many of them were chosen not only for their spiritual and symbolic significance, but also for their perceived "pharmacological" effects. In writing on the medical practices of the indigenous people of the Gold Coast in the seventeenth century, William Bosman ascertained the fact that wounds and other ill-health were treated with green herbs which were very effective in curing the people.[24] In cases of bodily affliction, a medical preparation is ordered for the patient by the healer or anyone who has assiduously studied the healing art and science and acquired such a knowledge of the properties of herbs and plants as enables one to effect the cure of many complaints.[25] Spiritual rites are also performed to engage the deities and spirits to assist in the healing process. Therefore, to the African, diseases and illness are caused by natural or physical and the supernatural means.

Ill-health could be caused by a break in or a disharmony between the physical body and the spiritual part of the human or the human and the spirit world that guides the community. For instance, when a taboo is broken, it is believed that it can disturb the harmony between the spirit and the physical world. Therefore, a possible outbreak of ill-health among the human society could occur through a visitation from the spirit world. Hence, the pre-colonial indigenous African meaning of health was complex and holistic. The definition of health by the World Health Organization (WHO) is similar to that holistic

[24] William Bosman, *A New and Accurate Description of the Coast of Guinea Divided into the Gold, the Slave, and the Ivory Coasts,* (London: The Ballantyne Press, 1907), p. 110 and 225. He pointed out that the African consulted the priest in times of some ill-health deemed to be caused by supernatural agents, but at the same time when some of the ill-health were by physical means like cuts or wounds, the people resorted to physical means like the use of herbs for treatment.

[25] Busia, *Fundamentals of Herbal Medicine*, p. 5 and Beecham, *Ashanti and the Gold Coast,* p. 204.

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understanding of health by the Africans. The WHO affirms that: "Health is not merely the absence of disease or infirmity…Health is the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[26] Moreover, health was a communal affair and not an individual one in the African view. What is missing in the WHO definition is that it does not capture religion as explicitly as the indigenous African tradition does.

Indigenous African Medicine, Healing Cosmologies and Practices

Medicine, healing and performance of medicine by a given people are based on the people's medical systems. The African medical system is a system of interrelated set of values, norms, attitudes and deliberate practices governed by a single paradigm of meaning, identification, mode of prevention and treatment of diseases which are often based on culture and ties with cosmology of a society.[27] According to WHO, indigenous African medicine is the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental and social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing.[28] It could be inferred

[26] The preamble to the constitution of the World Health Organization, as adopted by the International Health Conference, New York, 19 -22nd June 1946, and signed on 22nd July, 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100). World Health Organization, "General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine", 2000, http://whqlibdoe.whoint/hp2000/WHO-EDM-IRM-2000.Pdf Retrieved on 24th February, 2018. See also Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, p. 3.
[27] Twumasi, *Social Foundations of the Interplay between Traditional and Modern Medical Systems*, p. 6.
[28] This definition was agreed on at the World Health Organization sub-region of Africa meeting in Brazzaville in 1976. World Health Organization, "National Policy on Traditional Medicine and Regulation of Herbal Medicines"- Report of a WHO Global Survey. Http// apps.who.int/medicine. Does/enldjs916e/9/1.html Retrieved on 24th February, 2018. See also Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, pp. 11-12; Sindiga et al. (eds.), *Traditional Medicine in Africa*, p. 19. For similar definition of traditional medicine see Melvin Agunbiade O., "Spirituality in Knowledge and the Practice of Traditional

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from this definition that indigenous African medicine has been used from time immemorial and the medicine both the explicit and inexplicit parts guarded against diseases and cured people. Indigenous medicine is, therefore, closely bound to and integrated with longstanding culture and cosmology and customary knowledge, beliefs and practice of the African society that had it and is passed on from generation to generation through speech, observation, drum language and writing.

The explicit part of medicine is the simplified, observable and the direct application of plant, animal or mineral materials for healing purposes and which can be investigated, rationalized and explained scientifically.[29] Thus, the use of any physical material medica in the treatment of diseases is the demonstration of both the explicit and the physiological dimension of the African philosophy of disease causation and treatment. Although there is currently uncertainty about when Africans begun to use herbal medicine and how they acquired the knowledge, one of the early explanations for the human acquisition of herbal knowledge is the systematic collection of plant materials through careful observation of the environment and harmonious interaction with nature for the treatment of ailments.[30] The regular use of it enhances practitioners' skillfulness in the use of plants for medicinal purposes over time backed by the spiritual

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Herbal Medicine among the Yoruba People in Southwest Nigeria", Effie Gemi-Iordanou, Stephen Gordon et. al. (eds.), *Medicine, Healing and Performance,* (New York: Oxbow Books, 2014), pp. 177-191, p. 176 and Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, p. 112.

[29] The use of *Salix alba,* the willow plant containing the salicylates for the cure of fever and pains which led to the discovery of aspirin is an example of the explicit part of traditional medicine. Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, p. 13.

[30] Agunbiade, "Spirituality in Knowledge and the Practice of Traditional Herbal Medicine among the Yoruba People in Southwest Nigeria", p. 178.

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guidance of ancestors and the deities.[31] Traditional medicine and therapeutic practices in general have their roots in ancient times and the systems and practices vary according to geography and culture.[32]

There are many rites of spiritual significance that are performed to ensure good health, healing, preventing danger to health, removing impurities in people and homesteads, and protecting people from evil spirits and misfortunes.[33] Even the indigenous African medical system of Khmet, emanated from and operated with empirical knowledge and magical actions. They were equally valid parts of a complex cultural system and the healer seems unlikely to have actively distinguished between them when treating a sick member of the community.[34] This is common to all other indigenous ethnicities in Africa. The indigenous African medical practitioners were also priests and practiced strictly according to the rules of their sacred books written by some earlier priests.[35] In most cases, when it comes to diagnosing diseases, the professional medical practitioner uses divination to enquire from higher spiritual forces about the causes of diseases. A diviner may do so by:

> [i]nterpreting the movements of a small metal ring hung on a thread and dangled before the patient; interpreting the positions in which cowrie

[31] Interview with Pastor Francis Christian, 49 years of age owner of Aumabg Herbal Treatment Centre, Cape Coast. Interview at Debekus Wood Ventures, Apewosika, Cape Coast on 27th January, 2018. He had knowledge about indigenous medicine through possession by a deity and when he is in trance, hence, no one taught him or passed the knowledge on herbs to him. His constant use of herbs helped him gain full knowledge of the medicinal properties of herbs. See also Agunbiade, "Spirituality in Knowledge and the Practice of Traditional Herbal Medicine among the Yoruba People in Southwest Nigeria", p. 178.
[32] Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, p. viii. See also Agunbiade, "Spirituality in Knowledge and the Practice of Traditional Herbal Medicine among the Yoruba People in Southwest Nigeria", p. 176.
[33] Interview with Dewood Yorke, aged 67 years, owner of Kaabiwe Herbal Centre, on 14th February, 2018 at Wangara Line, Kotokuraba road, opposite Aburaa Taxi station, Cape Coast. Also Interview with Sofomaame Efua Comfort Eshun, aged 61 years. See also Mbiti, *Introduction to African Religion*, p. 135.
[34] Roger, "Before Hippocrates: Healing Practices in Ancient Egypt", p. 25.
[35] Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, p. 3.

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> shells thrown randomly on the ground fall; examining the marks left on sand by an animal attracted by a bait; interpretation of the gestures or utterances made by possessed person in a trance; water gazing, in which the diviner communicates with the appropriate spirit whose image he sees reflected in a pot of water.[36]

From the above, it can be inferred that divination is sometimes supposed to make it possible for the practitioner to know which remedy to apply and to predict the cause of the illness. Hence, divination is at the same time a diagnostic, therapeutic and prognostic tool in the African medical system.[37] Obviously, some of the activities involved in dealing with illness may not have any overt value, but they are psychologically vital and no doubt play a vital role in healing the sick or helping the sufferer.[38] Divination was, and is used, perhaps, due to the psychological benefits of it on individuals that was why seers and oracles of Khmet were regularly consulted by the people who had problems including those pertaining to health and diseases.[39] There is a placebo effect with the use of divination in healing and treatment process in Africa. In any case, the healer makes time and also pays attention to the patient, which enables the practitioner to penetrate deep into the psychological state of the individual patient.

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[36] *Ibid.,* p. 16.

[37] For works that examine means of diagnosing diseases through divination see J. Abbink, "Reading the Entrails: Analysis of an African Divination Discourse," *Man*. Vol. 28, No. 4 (1993), pp. 705-726; J. P. Kiernan, "The Truth Revealed or the Truth Assembled: Reconsidering the Role of the African Diviner in Religion and Society," *Journal for the Study of Religion*. Vol. 8, No. 2 (1995), pp.3-21; Benjamin Kankpeyeng et al., "Insights into Past Ritual Practice at Yikpabongo, Northern Region, Ghana," *The African Archaeological Review*, Vol. 30, No. 4 (2013), pp. 475-499 and Knut Graw, "Beyond Expertise: Reflections on Specialist Agency and the Autonomy of the Divinatory Ritual Process," *Journal of the International African Institute*, Vol. 79, No. 1, (2009), pp. 92-109.

[38] Mbiti, *African Religions and Philosophy*, p. 165.

[39] This practice is not peculiar only to Khmet, but a whole customary health practice among most African communities. Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, p. 2. For earliest work that describe how divination and consultation of medical practitioners were done in pre-colonial Gold Coast, see Beecham, *Ashanti and the Gold Coast,* pp. 196-197.

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Magic could also be used in the treatment of diseases, in counteracting misfortunes, and in warding off or diluting evil power or witchcraft. The healer also purges witches, detects sorcery, and removes curses and control the spirit that causes the illness of the patients.[40] Thus, in indigenous African life, healing is performed through a holistic method and the utilization of magico-religious elements, ingredients and social concepts. It is because of the emphasis on the supernatural causes of disease that is indigenous African medicine tends to concern itself more with why illness strikes than how the disease process acts on the body. In other words, the magico-religious aspect of disease is reckoned to be more important than the pathological dimension.[41]

Medical practices also include knowledge and beliefs regarding the relationship between food and health, hygiene and health, physical acts and spiritual rites of a preventive and curative nature as well as the use of home remedies obtained from vegetables, animals and minerals for common ailments.[42] In writing on pre-colonial Ashanti and Gold Coast, John Beecham observed that in cases of bodily affliction, a medical preparation was ordered for the patient by the priest and priestesses who apply themselves assiduously to the study of the healing art, and acquired such knowledge of the properties of herbs and plants as enables them to effect the cure of many complaints.[43] One advantage of indigenous African medicine is that most of the herbal and other

[40] This was confirmed in an interview with Pastor Francis Christian, 49 years of age owner of Aumabg Herbal Treatment Centre, Cape Coast and also with Nana Clement Asamoah, aged 93 years, herbalist and bone setter at Wassa Asikuma.
[41] Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, p. 14. See also Botchway, "Note on the Ethnomedical Universe of the Asante," p. 169; Twumasi, *Medical System in Ghana: A Study in Medical Sociology*, p. 9 and Roger, "Before Hippocrates: Healing Practices in Ancient Egypt", p. 26.
[42] Botchway, "Note on the Ethnomedical Universe of the Asante," p. 171. See also Beecham, *Ashanti and the Gold Coast,* p. 204.
[43] Beecham, *Ashanti and the Gold Coast*, p. 204.

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remedies used are found in the community. The medicine could be obtained from natural things like bones, seeds, roots, juices, leaves, liquid, minerals, blood, milk and charcoal and in dealing with the patient, the healer may apply massages, needles or thorns and may bleed the patient. The healer may jump over the patient, use incantations and ventriloquism and may ask the patient to perform various sacrifices like offering a chicken or goat, observing some taboos or avoiding certain foods and persons.[44] The use of herbs and materials from plants feature prominently in indigenous medicine to the extent that indigenous medicine may be synonymous with herbalism and so all medical practitioners seen as herbalists.[45] The plant material medica are prepared in various ways such as teas, concoctions, poultices, cold or warm baths, tampons, enemas, powders for inoculation through scarifications or oral ingestion or sniffing, ointments, fumigant among others.[46]

Not all health conditions were taken to professional healers. Domestic complains like stomach upsets, headaches, cuts and skin ulcers normally were mostly treated at home with herbs and other medicines generally known to members of the community. This practice is a form of primary health care in the African context because the immediate family members of the ill person

[44] Mbiti, *African Religions and Philosophy*, p. 165. In addition to all the mentioned healing procedures, the healer may give the patient medicine. For works that deals with indigenous African healers see Addae, *Medical Histories from Primitive to Modern Medicine*, p. 13 and Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects,* pp. 14-18.
[45] The herbalist is any person recognized in the society as one who is well versed in the knowledge of herbs and other natural products and their medical uses. The herbalist also deals with supernatural causes of diseases and may indulge in the use of supernatural means in healing. Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects,* p. 17 and Beecham, *Ashanti and the Gold Coast*, p. 204.
[46] Interview with Nana Clement Asamoah, aged 93 years, herbalist and bone setter at Wassa Asikuma. Also, interview with Sofomaame Efua Comfort Eshun, aged 61 years. For works on this subject see Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, p. 17 and M.N.B. Ayiku, *Ghana Herbal Pharmacopoeia,* (Accra: The Advent Press, 1992), p. 5.

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became the "healer-of-first-contact."[47] However, persistent and serious complaints required the knowledge and skills of a professional healer in the community.[48] It is worth mentioning here that the causes of diseases or maladies and the generally unwanted things in the society is the thesis of the society, hence the role of the professional healer was to strive to produce the anti-thesis (counter measures to the causes of the diseases or misfortunes of the society). The counter measures were constantly employed until the individual was physically, spiritually and psychologically healed (synthesis). This practice or method of healing among indigenous Africans is in line with how western allopathic medicine works. For instance, western medicine and medical care may explain the causes of some diseases to be the introduction of parasites into the body of an organism. The pathogen or parasite is fought by introducing an antigen or vaccines that will boost the immune system of the affected organism to produce the required antibodies to fight the pathogen until the patient fully recovers from the illness or sickness. From this argument, it can be concluded that the indigenous African knowledge system of healing patients is scientific for it employs the causes and effect in treatment of diseases and misfortunes.

African medicine is thus, a practice in which there is no conceptual separation between natural and supernatural entities. In the treatment of illness, both the organic and spiritual aspects of the disease are taken into consideration. This is essentially based on the belief that the human being is a compound of

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[47] John Fry, *General practice and Primary Health Care, 1940s -1980s,* (London: The Nuffield Provincial Hospital Trust, 1988), p. 6. John ascertains the fact that there must have been primary health care workers ever since the human race began to live as families and communities. His argument is that so far as nothing seems more basic to the human needs than a "healer-of-first-contact" with some skills and knowledge to which the sick and injured can turn to for assistance and succor.

[48] Mbiti, *Introduction to African Religion*, p. 155

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material and immaterial substances, which makes the maintenance of balance between the spiritual and material in man a condition for sound health.[49] The point here is that healers therefore use a holistic approach in dealing with issues of health and illness. They take into consideration the social, psychological and physical aspects of illness in building their paradigm of social causation theory and at the same time may employ herbal or physical treatment.[50] This explains why healing was, and is, very effective when it comes to mental health.[51] The healing processes ensured holistic remedy of the body and the soul or the spirit. This is done from the endogenous conviction that mind and body, life and death, individual and society, spirit and matter are all interconnected and, therefore, the methods and therapeutic practices in dealing with ill-health encompass natural, spiritual, metaphysical and psychosomatic aspects.[52]

Public health and sanitation measures were also employed in pre-colonial Africa as a measure to control the outbreak of diseases. In pre-colonial Gold Coast for instance, most Akan ethnic groups had their towns originally divided into wards, or "quarters", each with its own "Asafo Company" among whose function was to serve as police in their towns, suppress nuisances in the streets, and to clean the paths and roads in their neighbourhood.[53] In most

[49] Opoku, *West African Traditional Religion*, p. 149.
[50] Twumasi, *Social Foundations of the Interplay between Traditional and Modern Medical Systems,* p. 7. See also Agunbiade, "Spirituality in Knowledge and the Practice of Traditional Herbal Medicine among the Yoruba People in Southwest Nigeria", p. 179; Botchway, "Note on the Ethnomedical Universe of the Asante, an Indigenous People of Ghana", p. 172; Busia, *Fundamentals of Herbal Medicine,* p. 4; Sindiga et al. (eds.), *Traditional Medicine in Africa*, p. 21 and Middleton et al., *New Encyclopedia of Africa*, p. 538.
[51] Paul Tiyamba Zeleza & Dickson Eyoh (eds.), *Encyclopedia of Twentieth Century African History,* (London & New York: Routledge of Tylor & Francis group, 2003), p. 257.
[52] Botchway, "Note on the Ethnomedical Universe of the Asante, an Indigenous People of Ghana", p. 170.
[53] *Asafo* Company was a group of able-bodied young men or youth in a town who were to enforce law and other, go to war and ensure general sanitation and cleanness of their town and communities. *Asafo* Company was responsible for the policing, sanitation and protection of the neighbourhood. They lead in organizing communal labour in their communities. According to Roger S. Gocking, the *asafo* system was most developed among the coastal Fante. Roger S.

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African states, the ward branch of a chiefdom or paramountcy was headed by a headsman or woman who supervised the women who were responsible for cleaning their own houses and the frontage.[54] In this case, Gold Coasters practiced public health before colonization in so far as there is evidence that, there were "organized community efforts aimed at preventing disease and the promoting of health"[55] at various levels of the community.

A call to Social Service: The Training of Indigenous Medical Practitioners in Africa

Aside the general and common medical knowledge among members of a community, there were individuals who acquired skills in medicine in healing specific diseases and ill-health.[56] Such persons had the medical knowledge either by birth (hereditary), training and possession by a deity (calling) or a combination of some of these media. In most African communities, there are

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Gocking, *The History of Ghana*, (London: Greenwood Press, 2005), p. 8. This claim is supported by F. K. Buah. According to F. K. Buah, "At Mankessim, the Fante grouped themselves into different quarters of the town. Each quarter had a leader whom the early Europeans referred to as the Brafo. Each Brafo was responsible for the general welfare of people under his charge, and was the captain of the Asafo company, a military body which also undertook communal work and provided social as well as emergency services." See F. K. Buah, *A History of Ghana* (London: Macmillan Publishers Limited, 1980), p. 15. For the duties and activities of the *Asafo* Company, see Ansu K. Datta and R. Porter, "The Asafo System in Historical Perspective", *The Journal of African History*, Vol. 12, No. 2 (1971), pp. 279-297; David Kimble, *A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1928,* (Oxford: Clarendon Press, 1963), p. 142; David Owusu-Asanah, *Historical Dictionary of Ghana,* Third Ed. (Maryland: The Scarecrow Press, 2005), p. 45; Brodie Cruickshank, *Eighteen Years on the Gold Coast of Africa,* Second Ed., Vol. 1. (London: Frank Cass & Co. Ltd., 1966), pp. 251-254; John Parker, *Making the Town: Ga State and Society in Early Colonial Accra,* (New York: Portsmouth, 1960), pp. 48-49.

[54] Joseph Casely Hayford, *Gold Coast Native Institutions*, New Edition, (London: Frank Cass, 1970 [1903]), p. 110.

[55] The U.S. Academy's Institute of Medicine's definition of Public Health cited in Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health,* p. 136. See also George Rasen, *A History of Public Health* (New York, 1958).

[56] Interview with Mr. Christian Agyemang, aged 68 years, C.E.O of Taabea Herbal products. Interview conducted on 28th December, 2017 at plot 24, Block U, Aputuogya-Bosomtwe, Ashanti Region. Also, Interview with Nana Clement Asamoah, 93 years.

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rules governing how one is "called" to become a medicine-man which are always based on the dictates of the society.

In some African communities where the office of male and female chiefs and priests and priestesses existed, these rulers did not simply hold political positions, as they were called to office to serve as the mystical and religious heads, the divine symbol of their people's health and welfare.[57] This means that some of the occupants of politico-religious positions in African society were as well medical practitioners. The successors to such positions were selected on ethical criteria, which included qualities such as patience, strong faith in special detail and ancestors, courage and love of humankind.[58] The practitioners in the "formal domain" of political power bequeath their politico-religious positions and medical knowledge to younger successors who they choose by themselves or are called by the deities through spirit possession or dreams. This may come when the one being called is still young and unmarried or in his middle or later life.[59] Hence, in such African communities the mode of calling into this social service were hereditary, although the skill and success of healers varied, naturally, from person to person. In other cases, healers passed on the profession to their children or younger relatives through informal training usually by observation.[60] In some societies it was believed that healers possessed special

[57] The individuals who serve on such positions in the society may not have outstanding talents or abilities in dealing with the health needs of the people; however, their office is the link between human rule and spiritual government. Mbiti, *African Religions and Philosophy*, p. 177.
[58] Botchway, "Note on the Ethnomedical Universe of the Asante", p. 170.
[59] The younger and unmarried persons were the ideal candidates for the training into both the politico-religious and medical practice because persons who had engaged in sexual act before been married were deemed unholy and were often rejected by the deities. Interview with Nana Clement Asamoah, aged 93 years herbalist and bone setter at Wassa Asikuma. Interview conducted on 3rd February, 2018 WA/B5 at Asikuma in the Western Region.
[60] Interview with Nana Clement Asamoah, aged 93 years and also Opanyin Franklin Ntim, 65 years old.

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gifts or powers obtained either through birth or eating certain "medicines".[61]

The agents of calling of a trainee of medical practitioners could be broadly grouped into two, thus, the supernatural agents and the human agents. The supernatural agents of the "calling" could be the deities worshiped by the community, who were believed to call people to become healers and so all healing takes place under the guardianship of the deity.[62] There are healers who believed that spirits or the living-dead "called" them in dreams,[63] vision or in waking, to heal.[64] Ancestors were also involved in the practice of medicine and calling of human agents to perform healing of serious illnesses. In some cases, dwarfs and ancestors too acted as calling agents.[65] In every case, healers underwent formal or informal training. Candidates acquired knowledge in matters pertaining to medicinal value, quality and use of parts of plants and animals, minerals, water and smoke. They learnt about the causes, cures and prevention of diseases and various secrets of the healing work, observation of strict taboos and other disciplines and instruction in natural and religious laws among others.[66] At the end of the training, the candidate was publicly initiated

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[61] Mbiti, *African Religions and Philosophy*, p. 163.
[62] Interview with Nana Clement Asamoah, aged 93 years and also, Opanyin Franklin Ntim, 65 years' old.
[63] *Ibid.* Also, Interview with Sofomaame Efua Comfort Eshun, aged 61 years.
[64] The "call" here is manifested when one is possessed personally by the spirit of a communal deity. The medical knowledge may be acquired through instruction, dreams and visions and "voice" heard in the bush while collecting herbs. Mbiti, *African Religions and Philosophy*, p. 163. See also Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, p. 34; Twumasi, *Medical System in Ghana: A Study in Medical Sociology*, p. 25 and Opoku, *West African Traditional Religion*, p. 74.
[65] Among the Yoruba people of Nigeria, Elesije, the first doctor and ancestral genius of medicine, is always invoked in the medical performance to make the medicine more efficacious. Also, among the Akan people of Ghana, Ancestors are believed to send special cures to their relatives suffering from serious illnesses. It is common to hear a mourner at a funeral asking the dead to send a cure for his or her ailment or asking the dead to convey the request to some other ancestor to send medicine. Opoku, *West African Traditional Religion*, pp. 149-150.
[66] Mbiti, *African Religions and Philosophy*, p. 164, see also Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, pp. 30-31; Checole, "Man Cures, Gold Heals," p. 128 and C. A. Dime, *African Traditional Medicine: Peculiarities,* (Ekpoma: Edo State University Press, 1995), p. 28.

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for public recognition.[67] Healers may be specialists like bone setters, herbalists,[68] psychiatrists, and birth attendants.[69]

Indigenous African Medicine on the Eve of Colonization: The Case of Gold Coast

On the eve of the colonial conquest and occupation of the continent by European imperialists, Africa was far from being medically primitive, static and asleep or in a Hobbesian state of nature.[70] African societies were familiar with the treatment of different maladies. By the eve of colonization of the states and people in the area that became known as the Gold Coast (now Ghana) and Africa at large in the late nineteenth century, Arabo-Islamic and European medicine were already competing and complementing indigenous African medicine. The trans-Saharan trade and the Atlantic trades facilitated this.

The Trans-Saharan Trade linked North Africa, the Mediterranean world and Europe, the Sahara, the savanna and the forest areas of West Africa. Its development begun from about the third or fourth century however, it gathered

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[67] There are some societies in Africa where there are fixed number of years for the medical training. For instance, among some of the Akan communities in Ghana, the fixed number of years is three. Among the Azande (an ethnic group fund in present day Democratic Republic of Congo), it takes five years. Each year has the specific practical and magico-religious medical training given to the trainee. Whatever the training is, it must be in accordance with the objective of equipping the trainee to know the religious, magical, cultural, epidemiological, nosology and pathological bases of ill-health and diseases of the community. Mbiti, *African Religions and Philosophy*, pp. 163- 164, See also Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects*, pp. 30-31; Twumasi, *Medical System in Ghana: A Study in Medical Sociology*, pp. 26-29; Checole, "Man Cures, God Heals", p. 129 and Evans-Pritchard, *Witchcraft, Oracle and Magic among the Azande*, pp. 202-250.

[68] Interview with Nana Clement Asamoah, aged 93 years, herbalist and bone setter at Wassa Asikuma. See also Dime, *African Traditional Medicine: Peculiarities*, p. 39.

[69] The traditional birth attendant who is generally a woman, specializes in maternity needs, prescribes medicine and is useful during antenatal, pre-natal and post-natal periods. She combines the work of a gynecologist and a pediatrician. Checole, "Man Cures, Gold Heals," p. 128.

[70] Adu A. Boahen, *African Perspectives on Colonialism,* (Maryland: John Hopkins University Press, 1989), p. 23.

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momentum from the seventh century onwards and reached its peak and intensity between the fourteenth and sixteenth centuries.[71] The spread of Islam into West Africa began with the Arab conquest and occupation of North Africa from Egypt to Morocco between 639 and 708 AD.[72] From there, Islam and Islamic or Arabo-Islamic medicine spread into the savanna and the forest fringes of West Africa and had taken root in Dagomba and Gonja by the end of the sixteenth century.[73]

Like in other parts of Africa, Islam was widely and largely accepted in most parts of Northern regions of the Gold Coast. So too was the Arabo-Islamic (Koranic) medicine that came with Islam, which among other therapies offered charms and amulets, which were believed to offer protection in war as well as against evil forces.[74] Islamic charms and amulet were widely used by people who came into contact with Muslim Arab traders and merchants. For instance, Asante leaders relied on the Arabo-Islamic medicine and health care traditions

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[71] One of the factors that gave impulse to the Trans-Saharan Trade was the conquest of the whole of North Africa by Arabs from 641 and 708 AD. For the role of the Arabs or Islam in the Trans-Saharan Trade see Adu A. Boahen, J. F. Ade Ajayi & Michael Tidy, *Topics in West African History,* (London: Longman Group Ltd., 1986), pp. 1- 10; Elizabeth Isichei, *History of West Africa since 1800,* (Hong Kong: MacMillan Publishers, 1977), pp. 3-6; Davidson Basil, *A History of West Africa 1000-1800*, New Edition, (London: Longman Group Limited, 1977), pp. 28-33 and Philip Curtin, "The External Trade of West Africa to 1800", J.F.A. Ajayi & Michael Crowder (eds.), *History of West Africa*, Vol. 1., Third Edition, (Hong Kong: Longman Group Ltd., 1985), pp. 624- 647 and J. F. Ade Ajayi & I. Espie, *A Thousand Years of West African History,* (Ibadan: Ibadan University Press, 1965), pp. 3-61.

[72] Muslim conquerors, traders, travelers, itinerant preachers, and medical practitioners brought Islam and popular and literate Islamic medical tradition to Africa. For the spread of Islamic traditional medicine and practices into African from North Africa see John, Middleton & Joseph C. Milddeton, *New Encyclopedia of Africa* Vol 1, (New York: Charles Scribner's Sons, 2008), p. 539; Boahen et al., *Topics in West African History*, pp. 1- 10; and John O. Hunwick, "Islam in West Africa, A.D. 1000-1800", J. F. Ade Ajayi & Ian Esphie (eds.) *A Thousand Years of West African History*, (Ibadan: Ibadan University Press, 1965), pp. 113- 131.

[73] The ruling family of Gonja was converted to Islam at the beginning of the seventeenth century. Islam was strengthened and expanded further into Mossi and the forest areas as far as south as Kumasi. By the end of the eighteenth century there was a Muslim community in Kumasi and some of the rulers' closest advisers were Muslims. See Boahen et al., *Topics in West African History,* p. 11; Maier, "Nineteenth-Century Asante Medical Practices*",* *Comparative Studies in Society and History*, p. 68.; Hunwick, "Islam in West Africa, A.D. 1000-1800", p. 128.

[74] Boahen et al., *Topics in West African History,* p. 12.

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which were part of the Islamic culture that penetrated Asante through the Trans-Saharan Trade network which connected West Africa to the Arabo-Islamic world.[75] Healers who employed Arabo-Islamic medicine were held in high esteem in other courts in the tropics, and their interactions with the deities on behalf of their royal clients are documented among the Asante.[76]

By the second half of the fifteenth century, the second line of communication with the wider world was made possible by the Atlantic Ocean which served as the bridge that connected West Africa, Europe and the New World in what became known as the Atlantic Trade which came to have a great interest in the buying and selling of enslaved people.[77] Related to this trade, Eurocentric Christianity from Western Europe and North America came to Africa, not simply carrying the Gospel of the New Testament, but as a complex phenomenon made up of trade, western culture, politics, science, technology,

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[75] Botchway, "Note on the Ethnomedical Universe of the Asante, an Indigenous People of Ghana", p. 163. See also Owusu-Ansah, "Islamic Influence in a Forest Kingdom: The Role of Protective Amulets in Early 19th Century Asante.", pp. 100-133.

[76] Not only Asante but the Ganda of Uganda as well as king of Darfur, Taqali, and Sennar in present-day Sudan all experienced Islamic medicine. John Middleton & Joseph C. Miller, *New Encyclopedia of Africa,* p. 540 and Maier, "Nineteenth-Century Asante Medical Practices", p. 74.

[77] The Atlantic trade started initially as trade in natural products from the mid-fifteenth century. However, it was expanded quickly into trade in enslaved Africans in the infamous Trans-Atlantic Slave Trade. Few decades to the era of the scramble and petition of African among European imperialists, the infamous trade was changed again to the trade in natural products which also became known as "Legitimate Trade." For works on the coming of Europeans into Africa and the said trade see Abaka, *House of Slaves and "Door of No Return": Gold Coast Castles and Forts of the Atlantic Slave Trade*; Eric Williams, *Capitalism and Slavery*, (New York: University of North Carolina Press, 1944), pp. 3-51; David Northrup (ed.), *The Atlantic Slave Trade,* Second Edition, (New York: Houghton Mifflin Company, 2002); Green Toby, *The Rise of the Trans-Atlantic Slave Trade in Western Africa, 1300-1589* (New York: Cambridge University Press, 2012); Lisa A. Lindsay, *Captives As Commodities: The Trans-Atlantic Slave Trade*, (New Jersey: Upper Saddle River, 2008); James Kwasi Anquandah, Naana Jane Opoku-Agyemang & R. Michael Doortmont (Eds.), *The Trans-Atlantic Slave Trade: Landmark, Legacies, Expectations*, (Accra: Sub-Saharan Publishers, 2007); Boahen, *African Perspectives on Colonialism*, pp. 1-5; Adu A. Boahen, J. F. Ade Ajayi & Michael Tidy, *Topics in West African History,* pp. 102-110; F.K. Buah, *A History of Ghana*, (Malaysia: Macmillan Publishers Ltd., 1980), pp. 65- 75 and Dickson B. Kwamina & George Benneh, *A New Geography of Ghana,* Revised Edition (Malaysia: Longman Group Ltd., 1988).

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medicine, schools and new methods of conquering nature.[78] However, the West African coast was deemed to be full of diseases. "The coast is certainly the father and mother of all fevers: its history is practically the history of malarial and yellow fever".[79] This "coast" struck terror into the hearts of European sailors and soldiers because of the very high death rates among them. This Western part of Africa was called the "white man's grave", because the "white men" were visitors whose immune systems were not attuned to the disease conditions on this coast. European ships, which conventionally had surgeons, provided, initially, intermitted medical assistance to the permanent European occupants of the slave forts and castles as well as inspecting each slave before purchase on the West African coast.[80]

The establishment of permanent settlements on the coast brought the European traders face to face with local diseases.[81] Consequently, European medicine and diseases also entered West Africa and by way of adapting to new medical needs and epidemiological challenges, some coastal indigenes relied, precariously, on European barbers and pseudo-surgeons based within the European trading posts, for treatment of worms, infection and exotic diseases

[78] Mbiti, *African Religions and Philosophy*, p. 212. See also Wiltgen, *Gold Coast Mission History, 1471-1880*; Philip Foster, *Education and Social Change in Ghana,* (London: Compton Printing Ltd., 1965); S. K. Odamitten, *The Missionary Factor in Ghana's Development up to 1880s,* (Accra: Waterville Publication House, 1978) and Kofi J. Agbeti, *West African Church History,* (Amsterdam: E. J. Brill Publishers, 1986).

[79] Tom Gale, "Hygeia and Empire: The Impact of Disease on the Coming of Colonial Rule in British West Africa", *Trans-African Journal of History*, Vol. 11 (1982), pp. 80-91, p. 85. It is not only in Africa but also in the western hemisphere, Central America, the islands of the Caribbean and the northern pasts of Southern America were also described as areas which yellow fever had been naturally endemic. See David Scott, *Epidemic Disease in Ghana, 1901-1960,* (London: Oxford University Press, 1965), p. 26.

[80] European doctors and surgeons accompanied the European soldiers and sailors, explorers, traders and missionaries and settlers who appeared along the West African coast from the late fifteenth century. See Abaka, *House of Slaves and "Door of No Return"*, p. 60, 109, 300, 308 and 310. See also Gale, "Hygeia and Empire: The Impact of Disease on the Coming of Colonial Rule in British West Africa", p. 85 and Bosman, *A New and Accurate Description of the Coast of Guinea Divided into the Gold, the Slave, and the Ivory Coasts,* p. 225.

[81] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 9.

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which entered West Africa through the Atlantic Slave Trade.[82] Therefore, one of the major effects of African contact with Europeans was the slave trade which caused people to move on a scale not previously known, disrupting health care based on local knowledge on both diseases and cures, and depriving the sick of familiar nursing skills.[83] With the peoples contact with European traders and missionaries, there was increasing acculturation of indigenous medicine and health care in what became known as Gold Coast.

Although there was a gradual acculturation of indigenous medicine by European ones, until the late eighteen century there was little that distinguished European medical skills from those of the Africans they encountered.[84] In the second half of the seventeenth century, William Bosman reported on the Gold Coast Africans that:

> [T]he green herbs, the principle remedy in use amongst the Negroes, are of such wonderful efficacy, that its much to be deplored that no European physician has yet applied himself to the discovery of their nature and virtue; … I don't only imagine, but firmly believe that they would prove more successful in the practice of physic than the European preparations, especially in this country because before they reach us, they have lost all their virtue and are mostly corrupted…therefore this country remedies in all probability are better for our bodies than the European.[85]

In 1817, T. E. Bowdich, the leader of a four-man team of the British that went to Asante on a political mission, observed that there were domestic herbal

[82] Botchway, "Note on the Ethnomedical Universe of the Asante", p. 162. It must be mentioned here that there are also records that confirm that the early Europeans who settled on the West African coast also did experience the indigenous medicine and how effective they were when they used them to cure their diseases. See Bosman, *A New and Accurate Description of the Coast of Guinea Divided into the Gold, the Slave, and the Ivory Coasts,* pp. 221-225.

[83] Paul Tiyamba Zeleza & Dickson Eyoh (eds.), *Encyclopedia of Twentieth Century African History,* (London & New York: Routledge, 2003), p. 258.

[84] Middleton & Miller, *New Encyclopedia of Africa*, p. 542; Abaka, *House of Slaves and "Door of No Return"*, pp. 24-60.

[85] Bosman, *A New and Accurate Description of the Coast of Guinea,* p. 225.

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preparations utilized as purgatives to treat bone fractures, to cause abortions, to treat sprained figments, to relieve stomach pain, dysentery and diarrhea, to neutralize symptoms of dyspepsia among pregnant women, and to treat boils, swellings, earache, coughs, eye pains, yaws and other aliments including venereal disease.[86] Moreover, indigenous medicine in the Gold Coast was, to a very large extent, strove very strongly to cure most of the indigenous and exotic diseases in the Gold Coast. For instance, in the 1830s, a Gold Coast African herbalist saved the life of a Basel missionary, Andreas Riis, in his struggle with malaria. However, the same malaria killed his colleagues, Peter Jager and Friedrich Heinze, the latter of whom was a medical doctor from Saxony.[87] This is a clear indication that to a large extent European medicine was not effective enough to treat and combat tropical diseases at the time as compared to indigenous medicine prior to colonial rule in the Gold Coast. If it were, then, perhaps, between 1822 and 1825, the death rate for European civilians and military officials would not have been 450 per thousand as 55 out of a total of 111 Europeans died from fever and dysentery alone.[88] This shows that African medicine was very effective on the eve of colonial rule. Nevertheless, European

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[86] PRAAD- ACCRA ADM 5/3/1 (1817) Bowdich's Report and Correspondent on his Mission to Ashanti. See also T. E. Bowdich, *Mission from Cape Coast Castle to Ashantee,* (London: Frank Cass Publishers, 1966 [1819]), pp. 371-377. Some of the diseases introduced into the Gold Coast with the presence of Europeans were also cured by indigenous African and traditional medicine as in the case of Asante. The work of Bowdich proved that concoction made from bark of trees, which have medical components, and herbs forms the bulk of the biomedical materials among Asante. For further reading on herbal medicine in Ghana, see Dokosi Oscar Blueman, *Herbs of Ghana,* (Accra: Ghana University Press, 1998). The work contains 83 plant families which abound in Ghana and the West Africa sub-region. The names of the plants are mentioned in 17 local dialects spoken in Ghana; M.N.B. Ayiku, *Ghana Herbal Pharmacopoeia,* (Accra: The Advent Press, 1992). This work list 50 medical plants found in Ghana. It gives the scientific names as well as their names in local languages like Twi, Fante, Ga-Adagme, Ewe, Dagbani and Hausa.

[87] Botchway, "Note on the Ethnomedical Universe of the Asante", p. 164.

[88] It was not the presence of deadly fevers and dysentery that caused the high death rates in nineteenth century West Africa. Thomas S. Gale, "The Struggle against Diseases in the Gold Coast: Early Attempt at Urban Sanitary Reform," *Transactions of the Historical Society of Ghana*, New Series No. 1, Vol. 16, No. 2 (1995), p. 185.

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cultural intrusion, missionary activities and colonial rule challenged and altered the praxis of indigenous therapy in the Gold Coast[89] hence the subsequent chapters will explore how it was done.

Until then, it is noteworthy to mention here that from the start of the second half of the nineteenth century, the indigenous medical systems, despite their longstanding functional service to the Gold Coast societies, began to suffer from gradual competition from European medicine and health care systems. From 1852, Britain began a systematic introduction and extension of European medical care into the Gold Coast.[90] The fact is that, until the start of that century, the indigenous people treated illness as a household affair and most communities knew and used herbal remedies and when the disease was considered serious the patient would be taken to local healers in other parts of the Gold Coast. This situation continued until the formal declaration of colonial rule in Gold Coast when European medicine eventually overshadowed indigenous medicine largely because of the imposition of British public health policies and medical systems on the people mainly through the agency of the church, western school education and some political administrative departments. This was possible because the formalization of the colonial status of the Gold Coast coincided with the period of intense research and development of the medical sciences in Europe and North America.[91]

[89] Botchway, "Note on the Ethnomedical Universe of the Asante, an Indigenous People of Ghana", p. 163.
[90] It was with the introduction of the Poll Tax Ordinance in 1852 that an attempt was made to formally introduce the British Medical system in Gold Coast. This is because some of the proceeds were used to employ British doctors as "Poll Tax" doctors or "Surgeons to the natives." The instruction that went out was therefore that "natives are entitled to gratuitous medical treatment from the physicians to the Africans." Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, pp. 185-187. See also Amenumey, *Ghana: A Concise History*, p. 116; Boahen, *Ghana: Evolution and Change,* pp. 40-43 and Addae, *History of Western Medicine in Ghana,* pp. 16-21.
[91] Addae, *History of Western Medicine in Ghana,* p. 18.

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Conclusion

This chapter sought to discuss indigenous African medicine and medical system in pre-colonial era. It underscored the indigenous African medicine, healing cosmologies and Practices. It also examined how indigenous African medical practitioners are trained for their social service in their communities. It is evidenced that indigenous African medicine is not a queer collection of superstitions and error, but rather it deals with the whole human being in both his and her physical and spiritual dimensions in the process of healing the patient. Healers symbolized the hopes of good health, protection and security from evil forces, prosperity and good fortune, and ritual cleansing when harm or impurities were contracted. Before the formal colonization of Africa, preventive and curative medicine, good hygiene and sanitation, nutrition, observing customary rites, rituals, and taboos and seeking protection from magicians, sorcery and witchcraft through inoculation, sacrifices, the introduction of antidotes and the wearing of charms, amulets and talismans were generally the aspect of the medical system amongst Africans. The acculturation of indigenous African medical systems started with their contact with Arabic and Islamic cultures in the seventh century through North Africa and this continued through to the fifteenth century when Europeans imperial agents intruded Africa from the Atlantic Ocean. Indigenous African medical systems operated long before these contact with Arabo-Islamic and European cultures. However, the influence of European colonial rule on the African continent in the nineteenth century marked a significant turning point in the history of the indigenous medicine. This also influenced the gaps between indigenous African medical systems and western medicine. The next chapter examines the colonial

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public health and sanitation policies that were formulated, pursued and implemented in the Central Province from 1874 to 1918. This will help to appreciate the strategies and designs that the British colonial government of the Gold Coast employed to institutionalize western medicine and medical system in the Gold Coast following the declaration of the Gold Coast as a Crown colony.

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CHAPTER THREE

COLONIAL PUBLIC HEALTH AND SANITATION POLICIES, 1874-1918

"Today we are being ruled as if we had no indigenous institutions, no language, no national characteristics, and no homes."[1]

Introduction

The year 1874 was marked by a British military campaign led by Sir Garnet Joseph Wolseley against Asante. This campaign was designated as a final end to the recurrent invasion from Asante and their interference with trade on the coast,[2] and the British decision to remain on the Gold Coast and assume fuller imperial control for the protectorate.[3] Thus, the outcome of the 1874 Sagranti War was that southern Gold Coast was formally declared a British Crown Colony on 24th July, 1874, following a heavy defeat of Asante by the British and their coastal allies.[4] Before and during the 1874 war the British took

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[1] In a petition issued by John Mensah Sarbah on 5th June, 1889 to the Secretary of State. This he did on behalf of the principal inhabitants of Cape Coast. This was enclosed in a Dispatch, cited in David Kimble, *A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1928,* (Oxford: Clarendon Press, 1963), p. 143.

[2] From the 1820s, Asante and the British and its coastal allies had engaged in wars which, in most case, hindered the required and desired peace for economic activities in the Gold Coast. These two parties fought in 1824, 1826, 1863 and a final one for the century, 1874. It was the 1874 war that saw the independence of the southern states of the Gold Coast from Asante. See Isaac Indome, "A Brief History of Wassa Asikuma From Earliest Time to 2010", a Bachelor of Arts, Project Work submitted to the Department of History, Faculty of Arts, University of Cape Coast, pp. 21-26. See also W. W. Claridge, *A History of the Gold Coast and Ashanti from the earliest times to the commencement of the twentieth century,* Vol. 1. (London: J. Murray, 1915), p. 165; Wilks Ivor, *Asante in the Nineteenth Century*, (Cambridge: Cambridge University Press, 1975), pp. 207- 224; Henry Brackenbury, *The Ashanti Wars; A Narratives,* (London: William Blackwood and Sons, 1874) and C. C. Reindorf, *History of the Gold Coast and Asante* Third Ed. (Accra: Ghana Universities Press, 1985).

[3] Kimble, *A Political History of Ghana: The Rise of Gold Coast Nationalism,* p. 10.

[4] Sagrenti, an African rending of Sir Garnet, is the local name for what is conventionally reckoned the sixth Asante War. G. E. Metcalfe, *Great Britain and Ghana: Document of Ghana History, 1807-1957,* (London: Ipswich Book Co. Ltd., 1994 [1964]), pp. 347- 357; PRAAD-Accra, ADM 5/1/26 Annual General Report of Gold Coast for 1st April 1930- March 1931; PRAAD-Accra, ADM 5/1/22 Government of the Gold Coast Annual Departmental Report, April 1926 to March 1927. See also Claridge, *A History of the Gold Coast and Ashanti*, p. 165; Brackenbury, *The Ashanti Wars: A Narratives*, pp. 308-376; Wilks, *Asante in the Nineteenth Century*; Stephen Addae, *Medical Histories from Primitive to Modern Medicine, 1850-2000,* Vol. 1, (Accra: Durham Academic Press Ltd., 2012), p. 2; Roder S. Gocking, *The History of Ghana,* (London: Greenwood Press, 2005), p. 34; Michael Crowder, *West Africa Under*

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several steps to protect the lives of their soldiers among which included the formation of eight dry and seemingly health camp sites equipped with control stations and hospital huts in them, as well as filtered water, a bakery, dried wood for fire and a daily use of quinine.[5] After the British had taken such precautionary health and sanitary measures in a political significant war, that led to the formal declaration of southern Gold Coast as a Crown Colony, what health policies did the British employ to ensure the good health of its colonial officials in the Gold Coast Colony? How did the Gold Coast African respond to such policies? Also, what was the character of the colonial politico-administrative structure that implemented the public health and sanitation policies? The core objective of this chapter is to attempt to answer these questions. The chapter is developed along two major themes- colonial public health and sanitation policies, 1874- 1900 and 1900 -1918. The two periods are taken for the reason that in the case of the first period, it falls within the era of the formalization of the colonization of Gold Coast. The period also marks the embryonic stage of colonial political and administrative mechanism. On the second period, 1900 to 1918, is taken with an attempt to unearth the very changes that occurred in the public health and sanitation policies within the first two decades of the twentieth century.

Colonial Rule, (London: Hutchinson & Co. Publishers Ltd., 1968), pp. 146-147; Kwabena O. Akurang-Parry & Isaac Indome, "Colonialism and African Migration" in Martin S. Shanguhyia & Toyin Falola (eds.), *The Palgrave Handbook of African Colonial and Postcolonial History,* Vol. 1, (New York: Palgrave Macmillan, 2018), p. 376; Devine E. K. Amenumey, G*hana: A Concise History,* (Accra: Sankofa publications, 2000), p. 163 and David Owusu-Asanah, *Historical Dictionary of Ghana*, Third Ed. (Maryland: The Scarecrow Press, 2005), p. 7.

[5] One Surgeon-Major Gore was appointed sanitary officer and was instructed to report on all selected camping sites. The camps which included Praso, Fante Nyankumasi, Assin Nyankumasi, Ekumfi and Manso had surface drainages constructed in each. Every morning, before starting on the march, cocoa, biscuit and quinine, were given to the men. Brackenbury, *The Ashanti Wars,* pp. 316-327. See also Tom Gale, "Hygeia and Empire: The Impact of Disease on the Coming of Colonial Rule in British West Africa", *Trans-African Journal of History*, Vol. 11 (1982), p. 84 and Addae, *Medical Histories from Primitive to Modern Medicine*, p. 22.

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Under each period, there will be themes like health and medical facilities; water and sanitation; epidemiology and African responses and initiatives to the policies. The reason for the various themes is not to purport the idea that there was or is a sharp dichotomy between them. However, as long as the public health and sanitation policies are concerned, there is, as the evidence suggest, homogenic relation in the public health and sanitation policies that dealt with health and medical facilities, health resources, water and sanitation and epidemiology.

Background to the Political and Administrative Structure of the Gold Coast Colony

The declaration of formal colonial rule on 24th July, 1874, by the British over Southern Gold Coast meant that the power and authority to make laws and regulations governing the political, social, economic and religious life of the Gold Coasters fell into the hands of imperial Britain. Politically, the three arms of government, namely the executive, legislature and judiciary were established in the colony as councils.[6] For administrative purposes, the whole colony was divided into three provinces, namely, the Eastern, Central and Western Provinces with Accra, Cape Coast and Sekondi-Takoradi as the respective provincial capitals.[7] The provinces were headed by Provincial Commissioners who resided in the capitals. He exercised executive, legislative and judicial

[6] It is worth mentioning here that the establishment of these councils were first experimented in late 1850s following the signing of the Bond of 1844 by some states in Southern Gold Coast, however, it was aborted by 1864. See F. K. Buah, *A History of Ghana*, (Malaysia: Macmillan Publishers Ltd., 1980), pp. 82-83; Kimble, *A Political History of Ghana*, p. 168; Amenumey, *Ghana: A Concise History*, pp. 116-118; Adu A. Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century,* (London: Longman Group Ltd., 2000), pp. 40-43, 57 and Gocking, *The History of Ghana*, p. 32.

[7] PRAAD-Accra, ADM 5/1/25 (1929-30) Gold Coast Report for 1929-1930; PRAAD-Accra, ADM 5/1/24 (1928-29) Annual General Report of Gold Coast for 1928-1929.

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functions at the provincial level as he oversaw the day-to-day administration of the province. Each province was divided into districts and in some cases sub-districts.[8] For instance, the Central Province, had four main administrative districts namely Cape Coast, Winneba, Saltpond and Western Akyem.[9] Districts were headed by District Commissioners who exercised delegated powers and functions like the Provincial Commissioner at the district level. However, they were directly responsible and accountable to the former.[10] In this case, on the political and administrative ladder, the Provincial Commissioner was the Chief Commissioner among the various commissioners at the provincial level. It is worth mentioning here that the Gold Coast African chiefs were incorporated into the British political and administration of the colony particularly in places where they existed.[11] The Gold Coast African chiefs were directly below the commissioners in terms of the political and administrative structure although it was largely through the chiefs that their people living

[8] David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* (Los Angeles: Crossroad Press, 1981), p. 2.
[9] The Castle at Cape Coast served as the Cape Coast Town Council and other government department offices. The forts and castles on the shores of the colony served as the administrative office for the provincial and district capitals. Some served as prisons like the Cape Coast, Winneba, Anomabu and others as post office and among other functions in the early years of colonial rule. Edmund Abaka, *House of Slaves and "Door of No Return": Gold Coast Castles and Forts of the Atlantic Slave Trade,* (New Jersey: African World Press, 2012), p. 24. See also PRAAD-Accra, ADM 5/1/24 (1928-29) Annual General Report of Gold Coast for 1928-1929; PRAAD-Accra, ADM 5/1/25 (1929-30) Gold Coast Report for 1929-1930; PRAAD-Accra, ADM 5/1/26 (1930-31) Annual General Report of Gold Coast for 1st April 1930- March 1931.
[10] The district commissioners performed judicial functions in addition to their executive and legislative one. PRAAD-Accra, ADM 5/1/25 (1929-30) Gold Coast Report for 1929-1930. See also, Amenumey, *Ghana: A Concise History*, p. 164 and Kimble, *A Political History of Ghana*, p. 305.
[11] Adu A. Boahen, J. F. Ade Ajayi & Michael Tidy, *Topics in West African History*, (London: Longman Group Ltd., 1986), p. 123; Amenumey, *Ghana: A Concise History,* p. 163. The British showed some level of respect for the African political institution that existed at the time of colonization and in March, 1902, the Native Affairs Department was created as a branch of colonial secretary's office in the Gold Coast. "The intension was to secure greater continuity in the administration of Native Affairs Department and to collect more complete records with regards to them…" See PRAAD-Accra, ADM 5/1/58 (1903) Government of Gold Coast Departmental Report 1903.

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within the political jurisdiction of the Commissioners were governed at the district level.[12]

Administratively, various government departments and institutions were set-up to perform a specific function for the smooth operation of the colony. Those departments included those in charge of Medical and Sanitary issues, Agriculture, Education, Public Works, Meteorological, Police and Geological Survey Departments. The administrative arrangement of the Medical and Sanitary Department was a simple one which was headed by the chief medical officer who was appointed by the Secretary of State.[13] His responsibility was advising the governor on the formulation of public health policy and its execution and the administration of government health services.[14] It was from this administrative machinery that medical facilities were provided to ensure the health of the European administrators, traders and miners among other functionaries.[15] However, the services of the medical officers and health facilities were later extended to some fortunate Gold Coast Africans.

The political and administrative system of governance employed in the Gold Coast Colony was a decentralized- deconcentrated type.[16] By this system

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[12] Amenumey, *Ghana: A Concise History*, p. 189 and Kimble, *A Political History of Ghana*, p. 305. Unlike some other colonial imperialist who did showed a no or less regard for the chiefs.
[13] The Sanitary Branch was established in 1908, and hence, it was from this point that sanitation became part of the health policies in the colony. Addae, *Medical Histories from Primitive to Modern Medicine*, p. 34 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 11.
[14] Dr. J. McCarthy was the first Chief Medical Officer of the Gold Coast. He was transferred from Nigeria to the Gold Coast in 1883. There were medical officers who worked at the provincial and district levels. Their primary function at this period of colonial rule was to provide for the health needs of European officials, for, the great problem of the colonial government was how to keep Europeans alive and healthy for a decent period in the colony. Addae, *Medical Histories from Primitive to Modern Medicine,* p. 55. See also Sandra M. Tomkins, "Colonial Administration in British Africa during the Influenza Epidemic of 1918-19", *Canadian Journal of African Studies* / Revue Canadienne des Études Africaines, Vol. 28, No.1, (1994), pp. 60-83, p. 64.
[15] Boahen, *African Perspectives on Colonialism*, p. 58.
[16] The British Colonial Empire did not function as a centralized system. The keynote of British rule, as compared to that of other European overseas empires, was decentralized improvisation.

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the political and administrative officials at the provincial level enjoyed a measure of autonomy. However, they were directly responsible and accountable to the governor in the Colonial capital at Accra.

The Health Status of The Colony at the Time of the Colonial Rule

The Gold Coast authorities had to deal with several small coastal towns, each of which possessed similar unhealthy features. When Governor Pope Hennessy visited Cape Coast, the capital of the colony in 1872, he described it as "the most filthy and apparently neglected place I had ever seen under anything like a civilized government."[17] Due to the insanitary nature of Gold Coast, it was often very difficult to attract Europeans to serve in it[18] and shortly after the 1874 Sagranti War, three European senior officers turned down the governorship position because they deemed Gold Coast to be insanitary. However, the fourth person, who accepted it, died from malaria one month later.[19] The picture of the capital of the Colony, Cape Coast, was not better:

> …the town of Cape Coast, composed partly of the houses of the Europeans, and partly of the natives, the latter huddled together in the

Even Joseph Chamberlain, the Colonial Secretary, who was a the strongest of all colonial secretaries in terms of administration and policy formulation, left maximum initiative to the governors within each colony. Both the medical and political administration of the colony was a decentralized one. Raymond E. Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", *African Historical Studies,* Vol. 1. No.2 (1968), pp. 153-197, p. 166. See also Paul Tiyamba Zeleza & Dickson Eyoh (eds.), *Encyclopedia of Twentieth Century African History* (London & New York: Routledge, 2003), p. 259; Tomkins, "Colonial Administration in British Africa during the Influenza Epidemic of 1918-19", p. 64.

[17] Cited in Gale, "Hygeia and Empire: The Impact of Disease on the Coming of Colonial Rule in British West Africa", p. 88.

[18] Kimble, *A Political History of Ghana,* p. 94. The Gold Coast was deemed to be very insanitary because the various European officials who were destined to come and served in it compared the colony to Europe. These early colonial officials were stereotyping as they saw everything African as inferior.

[19] Gale, "Hygeia and Empire: The Impact of Disease on the Coming of Colonial Rule in British West Africa", p. 81. See also Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 157.

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> most crowded manner, and without the slightest regard to light, or air, or the convenience of approach. As circumstances permitted, by the falling of the houses into decay, or from an accidental fire, the English governors have endeavored to establish something like regularity here, by opening up a few good streets.[20]

Cape Coast, though the capital of the colony, was perhaps worse, than other small towns along the coast. In 1877, the medical adviser to the Colonial Office testified to the colonial secretary that too many previously healthy men were returning from the Gold Coast after only a few months "almost completely broken down in health."[21] The solution to this health issue was that in 1877 the capital was moved to Accra partly because the new capital offered the advantage, that is its environment was healthier than that of the former.[22] This raises the question of what really accounted for the insanitary and noxious environment of Cape Coast?

The reasons could partially be seen in its history. Historically, the insanitary and bad smell of the town particularly its coastal stretch had come about due to the over four hundred years of slave trade in which Cape Coast, the administrative capital of the British on the Gold Coast, played in it. The trade had effect on the sanitation of the area. In the pre-colonial era of the Gold Coast, particularly between the late fifteenth and early nineteenth century, Cape

[20] Brodie Cruickshank, *Eighteen Years on the Gold Coast of Africa,* Second Ed. Vol. 1, (London: Frank Cass & Co. Ltd., 1966), p. 23.

[21] Gale, "Hygeia and Empire: The Impact of Disease on the Coming of Colonial Rule in British West Africa", p 81 and Gale, "The Struggle against Diseases in the Gold Coast: Early Attempt at Urban Sanitary Reform.", p. 190.

[22] Accra was deemed comparatively healthier largely because of the absence of serious swampland around it. G. E. Metcalfe, *Great Britain and Ghana: Document of Ghana History, 1807-1957,* (London: Ipswich Book Co. Ltd., 1994 [1964]), pp. 364-5; Addae, *Medical Histories from Primitive to Modern Medicine,* p. 114; Gale, "The Struggle against Diseases in the Gold Coast: Early Attempt at Urban Sanitary Reform", p. 188; Abaka, *House of Slaves and "Door of No Return",* p. 23 and 49; Akwasi Kwarteng Amoako-Gyampah "Inherently Diseased and Insanitary? The Health Status of the Gold Coast (Ghana) from the 18th to the late 19th Century", *Nordic Journal of African Studies,* Vol. 27, No. 2 (2018), pp. 1-24, p. 6 and Boahen, *Ghana: Evolution and Change,* p. 57.

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Coast, Elmina, Anomabo, Winneba and Saltpond were port centres from which mostly the middle passage took off from the Gold Coast.[23] Again, the increasing commercial activities and the importance of Cape Coast from the early years of the Atlantic Trade to the early colonial period attracted a lot of immigrants into the region hence there was a demographic impact which further worsened the environmental determinate of health. As Kwarteng A. Amoako-Gyampah recently argues and points out "the European intercourse with the African population on the Gold Coast had negative consequences on the health status of the coastal settlements."[24] The overpopulation and increasing growth of Cape Coast in no small way contributed to the slum and filthiness of the town.[25] All the above-mentioned factors were instrumental in compelling the colonial government to move the capital of the colony to Accra.

The reasons that have been given for Accra being healthier and better than Cape Coast could be an exaggeration since almost all the coastal towns had the same unhygienic environmental situation at this time and Cape Coast was no exception. The colonial authorities were aware, however, that Accra was not without problems. "Accra is badly built, the streets are narrow and crooked every sanatory [sic] precaution is disregarded by the natives to which almost surpasses belief." As Hemming, who was to become the principal clerk in the West African Section of the Colonial Office wrote: "The sanitary question [is]

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[23] See Abaka, *House of Slaves and "Door of No Return",* pp. 4-11 and 22-23. The presence of the European traders in those coastal towns led to the demographic increase in the size of those towns. See W. W. Claridge, *A History of the Gold Coast and Ashanti from the earliest times to the commencement of the twentieth century*, Vol. 1. (London: J. Murray, 1915), p. 115.

[24] Amoako-Gyampah, "Inherently Diseased and Insanitary? The Health Status of the Gold Coast (Ghana) from the 18th to the late 19th Century", p. 18. Amoako-Gyampah argues that the sanitation and health of the Gold Coast littoral did not seem to be in good shape, yet the presence and activities of European residents did not help to improve the situation either, at least, prior to the 20th century.

[25] Kimble, *A Political History of Ghana,* p. 141. See Amenumey, *Ghana: A Concise History*, pp. 106-107.

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of primary importance and in this respect, Accra seems to bear the palm."[26] In Accra, the health situation, however, remained extremely bad as officials found themselves living in the most unhealthy surrounding and merchants lived in better quarters than officials who had to reside in the old forts or rented quarters.[27] Again, in the first sanitary report of 1883, revealed that:

> …the whole native town [Accra] is one built on the most insanitary [sic] conditions that ingenuity for that purpose could advise. The mud-huts for they are very nearly all mud- are huddled together in the greatest confusion and in heavy rain the narrow and tortuous pathways between the houses are converted into rivulets of dirty water….There is a large accumulation of water just beyond the market, of the dirtiest and filthiest kind, in which pigs rejoice to wallow and natives to bathe: and … they even drink this stuff. [28]

Furthermore, in a lengthy sanitary report by the Chief Medical Officer, J. Easmon, in 1896, called Accra a "sink of filth."[29] Eminent British traveler, Mary Kingsley, described this capital town in 1897 as "a mass of rubbishy mud and palm-leaf huts, and corrugated iron dwellings for the Europeans."[30] It must be mentioned here that for almost two decades after the capital had been moved from Cape Coast to Accra, almost all the annual colonial reports on the Gold Coast emphasized the poor and insanitary state of all the coastal towns particularly, the former capital and the current one.[31]

[26] Gale, "The Struggle against Diseases in the Gold Coast", p. 189.
[27] *Ibid.*
[28] Blue Book of Gold Coast (1883) PRO, CO 100/33 Cited in Addae, *Medical Histories from Primitive to Modern Medicine,* p. 114.
[29] Gale, "Hygeia and Empire: The Impact of Disease on the Coming of Colonial Rule in British West Africa", p. 88 and Gale, "The Struggle against Diseases in the Gold Coast", p. 193.
[30] *Ibid.*
[31] See colonial reports of the Gold Coast between 1880 and 1890s particularly PRAAD-Accra, ADM 5/1/53 (1897) Government of Gold Coast Departmental Report 1897; PRAAD-Accra, ADM 5/1/55 (1899) Government of Gold Coast Departmental Report 1899.

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From the above arguments and the reports, the factor responsible for the transfer of the capital to the Eastern Province was not primarily because of health and sanitation reasons. Definitely, politico-economic factors also gave impulse for the change of the capital of Gold Coast colony. The fact is that the incessant demand and extension of the sphere of influence and territory of the British to the south-eastern boundary of the colony as far as Anlo and the coastal towns within the area of Some, an Ewe populated area, could be a factor.[32] The point here is that, this "eastern question" thus, the desire of the British to extend their spheres of influence towards the eastern part of the Gold Coast was also a factor which precipitated the change of the capital from the Central Province to the Eastern Province. The desire for the "eastern region of the Gold Coast" was viewed as a measure "to check the activities of merchants who were landing their goods just east of the boundary and smuggling them free of duty into the Gold Coast."[33] This politico-economic consideration was a very important concern to the British colonial authorities. It is worth mentioning here that the desire for a coastline for economic and political motive had been used by the British when it exchanged forts and castles with the Dutch in 1872.[34] The former's only European rivalry in Gold Coast. Hence, the politico-economic drive was perhaps the main factor for the transfer of the capital to the Eastern Province so that government could effectively check smuggling and maximize its economic gains in that region of the Gold Coast.

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[32] Amenumey, *Ghana: A Concise History,* pp. 136-7. See Kimble, *A Political History of Ghana,* pp. 12-13; Boahen, *Ghana: Evolution and Change,* p. 59.
[33] The British administration signed a treaty with the chief of Aflao in 1879 to cede Aflao to the British. See Amenumey, *Ghana: A Concise History*, p. 137; Gocking, *The History of Ghana,* p. 32; Boahen, *Ghana: Evolution and Change*, p. 69; Kimble, *A Political History of Ghana,* pp. 12-13. Kimble calls the British operation to move to the south-east, "the extension of the smugglers frontiers."
[34] Boahen, *Ghana: Evolution and Change*, p. 54; Gocking, *The History of Ghana,* pp. 33-34 and Buah, *A History of Ghana*, p. 92.

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Added to this reason was the increasing threat from Germany and France for the boundary between Gold Coast and Togo hence the transfer of the capital of the colony to the east of Cape Coast.[35] It is therefore pertinent to note that the "eastern question" was a key motivating factor for the transfer of the capital from Cape Coast to Accra. However, the health and sanitary issue was used as the pretext as far as the transfer of the administrative capital is concerned. If sanitation and health issues were the sole reasons then perhaps Accra would have been made the capital of the British settlement in Gold Coast years before the 1874 Sagrenti War.[36] Generally, the health and environmental situation in the coastal towns were very bad as compared to the interior part of the colony where European presence and influence were not felt much. The question then is what sanitary reforms were necessary to render the Central Province reasonably healthy for its inhabitants in the early years of the colonial rule?

Colonial Public Health and Sanitation Policies, 1874-1900

The public health and sanitation policies that were formulated, perused and implemented between 1874 and 1900 included the provision of health promoting infrastructures, medical officers, water distribution and the prevention of diseases using measures like residential segregation, quarantine among others. All the policies are grouped under the theme, health and medical facilities, water and sanitation and epidemiology.

[35] Amenumey, *Ghana: A Concise History*, pp. 137-138; Boahen, *Ghana: Evolution and Change*, p. 70 and Crowder, *West Africa Under Colonial Rule*, p. 70.
[36] Metcalfe, *Great Britain and Ghana: Document of Ghana History,* pp. 364-5. Although the decision to transfer the capital was taken in 1874, it was not until 1877 that it was implemented.

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Health and Medical Facilities

Until 1874, no clear medical policy seems to have been formulated for the Gold Coast. However, from about the 1890s, an effective medical policy became not only necessary, but urgent, due largely to the increasing number of British officials and also the high mortality among them in the colony.[37] The first attempt to provide civil health facilities in the Central Province was made in 1878 when the army medical service which was located in Cape Coast and Elmina was changed to a civil one.[38] The pace of the development of the health system was dictated mainly by available resources and by specific British concerns. In 1892, there was a smallpox hospital in Cape Coast and there were dispensaries at the coastal towns of Saltpond and Winneba Districts.[39] The infirmaries consisted of bush hospitals; they were sometimes built with bamboo or swish with thatched roofs. Equipment and drugs stocks were poor and inadequate. During the rainy season travel was dangerous and difficult because of the lack of motorable road network. It took a long time for messages summoning the medical officer to a medical emergency to reach him.[40] Even at the coastal towns of the province essential health facilities were not better and there were very few medical personnel in the province. For instance, at the provincial capital, the shortage of health personals was so serious that merchants

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[37] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 29. In 1893, 1894, 1895, 1896 and 1897 the death rate of European Officials per thousand were 31.2, 33.7, 66.9, 60 and 37.5 respectively.
[38] *Ibid.,* p. 30. These hospitals in the province had admission facilities in them.
[39] Samuel Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health,* (Accra: Page links Publishers, 2005), p. 189. See also Addae, *Medical Histories from Primitive to Modern Medicine,* p. 30.
[40] As at 1902, the contagious disease hospital at Elmina consisted of palm huts on a site half a mile from the town. Saltpond dispensary was just a rough structure built of wood. It consisted of three rooms-one was used as a consulting room, one as a store and the third for dressing. Hence, the so-called hospitals were nothing but a shed and very dilapidated one. See PRAAD-Accra, ADM 5/1/57 (1902) Government of Gold Coast Departmental Report 1902, Medical Department; Addae, *Medical Histories from Primitive to Modern Medicine*, p. 59.

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complained that there was only one colonial medical officer to serve 15, 000 Gold Coast Africans and 50 Europeans.[41]

The acute shortage of health personnel was a by-product of colonial policy as the Colonial Office was often reluctant to approve the appointment of many Europeans into the colony on the grounds of health as well as the economy.[42] The effect was that the district commissioner and the medical officer of the same district performed duties which complemented each other in the other's absence. In the first place it was a matter of a policy, perhaps, for reasons of economic, the medical officer had to fully assume the duties of the district commissioner when the latter was on leave, invalided or when the position was vacant for any reason.[43] For instance, in the 1890s one P. D. Oakley served as the medical officer as well as the District Commissioner of Winneba. The medical officer of health in the districts of Saltpond and Western Akyem, also performed a dual mandate of medical officer and District Commissioner.[44] The fact is that at this early stage of colonial rule, the district commissioner and the medical officer were the two-senior educated and responsible members of the administration in the district. The policy which could be termed as "the dual

[41] Report on Cape Coast, read at Liverpool Chamber of Commerce, *Liverpool Journal of Commerce,* 13th July 1896, p. 5. Cited in Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 154.

[42] Kimble, *A Political History of Ghana,* p. 94 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 12.

[43] The medical officer performed, and assumed the political duties of the district commissioner in his absence. Some of those duties included, but were not limited to, customs and preventive work; supervision of government stores, judicial work, treasury work, collection of caravan taxes, overseeing accounts of the post office and surveying public work stores. Some medical officers protested against their extra-professional duties and the general conditions of service. See PRAAD-Cape Coast, ADM 23/ 1/ 275 (1916-37) Medical Officers as District Commissioners. See also Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 12; Addae, *Medical Histories from Primitive to Modern Medicine,* pp. 200- 201.

[44] PRAAD-Cape Coast, ADM 23/ 1/ 275 (1916-37) Medical Officers as District Commissioners.

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mandate of the medical officer" really meant that the medical officer, upon the assumption of the duties of the district commissioner, will spent much of his time taking care of political duties instead of his own professional duties. This dual mandate expected of the medical officer in the early years of the colonial rule was largely because there were few Europeans in the entire colony and partly because the Colonial Office did not have money to employ many Europeans for the colonial enterprise at this point in time. Hence, the Gold Coast Africans were largely ignored in health care services that medical officers were to provide. This explains why medical officers were given the responsibility to take care of the health needs of the European senior administrative officers in the service of the colonial government and not really the Gold Coast Africans.[45] Aside this challenge in the provision of health facilities and health officers, the colonial government had to also deal with issues concerning water and sanitation in the Central Province.

Water and Sanitation Policies

Perhaps no public health measure is as important to the prevention of disease as the provision of good drinking water. One of the important needs of the Central Province, from the beginning of colonial rule, was improved water supply. Drinking water was mainly stored rainwater or water from shallow wells and pits. At the interior or in the rural areas, nearby ponds, streams, lagoons and swamps served as both source of water and in some circumstances the surrounding banks of the water bodies served as latrines.[46] The Kyina stream

[45] Twumasi, *Medical System in Ghana: A Study in Medical Sociology*, p. 62. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 12.
[46] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 130.

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which lies between Cape Coast and Kyinaso served the communities around it;[47] the Amissah River which lies between Asikuma and Saltpond was the source of water for the nearby communities;[48] the Kakum River (Sweet River) served Cape Coast and the Brukusu River served Cape Coast and Saltpond.[49] The cheapest and the most widely used means in the supply of water was public wells. These sources of water for diverse purposes were not dependable as there were frequent reports about shortage of water, especially, during the dry seasons.[50] The European community depended on rainwater stored in metal tanks at the various district bungalows.[51] Based on this, the Public Works Department whose task included among other things the storage and supply of water made it a practice to first supply the European officials before extending supply to non-officials who included Europeans and a few privileged Africans.[52] This practice became the norm in most of the urban centers in the Central Province. The colonial government always satisfied the needs of its European officials first on its scale of preference so far as health and sanitation was concerned. It is therefore possible that at this early stage of the colonial rule Gold Coast Africans who lived in the interior part of the province depended on their usual sources of water while those who lived in close proximity to the

[47] PRAAD-Cape Coast, ADM 23/ 1/ 799 (1930- 48) Water Supply- Towns and Villages in Central Province.
[48] PRAAD-Cape Coast, ADM 23/ 1/2162 (4/5/1918- 15/8/1918) Saltpond Water Supply 1918.
[49] PRAAD-Cape Coast, ADM 23/ 1/2310 (1925-30) Cape Coast Water Works. The Akura river at Winneba served as a source of water for the town and its environs. See PRAAD-Cape Coast, ADM 23/ 1/ 435 (1922-45) Sanitary Department.
[50] PRAAD, Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks and Wells.
[51] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 130.
[52] In 1891, the people of Saltpond built a catchment area for their water supply but the Public Works Department improved it and assumed responsibility of its upkeep and free distribution of water to the people. See PRAAD, Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks and Wells.

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dwelling centres of European officials and non-officials may have benefited from the water supply from government tanks and wells.

The Central Province was often faced with water supply issues and so in the late 1880s the medical officer stationed in the Cape Coast District proposed the idea of bringing water by pipeline into Cape Coast from the Kakum River. However, this proposal did not yield any fruitful results as the Colonial Office argued that the revenue of the colony then was not enough to finance such projects.[53]

In the field of sanitation, the Gold Coast as a whole did not have good sanitary conditions and this alarmed the Colonial Office. It was as a result of this that the first public health ordinance was passed in 1878 by the Legislative Council.[54] This was the Town, Police and Public Health Ordinance of 1878. Under this provision, no building could be erected without the Governor's permission and old buildings were to be repaired or demolished. The Colonial Surveyor was responsible for cleaning and draining the streets. The construction of public cemeteries (as a substitute for house burial) became the responsibility of the Public Works Department. The Ordinance also prohibited the littering of streets and the government could impose fines on those committing public nuisances.[55] In the Central Province, the provision of the ordinance was applied to Cape Coast and Elmina largely because these areas had the largest number of Europeans in the province.

[53] In a dispatched to Lord Knutsford in 1891, Governor Griffith expressed the hope that in few years, if the revenue of the colony is maintained, it would be possible to supply pipe-borne water to Cape Coast. The pipe project did not materialize in the nineteenth century. See Addae, *Medical Histories from Primitive to Modern Medicine*, p. 132.
[54] Gale, "The Struggle against Diseases in the Gold Coast", p. 191.
[55] Amenumey, *Ghana: A Concise History*, p. 181; Addae, *Medical Histories from Primitive to Modern Medicine,* p. 115; Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 159; Gale, "The Struggle against Diseases in the Gold Coast", p. 191.

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In 1883 sanitary by-laws were passed under the Native Jurisdiction Ordinance (NJO). The ordinance laid down the principles of village and town sanitation, the African Chiefs became responsible for their implementation. This ordinance stipulated that the location of rubbish dumping site should not be less than 100 yards from human habitation, and it also ordered that infectious diseases were to be reported to the health officer, and that the African chiefs were to be consulted for permission before a house could be built.[56] In all, the by-laws provided for eleven aspects of sanitation. These included the siting and use of latrines and cemeteries, the cleaning of houses and its surroundings, providing sources of water for domestic application, the reporting and handling of infectious diseases and guidelines and laws on the construction of buildings and the handling of domestic animals.[57]

These by-laws were also enforced or supervised by the district commissioners and medical officers with the assistance of Chiefs or Headmen. Chiefs were given important and crucial roles in the enforcement of the sanitary by-laws in the areas within their jurisdiction. Fines for breaking the regulations ranged between two shillings and sixpence and twenty shillings.[58] Therefore, from 1889, the Colonial Office stood its ground and made attempt to stop all expenditures on public works and sanitation except as necessary to ensure the comfort of European officials. The chiefs and district commissioners would fine those found culpable of breaking the ordinance hence they would by this means raise money. Such internally generated funds would be used to cater for the

[56] This act was first introduced in 1878 but was reenacted in 1883. Amenumey, *Ghana: A Concise History,* pp. 166-167; Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, p. 189; Gale, "The Struggle against Diseases in the Gold Coast", p. 194.
[57] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 115.
[58] Gale, "The Struggle against Diseases in the Gold Coast", p. 191.

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sanitary needs of the province. Good as it was, this policy was largely a white-elephant as nothing much was done to improve sanitation on the Central Province. The British trading firms and chambers of commerce, the leading critics of West African health conditions,[59] had harassed the Colonial Office with complaints about the polluted ponds and wells, refuse-strewn streets and yards and open sewage pits, which stood as obvious sources of contagion as stipulated in the petition by the Cape Coast traders and chiefs who complained to Colonial Office of bad sanitation in 1889.[60]

The weak financial stand of the colonial administration hindered the full-scale implementation of the policy hence, the Colonial Office adopted another policy that sought to give power to local councils to levy their own taxes and thus, spare the colonial government the use of its own scarce resources to cater for sanitary projects.[61] To put this policy into effect, the British colonial government established the Town Council system under the 1894 Town Council Ordinance.[62] Cape Coast, the capital of the Central Province, vehemently opposed the Town Council Ordinance because of the 5 per cent compulsory rates that the people were to pay and also that the model of the local government

[59] *Ibid*., p. 193.
[60] This petition was precipitated by the fact that as many as about thirty Europeans died in 1895 in Cape Coast. The Liverpool, Manchester and London Chambers became very much concerned about health issues. The Liverpool Chamber resolved in the same year that "good health on the coast is even more important than good trade" Memorial of 500 European and African merchants criticizing various aspects of British Gold Coast administration, Enclosure in Griffith (171) to Ripon, 12th June, 1893. See Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 158; Gale, "The Struggle against Diseases in the Gold Coast", p. 193.
[61] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 116; Gale, "The Struggle against Diseases in the Gold Coast", pp. 194-195.
[62] The policy established local government system. The Council was charged with the responsibility of ensuring public health and sanitation in the Provincial and district levels. Addae, *Medical Histories from Primitive to Modern Medicine*, p. 116. See also Kimble, *A Political History of Ghana*, p. 423.

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system was the British type.[63] The Gold Coasters raised objections to this ordinance on the grounds that "they wanted a genuine town council and not merely a board responsible for sanitation; they argued that they paid enough indirect taxes to create surpluses in most years."[64] There is therefore a historical parallelism between the pre-colonial poll tax protest and the protest against the Town Council Ordinance at this stage of the colonial rule. Based on the protest from the Gold Coast Africans in the Central Province, all efforts by the colonial government to generate interest in elective town councils failed owing to the government's refusal to work through the existing indigenous organizations and the resistance of both chiefs and educated nationalist to any form of direct taxation.[65] The people wanted the Town Council to be modeled on their own native lines and not a British prototype.[66]

The argument of the educated elites was very laudable in that it was difficult to expect the town councils to construct expensive public work projects when government, even with the full resource of the colony behind it, had not been able to provide a single town in the province with a satisfactory water, drainage and sewer system. Sewage disposal constituted one of the most

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[63] The Town Council of 1894 was for Accra, Cape Coast and Sekondi. The Gold Coast Africans at Accra also opposed the election and implementation of the ordinance. Amenumey, *Ghana: A Concise History*, pp. 164-166; Buah, *A History of Ghana*, pp. 104-105; Kimble, *A Political History of Ghana*, pp. 425-6; Boahen, *Ghana: Evolution and Change,* p. 61; Gocking, *The History of Ghana*, pp. 51-54.

[64] The Gold Coast had a painful history of attempts by the British government to impose direct taxation on the inhabitants through local self-governing bodies. The Poll Tax of 1852 marked the introduction of direct taxation in the history of the Gold Coast and the people rose up against it. Kimble, *A Political History of Ghana,* pp. 169-185; Addae, *Medical Histories from Primitive to Modern Medicine,* p. 116; Boahen, *Ghana: Evolution and Change,* pp. 40-43; Gale, "The Struggle against Diseases in the Gold Coast", pp. 195-196.

[65] Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 169.

[66] The Gold Coast Intelligentsias in the Central Province had become very critical and conscious of their native institutions within the colonial order. Thus, John Mensa Sarbah's *Fanti Customary Law* (1897), *Fanti National Constitution* (1906), and Joseph E. Casely Hayford's *Gold Coast Native Institutions* (1903) were some of the examples of works that were calling on the colonial government to model it political and health policies on indigenous African line.

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difficult problems of sanitation and it was capital intensive. The bushy areas around villages or towns were commonly used as latrine site, but, in coastal towns, beaches were used for a similar purpose. Public pan-latrines began to be constructed and came into use by the end of the nineteenth century.[67] Pan latrines were largely used in the district capitals and other larger towns throughout the province where the Sanitary Branch of a district had sufficient staff to carry out the conservancy and, in most cases, prisoners in the various districts were largely used to do away with excreta.[68]

In 1897, it was reported that three principal reasons accounted for the state of the insanitary condition of the province. These were the lack of proper hygiene by many of the local people or their disregard for hygienic practices. The lack of finance as it was very expensive to deal with sanitary issues in the province. Another issue that mitigated against the good sanitation of the province was the absence of personnel to watch the streets like the highway and the beaches which were sources of nuisance and latrine by the people.[69] The earliest attempt made by the colonial government to meet this insanitary situation in the Central Province in a half way was that government employed ten scavengers in late 1897 to clean up Elmina and other district capitals. They were also concerned with construction of surface drainages, digging wells, pulling down ruined houses, the formation of "open spaces" and the construction of public latrines to improve the conditions of the province as was

[67] Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p.60. See also, Addae, *Medical Histories from Primitive to Modern Medicine,* p. 139.
[68] PRAAD-Accra, ADM 5/1/55 (1899) Government of Gold Coast Departmental Report 1899. See also Addae, *Medical Histories from Primitive to Modern Medicine,* p. 139. Cape Coast and Saltpond had a fairly good number of latrines and scavengers who saw to the disposal of waste and plans were made to increase the number. However, the use of prisoners was very common.
[69] PRAAD-Accra, ADM 5/1/53 (1897) Government of Gold Coast Departmental Report 1897.

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suggested by the Medical Department in the same year.[70] The prevention and control of diseases is another aspect of ensuring public health which the colonial government had to pay attention to.

Epidemiology Policies

Tropical diseases, particularly, those that pertained to the Coastal areas of West Africa were not new to Europeans and, for that matter, the British and so after the latter had formally colonized the Gold Coast, measures to combat the causes of diseases and ensure the general public health became largely the responsibility of the colonial government. One of the earliest methods employed to prevent the spread of disease was quarantine. Quarantine as a measure of preventing communicable diseases was first introduced into the Gold Coast in 1873 when Sir Garnet Wolseley passed a Quarantine Ordinance at Cape Coast with the objective of warding off yellow fever from the Gold Coast prior to the campaign against Asante.[71] However, in the latter part of the century, a new Quarantine Ordinance was promulgated "to make better provision for establishing quarantine in the Gold Coast" in 1891.[72] Hence, based on the provisions of this ordinance, at the outbreak of epidemic, victims were taken away from their homes or community into a quarantine or to hospitals meant for treatment of contagious diseases.

In the nineteenth century, public and professional opinion of some scientist attributed malarial fevers to poisonous vapours emitted by the action of strong sunlight or heavy rains upon decaying vegetable matter in swamps.

[70] *Ibid.*
[71] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 23.
[72] *Ibid.*

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Therefore, there was little possibility of developing effective programmes of protection or prevention against malaria.[73] Although quinine was commonly used in malaria therapy before the turn of the nineteenth century when deeper knowledge on the causes and behaviour of mosquito was discovered,[74] only slight attention was given by government doctors to the daily use of this drug as a prophylactic. Therefore, by the end of the nineteenth century, there was an increasing understanding and general acceptance of the mosquito theory which linked the cause of malaria to a bite from a female anopheles mosquito which bites mostly at night.[75] This discovery did not only revolutionize the study of tropical diseases but endowed "tropical sanitation" with western scientific status as a means of malaria prevention in the form of segregation of European settlements from the local people in the colony.

Western medical practitioners who followed in the wake of colonial rule were far more concerned with the health of soldiers, and officials than that of the indigenous population, and public health based on racial science provided legitimization for segregationist policies and new modes of control in the name

VERITAS LUMEN NOBIS

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[73] Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 157.

[74] Roland Ross visited Sierra Leone and there he demonstrated the vector of human malaria for the first time on African soil. See E. Q. Archampong, *Medical Research and the Practice of Medicine in West Africa* (Accra: Ghana Universities Press, 1989), p. 2. For the systematic and the series of research by nineteenth century scientist leading to the final breakthrough in the etiology of malaria by Ronald Ross in 1898 with his mosquito theory see Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", pp. 158-162 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 35. See also Ross Ronald, "The Possibility of Extirpating Malaria from certain Localities by a New Method", *The British Medical Journal*, Vol. II, Part I (July 1899), pp. 1-4; Ross Ronald, "Malaria and Mosquitoes", *Journal of the Royal Society of Arts*, XLIX, 2506, (Nov. 30, 1901), pp. 18-24; Matthew, M. Heaton, "Health and Medicine in Colonial Society", Martin S. Shanguhyia & Toyin Falola (eds.), *The Palgrave Handbook of African Colonial and Post-Colonial History,* (New York: Springer Nature Publishers, 2018), pp. 303-317, p. 305.

[75] *Ibid.* Such type of mosquitoes is predominantly found in Tropical Africa.

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of "tropical hygiene."[76] In 1893, Dr. J. F. Easmon proposed moving European officials from the overcrowded African towns and, hence, from 1895, segregated government quarters began to be provided for Europeans, particularly, colonial officials.[77] Segregation was institutionalized as a measure to prevent malaria epidemic among Europeans in Africa since the latter was seen as the reservouir of plasmodium parasite and, hence, the British colonial regime hoped that keeping Europeans apart from the malaria-infected Africans would reduce the incidence of malaria cases among Europeans.[78] Another factor that gave impulse to the adoption of the segregation policy was the increasing knowledge about the behaviour of mosquitoes. Within this period under discussion, it was proven that mosquitoes, which are the causal agents of malaria, came out and bit at night therefore if segregation was enforced and European residents were also mosquito-proofed with nets, the contraction of malaria by Europeans would be minimized.[79] In the initial stages of the policy, the segregated Europeans were mostly government officials. In this way one

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[76] John, Middleton & Joseph C. Miller, *New Encyclopedia of Africa,* (New York: Charles Scribner's Sons, 2008), p. 542; Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", pp. 170-171.

[77] Residential segregation became one of the most important, effective and jealously guarded measures taken to secure Europeans well-being and health particularly against malaria. This method of isolating Europeans was first proposed by Dr. J. F. Easmon, the first medical office of health in Accra. See Addae, *Medical Histories from Primitive to Modern Medicine,* pp. 40-41 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 35. It must be pointed out here that the concept of segregation as a health policy was first adopted and practiced by the British in India from the early nineteenth century. It was used in West African in the latter part of the said century. See John W. Cell, "Anglo-Indian Medical Theories and the Origin of Segregation in West Africa", *The American Historical Review,* Vol. 91, No. 3. (1986), pp. 307-335.

[78] Initially the policy was viewed with prejudice (which certainly existed) but rested instead upon scientific research which pointed to African children as principal reservoirs of the malaria parasite. See Gocking, *The History of Ghana*, p. 53; Addae, *Medical Histories from Primitive to Modern Medicine,* p. 41; Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", pp. 170-179; Cell, "Anglo-Indian Medical Theories and the Origin of Segregation in West Africa", pp. 309-310; Gale, "The Struggle against Diseases in the Gold Coast", pp. 197-198.

[79] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 41. See also Cell, "Anglo-Indian Medical Theories and the Origin of Segregation in West Africa", p. 310.

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can say that residential segregation was one of the measures of controlling malaria and yellow fever in the early years of colonial rule.

Again, wherever segregated areas existed, they were set on the higher elevations of hills and ridges. This was so because such places were erroneously perceived as difficult for mosquitoes to reach and also because such locations were cooler. It was, therefore, presumed to be more hostile to mosquitoes and more comfortable for Europeans.[80] As a measure to prevent malaria, the segregated policy required that only an irreducible minimum number of adult Gold Coast Africans were allowed to sleep in segregated areas. The earliest public health and sanitation policies were European-centered and focused. This is what gave birth to the policy of segregation which was dreamed and implemented to protect the colonizers. Thus, such racially determined policies can be understood as "Segregated Health Care Policies".

To effectively implement the residential segregation, it became a policy that not less than a quarter of a mile was to be left as a free zone between the European residential area and the nearest African settlement which was about 440 -foot wide swath. The objective of the free zone or buffer zone was to minimize the danger of malaria-borne mosquitoes infected in the African settlement flying to the European quarters.[81] The smooth execution and

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[80] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 44; Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 179; Cell, "Anglo-Indian Medical Theories and the Origin of Segregation in West Africa", p. 310.

[81] It was erroneously perceived by Western scientists and European officials that Gold Coast mosquitoes and perhaps those elsewhere will not be able to fly the distance of a quarter a mile, hence, the 440 -foot wide. PRAAD-Cape Coast, ADM 23/ 1/632 (1926-45) Yellow Fever Outbreak. See Addae, *Medical Histories from Primitive to Modern Medicine*, p. 43; Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 172; Cell, "Anglo-Indian Medical Theories and the Origin of Segregation in West Africa", p. 311. It is worth mentioning here that Hill Town, a European enclave in Sierra Leone, for example, was built in the first decade of the twentieth

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effective implementation of the segregation policy means that the colonial government had to acquire large strip of land.

It is worth mentioning here that perhaps the introduction of the Lands Bill of 1894 and 1897 by the colonial government was a measure to seize land from the indigenous peoples of the Gold Coast so that among other reasons, the colonial government could unfairly and inexpensively acquire land to satisfy the residential segregation policy. However, the Gold Coast intelligentsia vehemently rose to oppose the Lands Bill. This resistance led to the formation of the Gold Coast Aborigines Rights' Protection Society.[82] Closely related to segregation as a preventative measure against malaria infection was the strategy of house to house inspection of domestic premises to get rid of mosquito larvae and the eventual institutionalizing prosecution of those in whose house larvae were found.

Vaccination was also carried out as a measure to cure patients of some illnesses. In 1898, the out-patient department of the Cape Coast colonial hospital treated 2, 903 cases of which the principal diseases were malaria fever and small pox.[83] With regard to small pox, vaccination was carried out by the Medical Department as a measure to cure the victims, and vaccinators travelled through affected districts to supply vaccine lymph to the patients.[84] The lymph

century at 750 feet above sea level, about four miles away from the nearly major city of Freetown. See Heaton, "Health and Medicine in Colonial Society", p. 307.

[82] The two lands bills sought to give the British government all the "waste" (unused) lands for their use. PRAAD-Accra ADM 5/4/33 (1935) Gold Coast Aborigines Rights' Protection Society Petition to the House of Commons. For detailed information on the strategies that the Society used for its operations see Tenkorang S., "John Mensah Sarbah, 1864-1910", *Transactions of the Historical Societies of Ghana*, Vol. 14, No.1 (June, 1973), pp. 65-78, p. 74; Boahen, *African Perspectives on Colonialism,* p. 70; Kimble, *A Political History of Ghana*, pp. 330-355; Amenumey, *Ghana: A Concise History*, pp. 155-159; Boahen, *Ghana: Evolution and Change*, pp. 45-55; Crowder, *West Africa Under Colonial Rule*, p. 421 and Metcalfe, *Great Britain and Ghana,* pp. 471-500.

[83] PRAAD-Accra, ADM 5/1/54 (1898) Government of Gold Coast Departmental Report 1898

[84] *Ibid*.

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was 12 tubes which was to be taken by the patient in two weeks. Vaccination of patients with small pox with lymph was the main means of cure within the early years of the colonial period.

Due to the poor water supply, the Central Province was permeated with dysentery and parasitic diseases like hookworm, round worms and Guinea worm. Dysentery was often associated with bad sanitation and poor general health. Many deaths were caused by this. In the case of the deadlier bacillary dysentery, dehydration and poisoning by bacterial toxins.[85] The colonial government continued to formulate and pursue health and sanitation policies in the twentieth century.

Colonial Public Health and Sanitation Policies, 1900- 18.

Within the second decade of the twentieth century, the world witnessed the First World War. The War had impact on the colonial public health and sanitation policies in the Gold Coast in general and the Central Province in particular. The impact of the War on colonial public health and sanitation policies that concerned health resources, water and sanitation and epidemiology. This section discusses three main themes. Thus, health resources, water and sanitation and epidemiology policies of 1900 to 1918.

Health Resources

The problem of shortage of medical staff was widespread in the Gold Coast and the Central Province in particular as there were some difficulties in

[85] Gale, "Hygeia and Empire: The Impact of Disease on the Coming of Colonial Rule in British West Africa", pp. 80-91.

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obtaining the services of well-trained medical officers as dressers and nurses in the twentieth century.[86] This shortage was bound to occur in the early years of the colonial period because there was virtually no "national" health system in Europe itself. In metropolitan Britain, health services were organized by local communities, families and trade guilds. The poor were looked after by local authorities or by religious and charitable organizations, which built hospitals.[87] This means even in Europe itself, within the nineteenth century to the beginning of the twentieth century, most states did not finance or owned health facilities for itself. Based on this picture in Europe itself, the Gold Coast colony and, for that matter the Central Province could not expect many health care practitioners from the Colonial Office in London.

Like the century before the twentieth century, there persisted the practice of providing for the health needs of Europeans in the Gold Coast colony. In the Central Province the initial purpose for the establishment of health facilities were to protect Europeans (administrators, the military, and merchants) in the first instance, and to treat African employees in the second. Some of the largest employers mainly colonial government's civil servants and company and firms maintained their own medical staff to screen job applicants and respond to emergencies; occupational health was an underdeveloped aspect of public health.[88] The grounds for the Colonial Office's acceptance of the need

[86] Based on the 1901 report from the Medical Department on the Gold Coast, there were as many as 25 vacancies in the Medical Department in the colony alone. PRAAD-Accra, ADM 5/1/56 (1901) Government of Gold Coast Department Report 1901, Medical Department, p. 13.
[87] Ofosu-Amaah, *Health and Disease in Ghana*, pp. 184-185. See also Reference Division, *Central Office of Information, London, Labour Relations and Conditions of Work in Britain*, (Manchester: Henry Black lock & Co. Ltd, 1964). The first National Health Insurance Scheme was instituted in England in 1911. However, prior to this the first Public Health Act of 1848 provided for environmental services as a measure of ensuring general public health in England and not government clinical measures to ensure public health.
[88] Paul Tiyamba Zeleza & Dickson Eyoh (eds.), *Encyclopedia of Twentieth Century African History,* (London & New York: Routledge, 2003), p. 259.

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to change the policy received partial preparation in 1908 when Sir John P. Rodger was the governor of the Gold Coast. Noteworthy, it was during his time that a committee, charged with the reorganization of the West African Medical Service, came out strongly in favour of the gradual extension of medical and sanitation services to the indigenous Africans.[89] With this, in 1912 when Sir Hugh Clifford arrived in the Gold Coast as the governor, he immediately started the policy to gradually extend the operations of the Medical Department to include the Gold Coast Africans living in places other than the immediate vicinity of administrative stations.[90] Therefore, by 1917, Sir Hugh Clifford stated in a dispatch to the Secretary of State for the colony that "attention has recently been drawn to the desirability of extension of the benefits of European medicine to the indigenous population of the colony and one way of doing this is to establish native dispensaries under reliable dispensers."[91] Hence, it was from the second decade of the twentieth century that there was the extension and inclusion of Gold Coast Africans into the public health facilities and policies and so it is reasonably safe to state that the beginning of a general public health policies in the Gold Coast colony in general and the Central Province in particular was from the 1920s. The supply of portable water and the provision of sanitary facilities was another area of great concern to the colonial government.

[89] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 31.
[90] Sir Hugh Clifford admitted to the injustice in a system in which those Africans who paid most of the taxes were excluded from even elementary health facilities. Addae, *Medical Histories from Primitive to Modern Medicine,* p. 31
[91] *Ibid.*

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Water and Sanitation Policies

In the field of water and sanitation policies which were perused between 1900 and 1918, within the first decade of the twentieth century, the colonial government kept on supplying rain and well water stored in either underground or erected tanks to officials and some non-official members in the Central Province. For instance, between 1900 and 1916, the *Omanhene* (Paramount Chief) of Cape Coast, Nana Kojo Mbra and his successor Mbra Enu were entitled to free supply of ten and a half gallons of drinking water twice a week.[92] The provincial engineer saw to the fixing of corrugated galvanized iron tanks which could contain about thousands of gallons of water. It was from the "Government Tanks" that rain or well water was stored and supplied to hospitals, schools, churches, rest houses, markets, prisons and all government departments.[93] However, water supply was inadequate due to the limited number of wells that supplemented rain water during dry seasons. Based on this, there were frequent reports of shortage of water from both those who received free supply or those who bought water from government tanks.[94] For instance, in April 1916, the acting district commissioner of Saltpond requested for the construction of additional wells in the district.[95]

[92] In Cape Coast for instance, there were as many as nine underground tanks. Six were at Cape Coast Castle, one at Fort William, one at Victoria and one at Government Boys' School. Some of the tanks could contain thousands of gallons of water. PRAAD-Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks and Wells.

[93] PRAAD-Cape Coast, ADM 23/ 1/2025 (1915-16) Tanks and Wells, 1915-1916; PRAAD-Cape Coast, ADM 23/ 1/2156 (8/2/1918-8/11/1918) Tanks and Wells. Due to the constant shortage of water, government made it a policy to buy individual or private wells from nearby towns. For instance, one W.H. Grimsditch, the inspector of works at Winneba bought a well that belonged to Mr. Ghartey for £ 20. See PRAAD-Cape Coast, ADM 23/ 1/2135 (9/7/1917-7/11/1917) Tanks and Wells Winneba.

[94] PRAAD-Cape Coast, ADM 23/ 1/2025 (1915-16) Tanks and Wells, 1915-1916; PRAAD-Cape Coast, ADM 23/ 1/2156 (8/2/1918-8/11/1918) Tanks and Wells; PRAAD-Cape Coast, ADM 23/ 1/2135 (9/7/1917-7/11/1917) Tanks and Wells Winneba.

[95] PRAAD-Cape Coast, ADM 23/ 1/2149 (24/1/18-23/4/18) Tanks and Wells, Saltpond.

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The scarcity of stored or tanked water in the Central Province was a real situation and so in 1913, Governor Clifford declared his policy to secure pipe-borne water supply for Cape Coast and other principal towns of the province. However, owing to the outbreak of the First World War in 1914, this policy did not materialize.[96] Prior to 1914, even the larger towns in the province had no pipe-borne water and neither did they have a good layout. On June 4th, 1918, the director of Public Works Department at Saltpond suggested to his superior officer in Accra that a pipe-borne water supply from the Amissah River, which is about 7 miles from Saltpond, could be considered as an alternative source of water supply to the district.[97] However, the poor financial standing of the colony following the end of the First World War did not make it possible for such a project to materialize.[98]

On the issue of sanitation, the poor sanitation in the Central Province still remained a challenge at the beginning of the twentieth century. Many houses were poorly ventilated and bushes grew practically everywhere as tins and bottles and general rubbish were strewn around.[99] Villages consisted of collections of huts, which could be described as hovel with thatched roofs. The villages had no streets and the dwellings had poor layout.[100] The medical report of 1901 lamented over the impossibility to devise any practical scheme for the radical improvement of such towns as Cape Coast and Saltpond as all the previous measures employed to better the sanitary situation in the province had

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[96] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 133.
[97] PRAAD, Cape Coast, ADM 23/ 1/ 2162 (4/5/1918-15/8/1918) Saltpond Water Supply 1918.
[98] *Ibid.*
[99] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 59.
[100] *Ibid.*

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not been effective.[101] As a measure to solve the sanitary issues in the province, Major Brown, the acting Governor, issued a proclamation imposing the 1894 Town Council Ordinance on the Central Province in 1905. However, the people of the province did not accept the operation of the ordinance on the grounds that it was still a British proto-type. It was not until 1908 that the elected members of the Cape Coast Town Council decided to work due to some modification to the function of the town council[102] or perhaps the outbreak of bubonic plague in Cape Coast in 1908 pushed the governor to make sanitation a top colonial priority and demanded the standardization of the system of sanitation in the colony.[103] Nevertheless, by 1908, the people of Cape Coast and the Central Province as a whole had agreed to have the Town Council Ordinance apply to them. At the inception of the Cape Coast Town Council, Mr. L.N. Peregrine, the Provincial Commissioner, Mr. H.C.W. Grimshew, the Cape Coast District Commissioner, Dr. H. J. Cookman, the Provincial Medical Officer, Mr. W.H. Fletcher, the Provincial Public Works Engineer and Mr. T. McKenzie all served as the official members of the Town Council while, J.W. de-Graft Johnson, E. J. P. Brown, T. F. E. Jones and J. D. Abraham were the elected unofficial members of the Town Council who were Gold Coasters from the Province.[104]

[101] PRAAD-Accra, ADM 5/1/56 Government of Gold Coast Department Report 1901, Medical and Sanitation Department.
[102] Amenumey, *Ghana: A Concise History,* p. 165.
[103] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 117; Gocking, *The History of Ghana,* p. 53; David Scott, *Epidemic Disease in Ghana, 1901-1960*, (London: Oxford University Press, 1965), p. 7 and Emmanuel K. Akyeampong, "Disease in West African History", Emmanuel K. Akyeampong (ed.), *Themes in West Africa's History*, (Oxford: James Currey Publishers, 2006), p. 199. The plague and yellow-fever epidemic claimed the life of ten Europeans and two Africans and that compelled Cape Coast to accept the ordinance. In the colony as a whole the plague caused 336 deaths according to an official report on the case. See also David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* (Los Angeles: Crossroad Press, 1981), pp. 48-49.
[104] Evelyn Ntim, "A History of Cape Coast Town Council up to 2014", a Project Work submitted to the Department of History, University of Cape Coast, 2015.

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The introduction of Town Councils in the province, in effect, marked the decline of the Colonial Office's interest in urban sanitary reform in the Gold Coast in general and the provinces in particular. It is worth mentioning here that the Town Councils in the Central Province did not work for long as its functions and responsibilities were modelled into a new colonial sanitary reform measure which established sanitary committees.[105] In 1909, the Department of Health was divided into two branches, that is the Medical and Sanitary sections. The establishment of the sanitary branch was crucial in the history of Gold Coast and the Central Province in particular as it was this body that established the bases of sanitary structures throughout the colonial period and beyond it.[106] Based on this sanitary reform, in all district headquarters, sanitary committees were to be formed consisting of local officials including the district commissioner and the medical officer of health, who served as the president and secretary of the committee respectively, the senior officer of the Public Works Department and two unofficial members who were appointed by the district commissioner.[107] A sanitary committee was expected to provide monthly reports of its meetings to the Senior Sanitary Officer (SSO) who was based in Accra.[108] The committee met on every second Monday of a month and, among

VERITAS LUMEN NOBIS

[105] PRAAD-Cape Coast, ADM 23/ 1/ 1953 (1929-34) Sanitary Committee. It is interesting to know that this new sanitary reform was precipitated by the fact that the Town Council had failure its core mandate. For instance, the medical expert, appointed to inquire into an outbreak of the bubonic plague in Accra in 1908, strongly pointed out that the Town Council was a sanitary failure. See Kimble, *A Political History of Ghana,* p. 145.
[106] In 1911 the organizational structure, powers and duties of the new Sanitary Branch was issued. The Sanitary Branch was headed by a Senior Sanitary Officer. His immediate superior was the Principal Medical Officer and his deputy, the Junior Sanitary Officer. Below them were the several medical officers of health and European sanitary inspectors. PRAAD-Cape Coast, ADM 23/ 1/ 1953 (1929-34) Sanitary Committee. See also Addae, *Medical Histories from Primitive to Modern Medicine,* p. 118 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 11.
[107] PRAAD-Cape Coast, ADM 23/ 1/ 1953 (1929-34) Sanitary Committee.
[108] As part of his duties, the Senior Sanitary Officer toured the provinces and districts to inspect the medical officers of the area in matters related to public health and prevention of disease.

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other duties, the committee made suggestions on the sanitary improvement in its district.[109] Members could individually report any insanitary conditions they observed when visiting, inspecting and supervising towns within their jurisdiction as well as on any ongoing sanitary works in the district.[110]

Closely linked to the sanitary reform was the enactment of the Towns and Public Health Ordinance of 1912 which provided for the establishment of a Central Health Board (C.H.B) which was based in Accra.[111] However, at the provincial and district levels, a prototype of the board existed. In the Central Province, the Health Board's duties at both the district and provincial capital included general sanitation; refuse disposal, layout of towns, the construction and proper maintenance of drains, lagoon reclamation works and mosquito control, water supply, sewage and sewage disposal, markets and slaughter houses sanitation; the handling of epidemics, health education and overseeing sanitation in towns and village planning along sanitary lines.[112] The ordinance also stipulated the naming and numbering of streets and houses respectively for easy identification of places and houses for inspection by members of the board,

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Addae, *Medical Histories from Primitive to Modern Medicine*, pp. 198- 119; PRAAD-Cape Coast, ADM 23/ 1/ 1953 (1929-34) Sanitary Committee.

[109] PRAAD-Cape Coast, ADM 23/ 1/ 1953 (1929-34) Sanitary Committee

[110] *Ibid.*

[111] The principal composition of the board included the Principal Medical Officer (as President), the Director of Public Work Department (as vice president), the secretary of Native Affairs, the Secretary of Mines, Senior Sanitary Officer, a member appointed by the governor and two natives residing in the towns of Accra, Cape Coast and Sekondi respectively among others. The board had the important power and function to make, alter or revoke, rules, subject to the governor's approval in connection with sanitation. They received and discussed the various proposed sanitary structures suggested by the provincial and district health boards. PRAAD, Cape Coast, ADM 23/ 1/ 209 (1912-16) Town and Public Health, 1912-1945; PRAAD-Cape Coast, ADM 23/ 1/ 2354 (1926-19) Provincial Health Board, Sanitary Committee and Central Board Meeting. See also Addae, *Medical Histories from Primitive to Modern Medicine,* p. 119.

[112] The Provincial Health Board could also be referred to as Central Board of Health because it coordinated and received the reports of the various districts' health board's minutes. However, for the purpose of clarification, the Provincial Health Board will be used to distinguished between the CHB and the Provincial health Board. PRAAD, Cape Coast, ADM 23/ 1/ 209 (1912-16) Town and Public Health, 1912-1945. See also Addae, *Medical Histories from Primitive to Modern Medicine,* p. 119.

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the Public Works Department and sanitary inspectors. Thus, the health board was concerned with the general health needs of an area although the sanitary committees also existed in same places. However, the sanitary committee reported to the health board at the district level.[113]

When these sanitary reforms started, the focus and direction of the sanitary policy was mainly on those towns and centres with significant European populations because of the colonial government's desire to privilege the European's health and well-being.[114] Cape Coast District, the ordinance was initially applied to Bantama, Cape Coast, Elmina, Kommenda and Moree. In Saltpond District, it was applied to Akra, Anomabu, Narkwa and Saltpond and finally, in the Winneba District, Winneba, Apam and Mumford were the towns where the ordinance was applied.[115] Some of the sanitary infrastructures that were provided in some of the districts were due to the effort of the sanitary committee and the health board. For instance, through the instrumentality of the sanitary committee and the Health Board of the province, Cape Coast had six pan latrines for males and the same for females constructed at Asante Road in Cape Coast in 1916[116] and, by 1917, there were about 18 pan latrines in the Winneba District.[117] Good sanitation is one of the environmental aspect of disease prevention in the quest to ensure public health, however, the colonial

[113] PRAAD-Cape Coast, ADM 23/ 1/ 2354 (1926-19) Provincial Health Board, Sanitary Committee and Central Board Meeting.
[114] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 40.
[115] PRAAD, Cape Coast, ADM 23/ 1/ 209 (1912-16) Town and Public Health, 1912-1945; PRAAD-Cape Coast, ADM 23/ 1/ 2354 (1926-19) Provincial Health Board, Sanitary Committee and Central Board Meeting.
[116] PRAAD, Cape Coast, ADM 23/ 1/ 2085 (1915-16) Sanitary Improvement, 1915-1916. In the same year the government was able to acquire two sites to construct latrines at Gegem and Kotokuraba road but due to opposition from the people the project was aborted. Same was the fate of government in an attempt to build a latrine in the Muslim community.
[117] Some of the latrines were built with corrugated iron and 15 out of the 18 were in bad shape as at 1918. See PRAAD- Cape Coast, ADM 23/ 1/ 2121 (22/2/1917-31/12/1917) Sanitary Improvement, Winneba.

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government employed other means of disease prevention and control within the early years of the twentieth century.

Epidemiology Policies

In 1905 a scheme was inaugurated to teach elementary hygiene and sanitation in government-assisted schools. The subject was also made compulsory at the teacher's examinations.[118] This was a pragmatic step to create awareness and eradicate the spread of communicable diseases among the local populations in the Gold Coast. Following this policy, books and pamphlets on disease prevention were distributed to the literate in the Gold Coast and instruction in hygiene and sanitation was made obligatory in Gold Coast primary schools in 1906.[119] As the hub of western formal education in the Gold Coast, the Central Province greatly benefited from this health education programme as it had the largest number of schools in the colony as at this time.[120]

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[118] PRAAD-Accra, ADM 5/1/62 (1907) Government of Gold Coast Departmental Report 1907, Medical and Sanitation Department. It is worth of note that health education was part of the colonial western school-based education curriculum. See David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* (Los Angeles: Crossroad Press, 1981), p. 8.

[119] Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 173. By 1919, the teaching of hygiene was made compulsory from standard IV. See PRAAD-Accra, ADM 5/1/76 Government of Gold Coast Department Report 1919, Medical and Sanitation Department.

[120] For works that discuss the earliest history of education in the Gold Coast and the position of Cape Coast in this regard, see Kimble, *A Political History of Ghana*, pp. 61-73 and 510; Philip Foster, *Education and Social Change in Ghana,* (London: Compton Printing Ltd., 1965), Ralph M. Wiltgen, *Gold Coast Mission History, 1471-1880,* (New York: Divine Word Publications, 1956); Adu A. Boahen, *Mfantipim and the Making of Ghana: A Centenary History, 1876-1976,* (Accra: Sankofa Educational Publishers, 1996); McWilliam H.O.A, *The Development of Education in Ghana,* (London: Longmans Green & Co. Ltd, 1964); Okechukwu C. Abosi & Amissah J. Brookman (eds.), *Introduction to Education in Ghana*, (Accra: Sedco Publishing Ltd., 1992). These schools and works admits the fact that Cape Coast and for that matter the Central Province was the hub of education in both pre and colonial period.

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The Education Department of the Gold Coast thus, became a vehicle for the creation of awareness and campaign against the spread of diseases in the colony. Hence, one could say that there was the realization of the need to employ a multi-departmental approach in the fight against diseases from the early twentieth century by the colonial government. Since the process of teaching and learning takes time, the very impact that health education had on the people's life as far as health and sanitation are concerned cannot be assessed within the period under discussion. Aside this, there is also paucity of information on the books that were used at this early stage of the policy as well as the impact of the health education program. Therefore, there is no much information on the impact of the health education on the people as long as the desire to control communicable diseases were concerned.

Precautionary measures in disease prevention was still used in this period hence by 1911, through the instrumentality of a Mosquito Ordinance, a special regulation was made on securing water barrels against mosquito breeding. This was one of the measures to prevent the breeding of mosquitoes in the local communities and homes. Thus, previously, open drums and other containers that were used to store water at homes aided the breeding of mosquitoes in homes. By this ordinance, rigorous domestic inspection and unrelenting prosecution of peoples whose homes were infected with mosquito larvae became a regular feature in the Central Province.[121] Complaints over the policy and the conduct of the inspectors were frequent. The policy was seen as

[121] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 131.

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"monstrous"[122] and the fines were arbitrary and expensive.[123] The inspection was zealously done in such a manner that women were disturbed in their baths by zealous inspectors.[124] There was widespread opposition to the zealous inspection of houses by sanitary inspectors in other parts of Gold Coast particularly in Eastern Province.[125]

Segregation was still the key policy in the prevention of malaria among Europeans, however, some expatriate firms had difficulty in building for themselves the required bungalows for their employees. As a reality, it was suggested in 1902 by the Medical Department, that merchant firms which could not provide better living conditions for its European workers should reduce the period of their service in the colony for such employees to at least eighteen months.[126] In this, it was hoped that the European workers will have a short stay in the Gold Coast and hence they would not get ill easily. By 1911, segregated areas existed for Europeans, mostly the colonial administrative officials in Cape Coast, Saltpond, Dunkwa, and Winneba. However, it was from 1914 that the commencement of the exodus of Europeans from the townships of the Gold Coasters to the segregated areas really began.[127] Noteworthy, mining

[122] Gold Coast Leader, 21 January, 1903, p. 4. Cited in Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 40.
[123] Cold Coast Leader, 20 July, 1912, p. 4. Cited also in Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 40.
[124] Gold Coast Leader, 31 August, 1912, p. 4. See also *Patterson, Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 40.
[125] Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, pp. 40-41.
[126] PRAAD-Accra, ADM 5/1/57 (1902) Government of Gold Coast Departmental Report 1902, Medical Department, p. 14.
[127] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 44. Segregated areas also existed in Sekondi, Kumasi, Tarkwa, Axim, Nsawam and Accra. The exodus in 1914 was because of the outcome of the 1912 conference of Principal Medical officers of all British West African colonies which advocated for absolute segregation as a policy to protect Europeans in new towns and quarters hence the gradual evacuation of "residential premises" in existing "native" areas. See Kimble, *A Political History of Ghana*, p. 384; PRAAD-Cape Coast, ADM 23/ 1/ 276 (1916-47) Segregated Areas- Saltpond; PRAAD-Cape Coast, ADM 23/ 1/ 323 (1919-27) Winneba Government Segregated Area. The hilly areas which is east of Saltpond were

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companies, merchants and missionaries resisted residential segregation, largely because of the cost of building bungalows on an approved plan and so it was not easy a task for the colonial administration to pursue this policy to its logical conclusion. The majority of European non-officials of the business companies lived on their business premises which were situated in the heart of African towns and the consequent effect was that they suffered far more severely from malaria, yellow fever and other illnesses than the colonial government officials who lived farther away from the African settlements.[128] From 1912 onwards, the use of mosquito nets in European dwellings became mandatory and wearing mosquito boots after dark became a general practice among the official members of the European community.[129] Evidently, the popularity of segregation as one of the remedies for malaria among Europeans in West Africa depended far less on the prestige of those who proposed it than on the motives of the colonial authorities who adopted and implemented it.[130]

Despite all these measures to protect people from malaria and other diseases, the Central Province did fall victim to the Influenza epidemic. This fatal epidemic which threatened the province and the colony as a whole between 1918 and 1919 claimed at least four percent of the population of the Gold

acquired for segregated area for Europeans. The Residency Hill, The East Hill and The Ridge were the names given to the segregated areas in Cape Coast, Saltpond and Winneba respectively. It is worth noting that the policy of segregation was practiced by all the European Imperialist in colonial Africa. The fact is, other segregated areas existed in Algeria, Dakar, Sierra Leone, Dar es Salaam in German East African territories. See Philip Curtin, "Medical Knowledge and Urban Planning in Tropical Africa", *American Historical Review,* Vol. 90, (1985), pp. 594-613.

[128] PRAAD-Accra, ADM 5/1/57 (1902) Government of Gold Coast Departmental Report 1902, Medical Department; Addae, *Medical Histories from Primitive to Modern Medicine*, p. 45; Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 172.

[129] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 49.

[130] Cell, "Anglo-Indian Medical Theories and the Origin of Segregation in West Africa", p. 332.

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Coast.[131] The epidemic exceeded the experiences and resources of the colonial Medical Department. Although in the past the department had had some success in forestalling epidemics of plague and smallpox by using maritime quarantine and vaccination.[132] However, these methods were less successful against influenza, which spread explosively and was less readily identifiable.[133] The limited available funds were allocated to the enforcement of maritime inspection and quarantine, urban sanitation, and the preservation of "European" life and health. By 1918, even fewer resources were being assigned to colonial medical administration owing to the demands of war in Europe.[134]

Cape Coast port was the first point of entry of the influenza epidemic into the Gold Coast. On 28 August, 1918, the Governor of Sierra Leone wired his counterpart in Accra that Freetown had recorded cases of influenza and that all ships reaching the Gold Coast from England or Sierra Leone should be considered infected.[135] The warning was too late as the S.S. Shonga, an American vessel outbound from Freetown, reached Cape Coast on 31st August and berthed. Thus, Cape Coast may have been infected as early as 31st August by the Shonga during the brief call of the ship.[136] Numerous cases were reported

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[131] Scott, *Epidemic Disease in Ghana, 1901-1960*, (London: Oxford University Press, 1965), p. 188; Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 64; Tomkins, "Colonial Administration in British Africa during the Influenza Epidemic of 1918-19", p. 68; The *Gold Coast Independent*, October 19th, 1918. 1, 19. In an editorial titled "Obituaries: Toll taken by the Influenza."

[132] PRAAD-Kumasi, ARG 1/14/2/4 (1908-50) Plague at Cape Coast Appearance in 1915. For other measures that were employed to prevent and control infectious diseases in the Gold Coast see David Scott, *Epidemic Disease in Ghana, 1901-1960*, (London: Oxford University Press, 1965), p. 7.

[133] Tomkins, "Colonial Administration in British Africa during the Influenza Epidemic of 1918-19", p. 70.

[134] *Ibid.*

[135] PRAAD-Accra, ADM 5/1/95 Gold Coast Departmental Reports 1918, Medical and Sanitary Report. See Patterson, "The Influenza Epidemic of 1918-1919 in the Gold Coast", p. 211 and Akyeampong, "Disease in West African History", p. 200.

[136] The *Gold Coast Independent*, September 7th, 1918. 1, 11. In an editorial titled "Influenza Now in the Colony". See also Patterson, "The Influenza Epidemic of 1918-1919 in the Gold Coast", p. 206 and Scott, *Epidemic Disease in Ghana, 1901-1960*, p. 188.

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by 17th September, 1918. Consequently, as a measure to check the wide spread of the epidemic, schools were closed by 20th September. Social life in the town was disrupted and many people died, including several prominent citizens.[137] One demented sufferer drowned himself in the sea.[138] Different interpretations were given to the outbreak of the epidemic. While some knew that it was physical, others believed it was the hand of God at work. Thus, some resorted to prayer to counter the flu. For example, an open-air prayer meeting was organized on 15th October which was well attended. The epidemic was clearly ebbing by the end of the month, but deaths were reported into early November, 1918.[139] Other coastal towns were attended at about the same time. Saltpond had its first case on 21st September, 1918 and the epidemic was at its height during the first week of October. Consequently, the district was declared an infected area and quarantine regulations were subsequently applied to the area. Winneba was infected by a sailor from Accra on the 24th of September and had its late case on 18th October, 1919.[140] One response to the epidemic was to quarantine victims. However, there is very little evidence that quarantine did work.

Hospital physicians could only advise people to avoid contact with the sick and to keep victims warm and rested. There were too few doctors to care for more than a small fraction of the victims. African healers, whether orthodox medical doctors, traditional practitioners, or quacks seeking to exploit the

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[137] Some of the impact of the epidemic on socio-economic life were that places of business were closed, the market more or less deserted, streets silent and empty and trade at standstill. Scott, *Epidemic Disease in Ghana, 1901-1960*, p. 191.
[138] Patterson, "The Influenza Epidemic of 1918-1919 in the Gold Coast", p. 211.
[139] *Ibid.*, p. 207.
[140] *Ibid.*, pp. 207-208. See also Scott, *Epidemic Disease in Ghana, 1901-1960*, p. 188; PRAAD-Accra, ADM 5/1/76 (1919) Government of Gold Coast Departmental Report 1919, Medical and Sanitation Department; The *Gold Coast Independent,* September 28th, 1918. "The Editorial Note."

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situation, were equally ineffective in their approach. A local entrepreneur in the province marketed a curative powder, which was to be taken with liquor, which perhaps had more effect than the actual remedy.[141] An herb-pepper mixture was suggested for symptomatic relief. The public was warned against two potentially lethal medicines: a "native castor oil" and a pain killer made from sasparilla root, camphor, and Schnapps.[142] The number of people who were successfully vaccinated against smallpox in the Central Province increased year by year but did not reach a significant number of Gold Coasters until the 1920s. Prior to that time the impact of the epidemic was reduced through quarantine measures.[143]

Gold Coast Africans' Response to the Colonial Public Health and Sanitation Policies of 1874- 1918

Western medicine and medical system openly competed with indigenous African medicine and medical system.[144] The sick people in the Central Province were not turned away from attending hospitals, however, during the period under discussion, negligible number of the Gold Coast Africans patronized the health facilities like hospitals and clinics. One of the reasons why the Gold Coast Africans did not patronize the hospitals could be found in the fees charged for accessing the hospitals. The first Hospital and Dispensary Fee Ordinance was enacted in 1898.[145] The charges that it

[141] Patterson, "The Influenza Epidemic of 1918-1919 in the Gold Coast", p. 211.
[142] *Ibid.*
[143] Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 174.
[144] Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 28.
[145] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 58.

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established ranged from six pence to three shillings and six pence per day.[146] These charges were seen as very expensive by the ordinary Gold Coast African and even the African official and their wives and children who were given free treatment and medicine and were charged a small fee for admission were reluctant to visit the western health facilities.[147] This financial factor was reported by Dr. B.W. Quartey-Papafio, who worked at Saltpond and Anomabo in 1899. This explains why the larger number of African populations in the Central Province continued to use and visit their indigenous medical practitioners and healers as was observed by the Medical Department in 1899[148] and throughout the first decade of the twentieth century. Another reason was perhaps the remoteness of the health facilities from the large number of Gold Coast Africans due to the concentration of the health facilities in mainly the district capitals and some big towns in the province. Thus, the interior part of the province was far from reach of the urban centres where western health facilities existed.

Gold Coast Africans responded to the domestic sanitary inspection by sanitary officers and scavengers with much agitation.[149] The reason for this was because the sanitary inspectors represented the law as they had power to prosecute and they did prosecute people, often with zeal, when sanitary laws were broken. In 1902, it was reported by the Medical Department that the people of Cape Coast were very difficult and vehemently opposed any attempt to improve the town as they frequently assaulted the sanitary inspectors and

[146] *Ibid.*
[147] *Ibid.*
[148] PRAAD-Accra, ADM 5/1/55 (1899) Government of Gold Coast Departmental Report, 1899.
[149] PRAAD-Accra, ADM 5/1/57 (1902) Government of Gold Coast Departmental Report, 1902, Medical Department, p. 17.

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scavengers.[150] Similar reports came from other districts within the province. The power given to the sanitary inspectors to enter into homes was culturally alien to the people and hence was met with resentment.[151] The demolition of insanitary buildings was also met with same hostilities by the Gold Coast Africans who were victims hence a sanitary inspector was regarded as a malignant type of police officer.[152]

Another area in which the Gold Coast African raised concern about was government's failure to train Gold Coast African doctors and its lack of interest in the health of the non-white population. Governor Hugh Clifford and Dr. T. E. Rice, the Principal Medical Officer, felt compelled to make strong statements defending the hard work of the understaffed Medical Department. However, the suggestion of J. E. Casely Hayford, an African member of the Legislative Council, was that the staffing problem can be solved by recruiting more African physicians. By this suggestion, J. E. Casely Hayford compelled Dr. Rice to admit that slum conditions in coastal towns contributed to the death toll during the influenza epidemic and that the Medical Department was too small.[153]

Although the Medical Department was understaffed, Gold Coast African doctors with perfectly good qualifications were refused appointment. For instance, in 1913 Dr. R. A. Savage, a Medical Health Officer to the Cape Coast Municipality since 1907, lost his job when his position as a medical

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[150] *Ibid.* It must be pointed out here that it was not only the people of Cape Coast or the Central Province who opposed the sanitary officers or the medical officers of health but also other Gold Coasters. The people of Tamale referred to the medical officers of health and the sanitary inspectors as "Summa Summa"-summons, summons which they often resisted. This shows how zealous the sanitary inspectors were in the discharge of their duties. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 21.
[151] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 145.
[152] *Ibid.*, p. 146.
[153] Patterson, "The Influenza Epidemic of 1918-1919 in the Gold Coast", p. 212; Addae, *Medical Histories from Primitive to Modern Medicine*, p. 264.

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officer came under Gold Coast government control.[154] Dr. B.W. Quartey Papafio[155], Dr. John Farrell Easom,[156] Mr. Hutton Mills and other Cape Coast nationalists some of whom were medical doctors spoke against the discrimination in the appointment and promotion of medical doctors.[157] This policy was not canonized but was effectively and deliberately enforced throughout the colony by the colonial government.

Conclusion

This chapter discussed the colonial public health and sanitation policies which were formulated, pursed and implemented in the Central Province of the Gold Coast from 1874 to 1918. It examined the political administrative machinery that was employed to administer Gold Coast. The chapter affirms that western medicine and medical systems were foreign culture imported into the Gold Coast. They were formally institutionalized with the declaration of the British Crown Colony of Gold Coast. Since its institutionalization, the sick person was offered at least two alternative forms of medical treatment and systems. That was the indigenous medicine and medical system and the western one or the Arabo-Islamic medicine. This means the formalization of western medical systems and facilities brought about a double consciousness in the social setting of the Gold Coast Africans. Western medical services were

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[154] Crowder, *West Africa Under Colonial Rule*, p. 426.

[155] Dr. B. W. Quartey-Papafio, was passed over in fovour of a white candidate. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 13.

[156] Dr. Easmon was suspended from the position of Chief Medical Officer in 1897, for being too closely associated with the management of *The Independent*, indigenous newspaper as well as for carrying on private practice. See Kimble, *A Political History of Ghana,* p. 97 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 13.

[157] Kimble, *A Political History of Ghana,* pp. 94-100; Amenumey, *Ghana: A Concise History,* p. 181 and Crowder, *West Africa Under Colonial Rule,* p. 199 and 326.

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established in Gold Coast for a specific purpose: to make the environment hospitable for the colonial settlement and to treat specific illnesses that Europeans were not immune to. The health and sanitation in the Central Province were very poor. The transfer of the colonial capital from the Central Province to the Eastern Province was largely based on politico-economic factors than the perceived ground of the insanitary nature of Cape Coast. The health policies that were formulated and implemented between 1874 and 1918 could be termed as a "European-centered health policy" and not merely a public health as it focused on the latter than the Gold Coast Africans. For this reason, most health facilities or resources were located only at the centers with European population, particularly, the district capitals of the Central Province townships, with particularly large population of the Gold Coast Africans in the interior of the province were ignored. It was as a result of this that by the end of 1910, it was Dunkwa, Saltpond, Elmina, Cape Coast and Winneba which received the provision of wells and water tanks, incinerators, public latrines, construction of drains, and the draining of swamps, slaughterhouses and improved market. The educated elites in the Central Province were able to influence government health policies when they opposed the implementation of the Town Council Ordinance of 1894 until 1908 when colonial government met their demand for reforms in the implementation of the policy in the province. Hence, the interest of some groups had effect on colonial policies.

The provision of sanitary and health facilities was very capital intensive and the revenue of the Gold Coast colony was not adequate enough to finance such projects. Whatever the situation was, the colony or the Gold Coasters paid for the cost of the provision of any public health and sanitation facility. Hence,

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whenever the revenue of the colony was not favourable to execute the implementation of a policy, it was abandoned as it did happen to the construction of many sanitary structures and dams for the provision of pipe-borne water for Cape Coast. The next chapter looks at colonial public health and sanitation policies that were pursued during the inter-war period, 1919 – 1939. Thus, the chapter helps to ensure continuity and chronological presentation of the history of the colonial public health and sanitation policies in the Central Province of the Gold Coast.

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CHAPTER FOUR

COLONIAL PUBLIC HEALTH AND SANITATION POLICIES DURING THE INTER-WAR PERIOD, 1919 – 1939

Health is the true wealth of old and young, of rich and poor and mischief and labour. It has been clearly realized that a sense of personal responsibility for health is an essential to all progress in the campaign against disease...[1]

Introduction

It was not until the inter-war years, that is, 1919 to 1939, that medical service began to make impact on communities outside the major towns in the colony.[2] Thus, the colonial government strove to extend its health and sanitation policies to cover towns outside the usual European populated areas in the colony. The inter-war period was one of economic depression and instability which followed shortly after the end of the war. It was prior to the outbreak of the Second World War that the global economy became stable and hence, the inter-war period witnessed the introduction of pipe borne water supply, electric lighting, and, above all, the building of hospitals, dispensaries and other health care centres. Some towns in the province like Dunkwa, Aboom, Saltpond and Winneba were provided with street drainage, latrines, incinerators, streets and market areas.[3] Most of these developments had come about because at the metropolitan level, concerns over colonial welfare of the Gold Coast Africans and the Europeans in the colony gained ascendancy in the British Colonial Office in the 1930s, partly in response to labour resistance and nationalist

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[1] *Gold Coast News*, Accra "Health Week- Aims and Objectives of its Celebration," Accra, Wednesday, 8th September, No. 7. 1926, p. 2.
[2] Michael Crowder, *West Africa Under Colonial Rule,* (London: Hutchinson & Co. Publishers Ltd., 1968), p. 285.
[3] Adu A. Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century,* (London: Longman Group Ltd., 2000), p. 106.

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agitation in its colonies and partly because of the economic gains that the British colonial government benefited from the stable global economy.[4] The Colonial Office treated the nationalist agitations as a problem of development and welfare rather than a labour issue. By the late 1930s the focus of the colonial administration had shifted from promoting exports to providing the basic needs of Gold Coast Africans and "raising" their living standards. The provision of the social amenities and raising the standard of living of the Gold Coast African was the essence of development and welfare which the Colonial Office invoked to fend off anti-colonial resistance and to preserve colonial rule.[5] It is based on this background that the present chapter seeks to narrate and evaluate the public health and sanitation policies that were pursued and implemented in the Central Province of the Gold Coast in the inter-war years. For systematic and better appreciation of events, the whole period under discussion will be divided into two decades: 1919 to 1929 and 1929 to 1939. Under each of the two periods, health and health facilities, water and sanitation, epidemiology and, lastly, health education will be the themes that will be discussed. The reason for the various themes does not mean that there was a sharp dichotomy between them as far as public health and sanitation policies were concerned, but rather, there is, as the evidence suggests, a connection in the public health and sanitation policies that dealt with health and health facilities, water and sanitation, epidemiology and health education. The Chapter will also examine the responses and initiative of the people of the Central Province to these colonial policies.

[4] As it shall be discussed further the cocoa hold ups in the 1930s was an example of both labour resistance and nationalist agitations in the Gold Coast.
[5] Jeff D. Grischow, "K.R.S. Morris and Tsetse Eradication in the Gold Coast, 1938-1951," *Journal of International African Institute,* Vol. 72, No. 3 (2006), p. 383.

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Public Health and Sanitation Policies and Health Facilities Provided Between 1919 and 1929

From 1919, there were separate hospitals for Europeans and Gold Coast Africans unlike previously in the late nineteenth century when both Gold Coast African officials and Europeans shared the same ward and hospital building. In 1919, Sir Frederick Gordon Guggisberg became the governor of the Gold Coast. Gordon Guggisberg's Ten-year Development Plan, contained public health and sanitation policies.[6] Guggisberg's public health policies sought to address eight issues, namely care of the sick; professional training of African medical and public health officers; infant welfare; general health education of the people; sanitation and improvement of towns and villages; medical research and epidemics.[7] Based on his Ten-year Development Plan, Guggisberg undertook a number of infrastructural projects. The very motive for the infrastructural development programmes was to help the colony raise revenue for internal development. As Governor Guggisberg said, the real object of the development programmes was "to give us sufficient revenue to carry out the educational and sanitary reforms necessary in this country and to make that revenue a permanent

VERITAS LUMEN NOBIS

[6] David Kimble, *A Political History of Ghana: The Rise of Gold Coast Nationalism,* 1850-1928, (Oxford: Clarendon Press, 1963), p. 56. During 1922 and 1927 there was revision of the expenditure. That for water supplies changed from £ 1, 208 to £ 634. The expenditure for town improvements and drainage changed from £ 300 to £ 740, and that of public buildings moved from £ 1, 000 to £ 2, 273 respectively for the years. For the Ten-Year Plan see Sir Frederick Gordon Guggisberg, *Ten Year Development Plan for the Gold Coast*, (Accra: Government Printer, 1924); D. E. K. Amenumey, *Ghana: A Concise History*, (Accra: Sankofa publications, 2000), pp. 182-183; G. E. Metcalfe, *Great Britain and Ghana: Document of Ghana History, 1807-1957,* (London: Ipswich Book Co. Ltd., 1994 [1964]), pp. 576-577; P. A. Twumasi, *Medical System in Ghana: A Study in Medical Sociology,* (Accra: Ghana Publishing Corporation, 1975), p. 45; R. E. Wraith, *Guggisberg,* (London: Oxford University Press, 1967), pp. 98- 128; P. A. Twumasi, *Social Foundations of the Interplay between Traditional and Modern Medical Systems,* (Accra: Ghana University Press, 1988), p. 17.

[7] Stephen Addae, *Medical Histories from Primitive to Modern Medicine, 1850-2000,* Vol. 1 (Accra: Durham Academic Press Ltd., 2012), p. 33; 66-68.

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one".[8] Hence, Guggisberg realized that there was direct relationship between economic development, the health of a people and wealth creation.

In 1921, Guggisberg's administration amended the Infectious Disease Ordnance of 1908 and instituted the Infectious Disease Regulations of 1921. This declared diseases like Small Pox, Yellow Fever, Plague, Cholera, Cerebrum Spinal Meningitis (CSM), Sleeping Sickness and Anthrax as infectious maladies.[9] Accordingly, medical officer of health with the assistance of the police, sanitary inspectors or any person acting on the instruction of the medical officer of health, were empowered to inspect buildings and premises to ensure that they did not accommodate persons with infectious diseases. People were encouraged and mandated to report any person suspected to have infectious disease to the nearest medial officer of health or the police; any person traveling from or to any infected area was to submit to the medical officer of health his or her name, intended destination and his or her place of residence there so that the medical officer could check if the intended destination was conveniently situated for medical supervision.[10] Such a traveler was required to present himself or herself for medical supervision for a specified period of time before the journey.[11] The regulations also stipulated free disinfection or burning of the articles or items like clothes of an infected person and no person was allowed to remove any property from premises that has been occupied by persons with infectious disease.[12] As a public health measure, the

[8] Kimble, *A Political History of Ghana*, p. 58; Crowder, *West Africa Under Colonial Rule*, p. 309 and Metcalfe, *Great Britain and Ghana: Document of Ghana History*, p. 576.
[9] PRAAD-Cape Coast, ADM 23/ 1/ 176 (1909-45) Small Pox Infection Disease.
[10] *Ibid.*
[11] *Ibid.* It was stipulated that the period for the medical supervision of the traveler shall not exceed 5 days in the case of plague and Cholera; 6 days in the case of Yellow Fever or CSM; 12 days in the case of Small Pox. The regulations also required natives to close any holes in their homes made by rats, mice and mouse.
[12] PRAAD-Cape Coast, ADM 23/ 1/ 176 (1909-45) Small Pox Infection Disease.

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regulations stipulated that when an infectious disease became an epidemic in any place, there shall be the prohibition of holding public meetings, funeral ceremonies or other local customs which was likely to tend to the spread of any infectious disease.[13] The outbreak of Small Pox disease in Accra in 1920 precipitated the promulgation of this infectious disease regulation, however, this regulation was applied to the whole of the Gold Coast.

The policy of providing dispensaries for the Gold Coast Africans which were far from the district hospitals was also carried out and so between 1921 and 1927, Guggisberg's government built 19 new hospitals, provided over 800 hospital beds and 20 dispensaries.[14] From the 1920s onward every district that had a medical officer stationed there was provided with a hospital or a dispensary for the people. Nearly all such health facilities had a theatre for surgery and received regular supply of drugs.[15] There were usually six senior medical officers, usually placed in coastal towns like Cape Coast and in districts where there were no or limited number of medical staff. In such cases, the medical officers were required to act as sanitary officers too.[16] There was generally frequent shortage of medical officers in the Central Province, however, the limited number of personnel that existed in the few privileged districts were overburdened with the task of combining their medical or health duties with either serving as District Commissioner or a Sanitary Inspector of towns.[17] This policy continued from the immediate post-War period to the 1930s when economic depression both globally and locally were at its peak.

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[13] *Ibid.*
[14] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 67.
[15] *Ibid.*, p. 71.
[16] *Ibid.*
[17] PRAAD-Cape Coast, ADM 23/ 1/ 275 (1916-37) Medical Officers as District Commissioners.

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This was a real challenge as it affected health care among the general public in health service delivery. For instance, in 1925, some towns like Swedru, Nyakrom, Nsaba, Kwanyako, Appam and Abodom, all in the Winneba District, had no medical officer attending to them regularly because of the limited number of medical officers in the province in particular and the Gold Coast in general. The only medical officer of health for the district was very occupied with another duty of devoting much time to the sanitation work in those towns than providing them with health care service at the hospitals.[18] Thus, the environmental aspect of health promotion was not the duty of medical officers of health but rather the sanitary officers, however, due to the shortage of sanitary officers, the medical officers of health assumed such duties as well.

Also, in 1926, one Dr. P. D. Oakley doubled as the medical officer of Winneba District as well as the commissioner of the district due to the absence of a commissioner.[19] Twifo Praso and Foso, which were within the administrative jurisdiction of Cape Coast District, were also faced with a similar situation of they not having a sanitary officer. The inhabitants of the two towns complained in 1927 that for a number of weeks the medical officer of health did not visit their towns to inspect the sanitary and health state of the towns.[20] Hence, the shortage of medical and sanitary staff and the general limited number of administrative officials in the colony following the end of the First World War posed a real challenge to the pursuit of health care policies. The issue of

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[18] PRAAD-Cape Coast, ADM 23/ 1/ 435 (1922-45) Sanitary Department.

[19] PRAAD-Cape Coast, ADM 23/ 1/ 275 (1916-37) Medical Officers as District Commissioners. The Colonial government made it a rule that medical officers who performed such dual role due to the general shortage of European officials in the colony received per diem of 2/6 shillings or 10 shillings depending on the nature of the role.

[20] The medical officer of health could not combine his duty of health care and the inspection role on sanitary matters in all the towns in the district. In fact, it was required of the medical officer of health to visit the towns in his district once or twice a week. See PRAAD-Cape Coast, ADM 23/ 1/ 595 Sanitation at Twifo.

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shortage of medical and sanitation officers and administrative officers was improvised when medical officers of health were made to perform a dual mandate as officers of health and at the same time commissioners at the district level. However, this improvisation did not yield the required results in the quest to solve the health and sanitation issues that engulfed the Central Province and colony at large.

Aside the issue of shortage of medical officers of health and administrative officials following the end of the First World War, there was also the challenge as to how to ensure better health among the labour force in the mining sector. In 1924 a more serious problem regarding the mining areas became apparent when an eminent physician, Professor Sir William Simpson, was sent out to conduct a special inquiry into the very grave death-rate among mining labourers in the colony. The outcome showed very unsatisfactory conditions in the mining areas. It was against this that there were suggestions that among other things inoculation against pneumonia, the improvement of hospital, medical and sanitary serves, and seek better village planning etc. should be carried out in the mining areas. The result of his survey and recommendation led to the enactment of the Mining Health Areas Ordinance of 1925.[21]

Another challenge to public health during the post-First World War period was high rate of maternal and child mortality. From 1924 the colonial government took pragmatic steps to create and also provide a separate health

[21] The ordinance imposed strict requirement with respect to the employment and housing of local labourers employed in the mines and the main objective of the ordinance was to reduce the mortality rate. See PRAAD-Accra, ADM 5/1/21 (1925-26) Government of Gold Coast Annual Departmental Report, April 1925 to March 1926; Kimble, *A Political History of Ghana*, p. 43.

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unit that will cater for maternal and children health needs. This policy came about due to the initiative of Dr. G. J. Pirie, the head of the Medical Department, who had taken interest in maternal and child health care.[22] Based on this initiative, in October 1928, Cape Coast, the capital of the Central Province, received a government centre for maternal and child health unit or an infant welfare clinic.[23] As part of their duties, the female medical officers, who were charged to manage the infant welfare clinic, visited schools and homes to inspect babies and children who were up to 12 years. It is worth mentioning here that this initiative increased the number of women medical officers in the Central Province and the colony as a whole as the government made it a policy to engage the experienced European women medical officers who were responsible for the health needs of women and children. The maternal and child health service resulted in the formation of the Gold Coast League for Maternal and Child Welfare Unit (G.C.L.M.C.W.U.) with its centre at Christiansborg, Accra. The members of the League were midwives, nurses and dispensers who met once every month and were addressed by medical and health officers on matters regarding their activities of visiting homes.[24]

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[22] Infant welfare work had been initiated in the Gold Coast first by Dr. Jessie Beveridge who opened a clinic and dispensary in 1921 for the treatment of minor aliment of school children at Christiansborg in Accra. However, it took the organizing ability and initiative of Dr. G. J. Pirie who made a formal proposal for government to take up a plan for maternal and child health units in the colony. See Addae, *Medical Histories from Primitive to Modern Medicine,* p. 228 and David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* (Los Angeles: Crossroad Press, 1981), pp. 14-15.

[23] The unit also served as the training centre for the auxiliary health staff who were Gold Coasters. Cape Coast, therefore, served as the headquarters of the Infant Welfare Association of the entre Central Province. See PRAAD-Cape Coast, ADM 23/ 1/ 976 (1939-47) Infant Welfare Clinic- Central Province; PRAAD-Accra, ADM 5/1/25 (1929-30) Gold Coast Report for 1929-1930; Addae, *Medical Histories from Primitive to Modern Medicine,* pp. 228- 229 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 24.

[24] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 231 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 24. The unit also went on health treks to towns and villages where health facilities existed to treat children and mothers of any form of ailment.

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It is worth noting that it was in late 1920s that Britain showed interest in the studying of West Africa indigenous *materia medica,* particularly, in African toxicology. This plan was discussed in November 1929 at a conference in Sierra Leone which was attended by the Gold Coast Director of Medical and Sanitation Service, Provincial Commissioners, the Director of Agriculture, the Deputy Director of Health Service, the Commissioner of Police and the Magistrate, Pathologist and Crown Law Officer.[25] This conference aimed at making a survey on poisonous plants in West Africa. At the end of the conference, the delegates unanimously agreed that further research should be conducted into indigenous drugs and poison in British West African. As part of the mode of the analysis of the West African toxicology, it was suggested that there should be a clear distinction between the pharmacological effect of the drug and the psychological effect of superstition and "juju".[26] Europeans use the term "juju", to mean the indigenous African religions, hence the term was used in reference to the religious aspect of the *materia medica* of the Africans.[27] The decisions of the conference therefore, began to manifest in the Gold Coast and the Central Province from the 1930s; however, the implementation was made very

[25] This Conference was, perhaps, West African's version or response to the 1924 report of the Medical Research Laboratory of the Colony and Protectorate in Kenya which called on the British Colonial government to undertake research into native toxicology by making facilities available. See PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medical Practitioners Licenses.

[26] *Ibid.* It was agreed also that investigations were to be made into the effect of toxic substances on internal organs like kidney, liver, stomach, bladder and among others. Medical officers were also urged to observe and record the interval between the time of intake of poisonous food or drink and the first appearance of the symptoms of the poison. And, lastly, they were to record the symptoms of the poison on the victim.

[27] "Juju" is one of the earliest derogatory terms used by early European explorers to describe the indigenous religion of West Africans. The term is synonymous to fetish, idolatry, primitive and paganism. As Mary Kingsley remarked "When I say Fetish or *Juju,* I mean the religion of the natives of West Africa." Cited in E. G. Parrinder, *West African Religion,* (London: SPCK, 1962), p. 15. See also T.N.O. Quarcoopome, *West African Traditional Religion,* (Ibadan: African University Press, 1987), p. 19 and John S. Mbiti, *African Religions and Philosophy*. Second Edition, (New York: Heinemann Educational Publishers, 1989), pp. 7-10.

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confidential among the various commissioners at both the provincial and district levels.[28] The reason was perhaps to keep the whole study unknown to the Gold Coast intelligentsia.

The call for the study of the indigenous African *meteria medica* mentioned here was not the first time that this had been suggested by Europeans. European desire and curiosity to know the effectiveness of the indigenous African *meteria medica* predates the twentieth century. In the seventeenth century, one William Bosman, who explored the West African coast came into reality with how effective the indigenous African *materia medica* was and, therefore, made a passionate call on Europeans who were to come after him to study it hence he remarked that:

> Those who are to come to this Country (Gold Coast), may if they please, endeavour to explore these plants; for my part, I shall here take my leave of them, with only informing you, the better to evince the strange efficacy of these Herbs, that I have several times observed that *Negroes* cure such great and dangerous Wounds with them, that I have stood amazed threat.[29]

Therefore, the colonial regime's desire to study West African's medical plants and medical ideas at this time in the later part of 1920s was perhaps to give them advantage in their health policy formation. However, it was in the early 1930s that the whole plan about how to study the African medical plants manifested in the Central Province which shall be discussed later.

[28] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses.
[29] William Bosman, *A New and Accurate Description of the Coast of Guinea Divided into the Gold, the Slave, and the Ivory Coasts,* (London: The Ballantyne Press, 1907), p. 225. Indeed, the British colonial government was almost close to heeding to this call in 1906 when one P. J. Garland, the principal medical officer, reported that "no research has been carried out as to the nature of Native drugs; a special training in chemistry, Botany, therapeutics, *Materia medica,* and Analytical work is required for this purpose, and especially selected dispenser should undergo training." See PRAAD-Accra, ADM 5/1/ 61 (1906) Government of Gold Coast Departmental Report, 1906.

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As Gold Coast was concerned and the Central Province in particular, the colonial government never paid attention to diseases like leprosy from the late nineteenth century when colonial rule began in the Gold Coast. In fact, leprosy was not mentioned as an infectious disease in neither the Infectious Disease Ordinance of 1908 nor the amended Infectious Disease Regulation of 1921. The reason for the lack of recognition for such an infectious disease may be because lepers were kept away from the sight of colonial officials as victims were often taken away from their communities into nearby bushes which housed them. A 1929 report on the Central Province indicated that the "Fante [of the Central Province] being an intelligent people, understand the danger of infection by this disease, and take precautions to avoid infections, isolating infectious persons in the bush in small huts."[30]

However, with the aid of the Gold Coast branch of the British Empire Leprosy Relief Association (BELRA), a survey was conducted to know the number of lepers in the Central Province so that government could have a defined policy towards the disease towards the end of the second decade of the twentieth century.[31] To make the survey a successful one a scheme or plan was devised. First, Dr. N. B. Duncan Dixey, the secretary of the BELRA and the

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[30] This information appeared in the work of one Dr. N. B. Duncan Dixey, the Medical Secretary for the Gold Coast branch of the British Empire Leprosy Relief Association. He had trekked the whole province between late 1928 and early 1929 in search of the number of lepers in the province. The quoted information was made known to him by Mission fathers, whom as it were took care of such banished people. See PRAAD-Cape Coast, ADM 23/ 1/ 311 (17/10/1918-27/11/1918) Leprosy; PRAAD-Cape Coast, ADM 23/ 1/ 4068 (1925-29) Leprosy, 1925-1929; PRAAD-Accra, CSO 11/9/ 2 (1929-31) Leprosy in the Gold Coast, Dr. Dixey's Report and Recommendation.

[31] The objective of the BELRA was "to stamp out leprosy in the British Empire." And their work was to initiate new work for helping lepers as well as to assist, advice and co-ordinate the work of all existing agencies for bringing relief to lepers. The government or viceroy of India was one of the sponsors of the activities of this association. PRAAD-Cape Coast, ADM 23/ 1/ 311 (17/10/1918-27/11/1918) Leprosy; PRAAD-Cape Coast, ADM 23/ 1/ 4068 (1925-29) Leprosy, 1925-1929. See also Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 74.

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Director of Medical and Sanitation agreed to use Elmina's dispensary as a centre and selected some days within the week to treat lepers. Secondly, it was planned that Dr. Duncan would visit villages to treat general sickness and at the same time look out to identify and treat people who showed symptoms of leprosy.[32] Accordingly, a medical trek was made in November 1928 to Beposo, Komenda, through several villages to Praso, Foso and Brofoyedro. 17 lepers were identified and a total of 223 medical cases were treated.[33] In December of the same year, the trek carried out through Agona, Eguafo, Beposo, Twifu and Dunkwa. 23 cases of leprosy were identified and 347 medical cases were treated.[34] The survey of the Central Province and that of other parts of the Gold Coast revealed the seriousness of leprosy and thus compelled government to make the construction of leper settlements an important component of government's public health policies. Until then, the colonial government continued to provide water and better sanitary facilities for the people in the province.

Water and Sanitation Policies

Water supply in the Central Province was still derived from wells and stored rainwater in government tanks which was often available to the coastal towns. And in the interior, the people continued to depend on rivers, streams

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[32] PRAAD-Cape Coast, ADM 23/ 1/ 311 (17/10/1918-27/11/1918) Leprosy; PRAAD-Cape Coast, ADM 23/ 1/ 4068 (1925-29) Leprosy, 1925-1929.

[33] *Ibid.*

[34] Based on Dr. Dixey's survey on lepers in the Gold Coast, it was reported that the Central and Western province had the lowest number of lepers in the whole of the Gold Coast. In all there were 80 lepers in the Central Province, 369 in the Eastern Province; 1, 702 in the Northern Territories, 1, 056 in Ashanti and 859 in the Togoland. It was, therefore, recommended that a leper settlement be established in the Northern Territories. See PRAAD-Accra, CSO 11/9/ 2 (1929-31) Leprosy in the Gold Coast, Dr. Dixey's Report and Recommendation. See also Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 74.

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and lagoons as their major source of water for diverse purposes. Taking the capital of the Central Province as an example, by 1920 there were 10 public wells of which 5 were mosquito proof; 301 private wells of which 296 were mosquito proof; 45 public tanks also existed of which 29 were mosquito proof while there were 128 private tanks.[35] There was, however, a general improvement in the method of water collection and conveyance as air, motor and wind mills were used to pump water from wells into tanks at Dunkwa, Aboom, Saltpond, Winneba and many other towns in the province.[36] Public services like drainage, or electricity were rudimentary in the towns and unknown in the villages. It was from 1926 that the Central Province was provided with pipe-borne water and this was done specifically in Cape Coast and Winneba.[37] However, it was on a pilot basis.

There was coordination between the Medical Department and the Public Works Department to ensure that quality pipe-borne water was provided to the few beneficiaries of the pipe-borne water supply in the Central Province. In August 1925, A. B. Monks, the Provincial Medical Officer of Health requested from the provincial engineer, information on Cape Coast pipe-borne water supply regarding purification, average daily water consumption, the number of stand pipes and private consumers and recommendations for improvement.[38] This confirms the fact that water supply was not just provided anyhow but that the need for the quality of its production and supply was required. This was

[35] PRAAD-Accra, ADM 5/1/79 (1922-23) Government of Gold Coast Annual Departmental Report, Jan. 1922 to March 1923. In all, the nature of the tanks was such that 10 were made of wood, 124 of iron and 71 were made of concrete.
[36] PRAAD-Cape Coast, ADM 23/ 1/2209 (1920-22) Sanitary Improvement; PRAAD-Accra, ADM 5/1/76 (1919) Government of Gold Coast Departmental Report 1919, Medical and Sanitation Department.
[37] Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 60 and Addae, *Medical Histories from Primitive to Modern Medicine*, p. 133.
[38] PRAAD-Cape Coast, ADM 23/ 1/2310 (1925-30) Cape Coast Water Works.

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because at the experimental stage of the pipe-borne water supply, the beneficiaries were European officials. On 12th December, 1928, Sir Ransford Slater, the Governor of Gold Coast, officially inaugurated the dam on the Brimsu river.[39] In its early stage the pipe-borne water supply was based on a "compound system," a system whereby water was paid for before it was supplied. The charges on the water supply was fixed at a rate of 15 per cent and it cost one a penny for 4 gallons of water in Cape Coast.[40]

On sanitation matters, the colonial government continued to decongest towns by demolishing buildings for better town planning along a good layout. In 1919, the unofficial members of the Cape Coast Town Council petitioned the provincial commissioner for immediate relief of the congested areas in the capital of the municipality.[41] Owing to this, in 1920, government declared the local community around the Cape Coast Castle a congested area and therefore paid a total of £ 120-10/ as compensation for 6 property owners whose buildings were demolished during the decongestion exercise.[42] The general sanitary condition in the Central Province was not better.[43]

In 1920, the colonial government employed 10 sanitary inspectors to work at the Cape Coast District to help better the sanitary conditions of the

[39] *Ibid.* The Cape Coast water supply scheme was proposed in January, 1924, but it was not until the 1928 that the project was completed and operational. The total estimated cost of the project was £ 204, 000.
[40] PRAAD-Cape Coast, ADM 23/ 1/2310 (1925-30) Cape Coast Water Works. The essence of the compound system was to prevent the general public from wasting or misusing water.
[41] PRAAD-Accra, CSO 11/14/199 (1939) Sanitary Condition and Layout of Cape Coast. The petitioners gave their support to the apprehension of anyone who opposed the demolition of a house in a congested area.
[42] PRAAD-Cape Coast, ADM 23/ 1/ 370 (1920-24) Congested Areas in Cape Coast; PRAAD-Accra, CSO 11/14/ 199 (1939) Sanitary Condition and Layout of Cape Coast. Land was acquired by the colonial government at Amanful where the evacuated people built their new settlement in a better layout. Between 1919 and 1922, government spent about £ 5, 000 as compensation for victims of decongestion in the Central Province.
[43] PRAAD-Accra, CSO 11/14/ 199 (1939) Sanitary Condition and Layout of Cape Coast.

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district. In that same year, 26, 205 houses were inspected, 137 houses were found with mosquito larvae, 353 houses were served with notice against mosquito larvae. 98 persons were fined for mosquito larvae, 49 notices were served to houses with insanitary conditions and 42 persons were fined for insanitary conditions.[44]

Table 1. **Sanitary Inspection at Cape Coast District, 1920**

Total number of houses inspected	Houses infected with Mosquito larvae	Notices Served to houses with larvae	Persons fined for larvae infestation	Notices to insanitary conditions	Persons fined for insanitary conditions
26, 205	**137**	**353**	**98**	**49**	**42**

Again, in 1921, 12 sanitary inspectors worked at the Cape Coast District to help better the sanitary conditions of the district. In that same year, 25, 639 houses were inspected, 137 houses were found to be infected with larvae, 667 houses were served with notice against larvae. 251 persons were fined for larvae, no notice was served for insanitary conditions in the district, however, 67 persons were fined for insanitary conditions.[45]

[44] PRAAD-Accra, ADM 5/1/79 (1922-23) Government of Gold Coast Annual Departmental Report, Jan. 1922 to March 1923.
[45] *Ibid.*

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Table 2. **Sanitary Inspection at Cape Coast District, 1921**

Total number of houses inspected	Houses infected with Mosquito larvae	Notices Served to houses with larvae	Persons fined for larvae infestation	Notices to insanitary conditions	Persons fined for insanitary conditions
25, 639	**321**	**667**	**251**	**Nil**	**67**

The colonial government employed as many as 28 sanitary inspectors for Cape Coast District between 1922 and the first quarter of 1923.[46] These inspectors worked assiduously to inspect 57, 725 houses and out of this number, 493 houses were found to be infected with mosquito larvae. 1, 251 notices were served to houses against larvae infestation and 376 persons were fined for larvae infestation; 186 notices for insanitary conditions and 145 persons were fined for insanitary conditions.[47]

Table 3. **Sanitary Inspection at Cape Coast, 1922- March, 1923**

Total number of houses inspected	Houses infected with Mosquito larvae	Notices Served to houses with larvae	Persons fined for larvae infestation	Notices to insanitary conditions	Persons fined for insanitary conditions
57, 725	**493**	**1, 251**	**376**	**186**	**145**

[46] *Ibid.*
[47] *Ibid.*

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It is worth mentioning here that Guggisberg's Ten Years Development Plan and the poor sanitation in Cape Coast, the capital of the Central Province inspired the District Engineer of Cape Coast to draft a Ten-Year Sanitary Improvement Programme for Cape Coast municipality in November 1921. The programme had 18 main items on its agenda. These included the demolition exercise for the decongestion of some areas in the Cape Coast District; town planning; roads construction; land reclamation; drainage; water (i.e. pipe-borne) supply; sewage system; refuse collection; refuse disposal; slaughter houses; market building; municipal baths; municipal laundry platform; street lighting; housing; contagious disease hospital.[48] This Ten-Year programme became the blueprint for the sanitary works in the provincial capital from 1922 to 1932.

The increasing congestion of most towns and villages in the colony precipitated the passage of the Building Regulation Act of 1921. The promulgation of the Building Regulation Act of 1921 saw a new wave of building styles and acculturation of indigenous architectural designs as far as housing is concerned. Just as the segregation policy stipulated the architectural design of the European bungalows, so was the new building regulations for the Gold Coasters. According to the regulation, the Gold Coast Africans were to seek a building permit from the Town Council with the knowledge of the president of the council or the district engineer after their application had met all the requirement like quality building materials and inspection and approval

[48] PRAAD-Cape Coast, ADM 23/ 1/2241 (23/8/21-7/11/21) Ten Years Plan, 1923-1933- Cape Coast. The plan or programme was to take effect from April 1922. The specific areas within the Cape Coast municipality to benefit from the various provisions of the programme were clearly spelled out. Following the footsteps of the municipality, Saltpond District also drafted a similar Ten-Year programme for the district within the same time frame of the municipal one.

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of the building site and the plan by a district engineer.[49] The regulation also permitted the demolition of old dilapidated and dangerous buildings or buildings that obstructed public ways or were poorly spaced and unventilated.[50]

For health and better sanitary environment, the regulation demanded that even when one was constructing a swish, wattle or mud house, one was to use concrete or mortar to level the floor and for the foundation of the building as a measure to prevent rodents and rats from infecting the individual with plagues.[51] Thus, this policy was to ensure public health and sanitary environment. As George E. London, the then Colonial Secretary noted:

> It was the policy of Government to encourage the erection of sanitary houses, and not to discourage building by exacting the extreme penalty of demolition, merely on account of any minor technical imperfection in construction or site, which is not detrimental to public health at the time or likely to be in the future.[52]

This regulation was applied to all the districts in the Central Province. In 1926, the Provincial Health Board ordered that the Building Regulation should be applied to the Hausa Zongo at Oda in the Western Akyem District.[53] Although the reason for the "zongo" being usually selected outside the developed areas of

[49] PRAAD-Cape Coast, ADM 23/ 1/ 639 (1926-41) Building Regulations. The regulation also stipulated the rules for the construction of three and four storey buildings.
[50] *Ibid*
[51] *Ibid.* Based on section 33 and 37 of the Regulation. It is worth noting that by this time, the colonial government and its medical team had established a connection between the wild rodents which periodically passed the diseases particularly, plague on to domestic rats thereby causing the recurrence of the disease in man. Although there appeared to no prove to this claim, yet the destruction of and prevention of rats and rodents in human habitation was deemed to be a good measure in the prevention of some diseases or infections. See David Scott, *Epidemic Disease in Ghana, 1901-1960*, (London: Oxford University Press, 1965), pp. 22-23.
[52] *Ibid.*
[53] PRAAD-Cape Coast, ADM 23/ 1/ 625 (21/5/1926-12/11/1926) Hausa Zongo Sanitation. In the Central Province, the Hausa speaking people being wanderers did not take interest in building their houses along sanitary lines or layout. However, the Fanti and Twi communities were better on this issue. See PRAAD-Accra, ADM 5/1/79 (1922-23) Government of Gold Coast Annual Departmental Report, Jan. 1922 to March 1923.

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towns was to isolate the occupants from the main population on grounds of health chiefly due to the type of settlement and buildings usually associated with zongos. However, this area in Oda was increasingly becoming plague zone within the district hence the need for the application of the regulation.

Government strove to ensure better sanitation in the province hence a large number of trained Gold Coast Travelling Inspectors were used to improve sanitation. Although this approach was good it however faced a challenge- dishonesty on the part of some of the inspectors. As the government strove to ensure that there was sanitary environment in the province, some of the Gold Coast sanitary inspectors who were to make sure that the general public observed the general sanitary regulations rather sided with some of the people by taking bribes. This was exemplified in an incident that happened in 1923 when the district engineer of Winneba, G. C. Cuthbert inspected works at Swedru and came to realize that the sanitary inspector had taken £ 1 each from one Amaga and Ayao to permit them to rebuild their already demolished swish huts.[54] Based on further investigation into this issue, it was realized that the late sanitary inspector, Mr. Fianu, had also earlier on given a similar illegal permit for the construction of a wooden structure in the Swedru town.[55]

Epidemiology Policies

It can be said that, by 1920 there was a change in the Colonial Office as regards the wider perception of the increased sense of responsibility for the welfare of the indigenous population in all the Central Province. This shift of

[54] PRAAD-Cape Coast, ADM 23/ 1/ 435 (1922-45) Sanitary Department.
[55] *Ibid.*

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gaze to the indigenous people's health was permitted largely by the phenomenal fall of the mortality rate among Europeans, increasing prosperity of the colony and the institutionalization of residential segregation[56] and the increasing demand for better welfare and health promoting facilities by the Gold Coast intelligentsia. The effort of the Medical and Sanitary authorities in promoting the treatment of diseases and spreading the knowledge of general hygiene continued and was very beneficial in disease prevention. Common diseases like malaria, hookworm and yaws remained widespread. Yaws permeated Gold Coast at every level in the 1920s and anti-yaws campaigns were undertaken in the mid-1920s.[57]

Residential segregation was key in disease prevention for the European. The segregated areas in some districts in the Central Province were expanded in this period under discussion. In 1921, the colonial government bought a piece of land from one J. Alex Abban at Saltpond for the extension of the Segregated Area so that some European firms operating in the Saltpond District could build their own bungalows at the place.[58] Again, in 1923, in the Winneba District, companies like the Bank of British West Africa, the Anglo Guinea Production Company and African and Eastern Trade Corporation were given plots of land to build their own bungalows at the ridge area of Winneba.[59] One could argue

[56] PRAAD-Accra, CSO 11/1/ 371 (1934) Sanitation and Medical Facilities in the Gold Coast. See also Addae, *Medical Histories from Primitive to Modern Medicine,* p. 32.
[57] PRAAD-Accra, CSO 11/1/ 371 (1934) Sanitation and Medical Facilities in the Gold Coast.
[58] PRAAD, Cape Coast, ADM 23/ 1/ 276 (1916-47) Segregated Areas- Saltpond; PRAAD-Accra, ADM 5/1/79 (1922-23) Government of Gold Coast Annual Departmental Report, Jan. 1922 to March 1923. Owing to the frequent outbreak of yellow fever at Saltpond and the increasing number of death cases of Europeans who were not staying in the segregated areas made the provision of new bungalows in the segregated area a necessity.
[59] From 1920, the above-mentioned companies partitioned Mr. J. L. Atterburg, the provincial commissioner on their application for a place in the said segregated area. See PRAAD-Cape Coast, ADM 23/ 1/ 323 (1919-27) Winneba Government Segregated Area. See also PRAAD-Accra, ADM 5/1/76 (1919) Government of Gold Coast Departmental Report 1919, Medical and Sanitation Department.

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that the congregation of homes of workers of those companies was to make their work easier and to make easy call on workers when the need arose, however, the health consideration for the workers was also a great factor. The fact is that the colonial government formulated a plan for such residence segregation for Europeans in general in the Gold Coast. Which means that segregation was still used as a measure to prevent malaria and other diseases among Europeans. However, complete segregation was obviously impossible as not all European companies or individuals could afford the purchase or building of the European type of buildings in the Central Province, and hence, such individuals continued to dwell in the towns of the Gold Coast Africans.[60] Attention was given to the towns and communities of the Gold Coast Africans as Town Councils were tasked with the responsibility of decongesting crowded quarters of the Gold Coasters, which were seen as prime breeding grounds for mosquitoes. It meant passing regulating ordinances that will ensure the removal of unsafe and insanitary structures which inevitably pitted European officials against the Gold Coast unofficial members of the Town Council.[61]

Another strategy that was introduced in this period was mosquito larvae index. The mosquito larvae index was introduced in the whole colony and it was enforced as a measure to reduce mosquito breeding in the homes and communities of the Gold Coast Africans. By this controlling measure, the larvae index also known as the house index was the ratio of houses or compounds

[60] It is worth of note that not all the colonial governors supported complete residential segregation policies. Governors like J. P. Rodger, J. J. Thorburn, Hugh Clifford and F. G. Guggisberg opposed segregation as needless expensive, offensive to Africans and ineffective. Nonetheless, leading medical figures continued to urge rigid residential segregation even into the 1930s. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 40.

[61] Roger S. Gocking, *The History of Ghana*, (London: Greenwood Press, 2005), p. 53.

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infected with mosquito larvae (i.e. found on routine inspections of one or more water receptacles with mosquito larvae) to all the houses inspected in a town or community.[62] In this way, those Europeans living among the Gold Coast Africans could be protected from yellow fever and malaria when the index was found to be high in such an area. Thus, areas where the index was high, Europeans were advised not to reside there while the colonial government took measures to solve mosquito larvae index. Hence, the mosquito larvae index was introduced first with the objective of making the Gold Coast African's communities relatively habitable for the European nationals in the Central Province.

Health Education

By 1920, a foundation had been laid in the teaching of hygiene and sanitation in the Gold Coast schools. The effort and achievement were facilitated by the publication of handbooks on sanitation for the use of teachers in 1922.[63] Such publications dealt with a wide range of health related topics such as personal and domestic hygiene, food and diet, rats and mosquitoes, smallpox and vaccination, elementary anatomy and physiology.[64] For instance, in 1922, one P. S. Selwyn-Clarke published *Vaccination or Small Pox* in the

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[62] PRAAD-Cape Coast, ADM 23/ 1/632 (1926-45) Yellow Fever Outbreak. Towns were divided into wards for the purposes of this mosquito index. Towns where the index was 100 per cent, yellow fever could be assumed to be endemic; when it was 10 per cent or below, it was assumed to be not endemic and below 5 per cent was seen as a probable occurrence of the disease. See also Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, pp. 40-41.

[63] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 143. The handbooks were written in simple language by various members of the Sanitary Branch, with the assistance of the Director of Education. It must be pointed out here that the Education and the Medical Department closely cooperated in their quest to prevent and create awareness on some diseases among Africans.

[64] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 143.

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Gold Coast.[65] By this book, Selwyn-Clarke sought to educate the reading public on small pox and the need for one to be vaccinated against the disease. He, therefore, asked his readers that "ask yourself whether you will protect yourself from the dreaded disease by submitting to a few scratches on your arm from a trained vaccinator or whether you would prefer to run the risk of dying or of being blinded for all time."[66] Selwyn-Clarke suggested that immediate notification, quarantine, demolition of congested areas and ultimately vaccination were the most preventative measures to save people from the small pox disease. This book was widely distributed to teachers, chiefs and government officials in the Central Province to promote public health education.[67]

Health education was part of the eight-point public health policy of Guggisberg's government. From 1925, Guggisberg's government introduced the celebration of what was called "Health Week" in the whole of the Gold Coast.[68] The purpose of "Health Week" celebration was to promote public awareness about the need for healthy living. In explaining this mandate, the *Gold Coast News* observed that:

> 'Health Week' is a valuable help in this matter as being a specific period in each year during which public attention can be directed to matters related to health of the community….many of the activities carried out during a health week could be equally well carried out throughout the

[65] Selwyn-Clarke, P. S., *Vaccination or Small Pox,* (Accra, Gold Coast: Government Press, 1922). For a copy see PRAAD-Cape Coast, ADM 23/ 1/ 176 (1909-45) Small Pox Infection Disease. See also Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, pp. 70-71.
[66] *Ibid.,* p. 2.
[67] PRAAD-Cape Coast, ADM 23/ 1/ 176 (1909-45) Small Pox Infection Disease.
[68] *Gold Coast News,* Accra, Wednesday, 8th September, 1926 No. 7., pp. 2-3; Addae, *Medical Histories from Primitive to Modern Medicine,* p. 143. These special occasions were the vehicles to spread knowledge of hygiene and bring to the general public the practicality of health education. See also PRAAD-Kumasi, ARG 1/14/14 (1925-30) Health Week- Kumasi, 1925-1930.

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> year and the Health Weeks are merely periods of intensive activity devised so as to provide the necessary stimulus to a community to take with fresh vigor the struggle against diseases.[69]

On such celebrations, practical implications of sanitation and hygiene and the preventative aspects of disease were effectively demonstrated by health officials and teachers to primary and secondary school children who participated actively in these exercises.[70] This policy was carried out throughout the Gold Coast and health education itself became a measure for preventing diseases among the public.

The Pivot of Progress and Retrogression in the Public Health and Sanitation, 1929 to 1939

Between 1929 and 1939, the colonial government began a programme of providing the necessary financial and material support to the Gold Coast Africans for them to build their own health and sanitary facilities. Also, the colonial government's desire to understudy the native *materia medica* and toxicology manifested within this period. There was a mixture of progression and retrogression in the public health and sanitation situation in the Central Province within this decade. The health and health facilities, water and sanitation, epidemiology and health education policies that were perused and implemented within the decade, 1929 to 1939 will be the main themes for discussion under this section.

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[69] *Gold Coast News*, 8th September, 1926, p. 2. This paper suggested the cooperation of all members of a community to the celebration of the week.
[70] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 144; *Gold Coast News*, 8th September, 1926, p. 3.

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Health and Health Facilities

According to Stephen Addae, by 1930, Gold Coasters had confidence in western medicine in that in the late1920s and early 1930s many villages in the Gold Coast began to apply for dispensaries and hospitals is a testimony of the fact.[71] Michael Crowder also remarks that "much of the treatment of the Gold Coasters was given in dispensaries rather than hospitals"[72] in West Africa. However, the colonial policies and measures that were employed to stimulate the so-called Gold Coaster's confidence in western medicine will be discussed here. The Great Depression caused a reduction in the revenue of the colony which virtually halted the expansion of public health structures and several previously existing hospitals and dispensaries were closed down or downgraded.[73] The medical staff was also reduced. Consequently, the colonial government which did not have adequate funds during the Great Depression compelled local authorities to build their own village dispensaries. The Gold Coaster's preference for out-patient treatment did a lot to encourage this.[74] Communities or local authorities who were encouraged by their district commissioners and were provided with subsidized building materials like roofing material, drugs, dressing, cash support of about £ 100 and equipment as well as trained medical personnel, strove to build their own dispensaries according to the approved building plan issued by government.[75]

[71] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 69.
[72] Crowder, *West Africa under Colonial Rule*, p. 327.
[73] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 73.
[74] *Ibid.,* p. 76.
[75] This was based on a communique from Dr. P. S. Selwyn Clarke, the director of medical service to the provincial commissioners. The building materials for the project were to be obtained from the public works department in the province or nearby district. PRAAD-Cape Coast, ADM 23/ 1/ 777 (1930-40) Establishment of Dispensaries in Cape Coast; PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries.

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It was based on this order that by July 1930, Winneba was able to complete the construction of a new hospital for the Gold Coast Africans in place of the old dispensary.[76] Also, it was in 1930 that the construction of a new contagious disease hospital was built at a location between Cape Coast and Elmina specifically along the Cape Coast- Elmina road so that it could serve both towns[77] and, in September of 1930, the Assin Manso state built its own dispensary under the initiative of the *Omanhene* (Paramount Chief), Nana Nkyi Ababio X.[78] In addition, the Native Authority of Fante Nyankomasi was able to build a dispensary by November 1936. By 1939, the people of Moree had successfully completed their own local clinic.[79] Hence many Native Authority dispensaries sprang up in this period. However, the effect of the Great Depression turned the few Gold Coast Africans who patronized western medical care away from visiting the hospitals or any health facility. The use of indigenous medical care by many indigenes became a concern to the colonial government. This then precipitated a confidential study of native *materia medica* and toxicology.[80]

[76] The new hospital had laundry, dressing sheds, kitchen, stores, mortuary, post-mortem blocks and nurses' quarters. On the day of the commissioning of the New Hospital for the Gold Coasters, the *Omanhene* of Winneba, Nana Ayirebi Acquah III appealed to government to reduce the hospital fees "which in many cases debar poor patients from attending hospitals for modern scientific treatment." See PRAAD-Cape Coast, ADM 23/ 1/ 164 (1909-48) Native Hospital- Winneba; PRAAD-Cape Coast, ADM 23/ 1/ 2333 (1925-30) Winneba Native Hospital; PRAAD-Accra, ADM 5/1/26 (1930-31) Annual Gold Coast Report, April 1930 to March 1931; PRAAD-Cape Coast, ADM 23/ 1/ 2398 (1928-48) Winneba Native Hospital.

[77] The population of Cape Coast at this time was 19,476 and that of Elmina was about 5000. However, the latter was without any hospital accommodation for infectious diseases, hence, it was suggested by the sanitary committee, particularly, the senior sanitary officer and the provincial engineer that the road between Cape Coast and Elmina was the best site for the said hospital. Hence, the population explosion was a factor for the construction of this hospital. See PRAAD-Cape Coast, ADM 23/ 1/ 721 (1928-37) Contagious Disease Hospital, Cape Coast; PRAAD-Cape Coast, ADM 23/ 1/ 924 (1936-41) New African Hospital Site, Cape Coast.

[78] PRAAD-Cape Coast, ADM 23/ 1/ 777 (1930-40) Establishment of Dispensaries in Cape Coast.

[79] *Ibid.* Fante Nyankomasi is the capital town of the Assin Atandanso State.

[80] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses.

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In September 1930, the secret policy to study the Gold Coast African *materia medica* became operational when P. C. B. Shirreffs, the District Commissioner of Saltpond pointed out to the commissioner of the Central Province the advantages in studying Gold Coast *materia medica* and toxicology and how they could be used to address the decreased use of hospitals by the indigenes.[81] P. C. B. Shirreffs had observed that in Saltpond District, that a ratio of 50 Gold Coast Africans to 1 represents those who consulted practitioners of indigenous medicine to personnel in hospitals. In fact, Shirreffs added that:

> Even the most enlightened Gold Coasters leave the doctors and seek the advice of the native practitioner if he considers his progress was not sufficiently speedy. The practitioners are all illiterate and the knowledge of the art is as a rule handed from uncle to nephew.[82]

Shirreffs, therefore, suggested a way to make the secret study of the indigenous *Materia Medica* and Toxicology of the Gold Coast to be successful, that the investigators were to be people who could obtain the confidence of the local medical practitioners. They were to be people who possessed knowledge of *materia medica* and the signs and symptom of poisoning; they were to be in possession of the ability to distinguish tropical *flora* from exotic one and, lastly, possess general knowledge of the local language.[83] Following this paradigm, various Commissioners and European officials in the province began to undertake this study.[84] For instance, in December 1930, the Assistant District

[81] *Ibid.* In a letter titled "Confidential Memorandum on West African *Materia Medica* and Toxicology." This letter was a response to an early one that the Provincial Commissioner had circulated to all Commissioners of the province on the same subject and heading.
[82] *Ibid.* There is no doubting that in African the enormity and potential value of knowledge of the medicinal uses of plants are handed down generations by oral traditions. See E. Q. Archampong, *Medical Research and the Practice of Medicine in West Africa* (Accra: Ghana Universities Press, 1989), p. 11.
[83] *Ibid.*
[84] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses.

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Commissioner of Twifo, Edward H. Devaux, reported on a number of indigenous drugs including both toxic and curative ones. Among those he reported on were *materia medica* for snake bites, guinea-worm, difficulty of urination, serious child birth, headaches, lung troubles, wounds, yaws, heart strains, paralysis, yellow fever among others.[85] Edward H. Devaux's report showed that the indigenous *meteria medica* was very effective and thus patronized hugely by the Africans.[86]

To a large extent the research was conducted without the knowledge of those the European erroneously called "illiterate medical practitioners"[87] but from whom the greater source of the knowledge on the African *materia medica* came from. It is possible that the colonial government made a conscious effort and set up a deliberate policy for western medicine and medical system to assimilate indigenous medicine and medical system. Nothing confirms this possibility than the increasing hostility and intolerance that the colonial government showed to both indigenous medicine and the practitioners of it. For instance, on 10th February, 1931, the Provincial Council of Chiefs in the Central Province suggested to the Provincial Commissioner that government medical authorities should recognize and pay attention to the local herbal medicine practitioners.[88] On 13th February, 1931, the Council of Chiefs therefore, appealed to the Provincial Commissioner that:

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[85] *Ibid.*
[86] *Ibid.*
[87] *Ibid.*
[88] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses. In a letter to the provincial commissioner. The question or request for the legalization of indigenous medicine and its practitioners was something that concerned Gold Coasters constant made to the colonial government and the Medical Department. The Society of African Herbalists was formed at Sekondi on December 1931 by J. A. Kwesi Aaba with the motive to "raise the local practice of medical herbalist up to a high and refine standard, and to seek for free or unhindered practice for its members". For more readings on this association and their

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> African Native Herbal Practitioners who are well known, competent and of good character, and who have been known to be able to cure a variety of bodily diseases including wounds, should not be recognized by government Medical Authorities? …. the question of such men being granted Government Licenses on such conditions as may be determined by the Medical Department.[89]

The colonial government's answer to this question was obvious. In a response to the question, on 16th March 1931, the Acting Governor of the Gold Coast, G. A. S. Northcote, directed the Provincial Commissioner to inform the Provincial Council of Chiefs that "I have to inform you for the information of the Provincial Council of Chiefs that as at present advised, Government is unable to entertain any general proposal for the recognition of "Native Doctors."[90]

Whatever the effort of the colonial government towards alienating the people of the Gold Coast from their indigenous medical systems, the economic depression and other developments in the colony and the Central Province in particular, drew the local people closer to their medical system because that was very affordable and easily accessible. For instance, in 1938, the *Omanhene* of Assin Atandanso, Nana Tsibu Darko IX, reported to the Provincial Commissioner and the Provincial Medical Officer that it was due to the shortage

activities see Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, pp. 28-30.

[89] *Ibid.* The local Medical Men mentioned here were not those who practice what was known as "fetishism." This was an old question which seems to have died out a few years ago. However, since it was not answered by the colonial government, the Provincial Council of Chiefs re-echoed it.

[90] The use of the expression, "At present advise" confirms the fact that it was a deliberate policy of the colonial government and, in this case, the British Colonial Office, to refuse to recognize officially the activities of indigenous African medical practitioners. In fact, the government used the criminal investigation department and the police of the province to pursue herbalist as well as women who sold medicine in bottles both in the province and Sekondi, in the Western Province. See PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* pp. 28-30

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of drugs that had turned most patients away from the Fante Nyakomasi dispensary. The *Omanhene* also added that the decrease in the attendance of the dispensary was due to the recent cocoa hold-ups because farmers did not have money to pay for the 2 shilling 6d as the medical fee.[91] In fact, the cocoa hold-ups that lasted from October 1937 to April 1938 was the people's response to the low prices of cocoa that the United African Company fixed arbitrarily.[92] The cocoa hold-ups therefore, affected the financial strength of farmers to patronize western medical care which was expensive anyway. Hence, there was, and is, a direct relation between the economy and the health of a people in any state.

Within the colony at large, the economic depression affected the activities of the Maternal and Infant Welfare Clinics. This unit began to face some financial difficulties which led to the collapse and closure of their headquarters in Accra. There was, therefore, a call for the withdrawal of the services of the workers of the Maternal and Infant Welfare Clinic throughout the colony. The Central Province vehemently protested against this

[91] This revelation was precipitated by the fact that the Director of Medical Services threatened to close down the dispensary in 1937 due to low attendance. The shortage of drugs in the said dispensary was so serious that in August, 1939, out of 137 drugs intended for the dispensary it was only 49 which were really received by the dispensers. The cost of treatment was also expensive as it cost 21 shilling for a yaws patient to complete a course of eight injections. PRAAD-Cape Coast, ADM 23/ 1/ 777 (1930-40) Establishment of Dispensaries in Cape Coast. See also PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries.

[92] The 1937-38 cocoa hold-up was led by one John Ayew. The cocoa hold-up that lasted from October 1937 to April 1938 was not the first time that Gold Coast had experience hold-up. It happened in 1921 and in 1930-31. However, it was the latter that was very well coordinated and successful. For history of cocoa hold-ups in the Gold Coast, see Boahen, *African Perspectives on Colonialism*, p. 80; Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century,* pp. 146-148; Gocking, *The History of Ghana*, pp. 63-64 and 67-68; Metcalfe, *Great Britain and Ghana: Document of Ghana History*, pp. 651-53; Austin Gareth, "Capitalists and Chiefs in the Cocoa Hold-Ups in South Asante, 1927-1938", *The International Journal of African Historical Studies*, Vol. 21, No. 1 (1988), pp. 63-95; Amenumey, *Ghana: A Concise History,* pp. 197- 198 and Francis Danquah, *Cocoa Diseases and Politics in Ghana, 1909-1966* (New York: Peter Lang, 1995).

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suggestion.[93] On 10th February, 1932, the unofficial members of the Cape Coast Town Council and other interested persons in the municipality petitioned C. E. Skene, the Provincial Commissioner, that, the colonial government's decision to withdraw the services of the female doctors in charge of the Infant Welfare Clinic on the grounds of economics would affect the municipality in terms of maternal and child mortality.[94] The petitioners pointed out that through the instrumentality of the unit, infant mortality in the town and, for that matter, the whole province had fallen by fifty per cent.[95] Therefore, the need to maintain the Maternal and Infant Welfare Clinic as well as the medical officers was very paramount. The solution that the colonial government offered to save the G.C.L.M.C.W.U. was to transform itself into the Gold Coast Branch of the British Red Cross Society (G.C.B.B.R.C.S).[96] Under a new banner, the new society helped to raise sufficient funds from private donations to undertake the management of the Infant Welfare Clinic in Cape Coast and other parts of the colony.[97]

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[93] PRAAD-Cape Coast, ADM 23/ 1/ 976 (1939-47) Infant Welfare Clinic- Central Province. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* pp. 23-24.

[94] *Ibid.* A total of 77 people signed this petition of majority of whom were females. The petitioners suggested that the government should cut down the cost of spending so to take care of health needs of the people. See also Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 24.

[95] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 233; Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 24. See also PRAAD-Cape Coast, ADM 23/ 1/ 976 (1939-47) Infant Welfare Clinic- Central Province. At Moree, the nursing sister who worked at the Infant Welfare clinic stopped working. This was the same in Sekondi in the Western Province where the people also vehemently protested against the removal of their nurse-midwife.

[96] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 234 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 24. The objective of the GCBBRCS was to stimulate voluntary effort in the promotion of health and in the giving of help to the sick and the suffering. The GCBBRCS wanted to assist government in providing for the health needs of women and children in the Gold Coast. See PRAAD-Accra, CSO 11/14/ 272 British Red Cross Society, Gold Coast Branch; PRAAD-Sekondi, WRG 8/1/579 Red Cross Society.

[97] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 234 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 24.

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One other notable thing that happened to health and sanitation situation in the Central Province was the declaration of Ochereso, Dentun, Okurukrom and Atiankama, all in the Western Akyem District, as mining health areas. These areas had three mining companies- The West African Diamond Syndicate Limited, The Holland Syndicate and the Morkwa Limited operating in the area in the early 1930s.[98] Accordingly, the Mining Health Areas Ordinance of 1925 was applied to those mining areas hence the power plants and machinery, employees' bungalow or mine labourers' villages were not allowed to be located outside of the boundaries of these concession areas for that would be a health hazard to the inhabitants of the nearby villages.[99]

Water and Sanitation Policies

The need to supply quality water was the concern of the Public Works Department in the Central Province. By April 1930, an Automatic Self-closing Value Supply machine was given to Cape Coast Water Works.[100] The Public Works Department went around the province to inspect the treatment and supply of water and ensure that water was chlorinated and purified with chemicals like aluminum sulphate, Soda, Magnesia, Lime and Sulphur Anhydride.[101] Hence, all efforts were made to prevent the spread of water-borne diseases. Following this development, all government departments and

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[98] PRAAD-Cape Coast, ADM 23/ 1/ 948 (1937-43) Mines and Villages Sanitation. There were as many as 1, 200 and 1, 000 labourers at the Ochereso and Antiankama mines respectively.
[99] By the Mining Health Ordinance, Europeans were to live in mosquito proof segregated bungalows at the site of the concession land while the Gold Coast labourers were housed in swish huts or wattle or palm huts. There was generally poor observation of sanitary rules in the mining areas as the system of alluvial diamond and gold-digging opened trenches which caused prolific mosquito breeding. The effect of this was the regular malaria cases among the non-European labourers on the mining sites. See PRAAD-Cape Coast, ADM 23/ 1/ 948 (1937-43) Mines and Villages Sanitation.
[100] PRAAD-Cape Coast, ADM 23/ 1/2310 (1925-30) Cape Coast Water Works.
[101] *Ibid.*

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bungalows in the provincial capital were connected to the pipe-borne water supply. To prevent the contamination of the dam at Brimsu, in 1935, the Public Works Department ordered that farms must be distanced about 25 yards from the bank of the Brimsu river. After 1936, ordinary farms for corn, cassava and yams were not allowed around the river body. Violation of these rules was punishable by law, and section 131 and 151 of the Criminal Code of the colony made it clear.[102]

It is vital to note here that pipe-borne water had not been supplied to all the towns in the Central Province by the end of the second decade of the twentieth century. A large part of the Central Province still depended on water supply from government tanks and wells which were mostly stored rain water.[103] For instance, the *Omanhene* of Eguafo, Nana Abutakyi II called on the Cape Coast District engineer to come and inspect the wells that the citizens of Eguafo had dug as their source of water.[104] Not all the immediate neighbours of Cape Coast were enjoying the pipe-borne water supply as at 1930. Some areas in the Cape Coast District which did not have pipe-borne water supply made request from the government for such water supply.[105] For instance, in March 1930, Nana Abbah Folson, of Elmina requested from Stanley Gifford, the Provincial Engineer, for an extension of the Cape Coast water supply to

[102] *Ibid.* The said regulation was signed by R.N. Fisher, the district engineer. The chiefs of the towns around Brimsu were those entrusted to make sure that their people whose lands were closer to the river body did not breach this law.
[103] Dunkwa was still faced with poor water supply to the extent that, the untreated and impure water that the people drunk made them prone to yaws, diarrhea, guinea-worm and other skin diseases. See PRAAD-Cape Coast, ADM 23/ 1/3748 (24/6/35/-5/9/35) Cape Coast Water Works.
[104] PRAAD-Cape Coast, ADM 23/ 1/2258 Water Supply- General Improvement. Eguafo is not far from Cape Coast yet it was not connected to the pipe borne water supply. The poor water from the wells in Eguafo necessitated the digging of deeper wells.
[105] See PRAAD-Cape Coast, ADM 23/ 1/3748 (24/6/35/-5/9/35) Cape Coast Water Works.

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Elmina.[106] By 1932, there were only five functioning public wells in Saltpond. However, these were woefully inadequate to serve the needs of the large population size of the district so an appeal was made to the colonial authorities for better supply of water.[107] Consequently, the *Omanhene* of Nkusukum and the Ahinfo and elders of Upper and Lower towns of Saltpond petitioned the Provincial Commissioner on the need for the extension of the Cape Coast pipe-borne water system to Saltpond on 23rd May, 1935.[108]

It can be inferred from those numerous requests from those Gold Coast Africans that the supply of pipe-borne water was not for all the people of the province. It has been the tradition of the colonial government to always satisfy the needs of European officials in the provision of the health and sanitation facilities before the extension of such facility to the local communities and towns and this was same in the pipe-borne water supply. Nevertheless, the colonial government explained that the main challenges to the inadequate expansion of the system of water supply was the shortage of skilled staff to dig deep wells and manage water supply of towns which have no pipe-borne water supply. The shortage made it impossible for government to provide adequate expert advice to local authorities and village communities who were seeking to

[106] PRAAD-Cape Coast, ADM 23/ 1/2310 (1925-30) Cape Coast Water Works. Nana Abbah Folson promised to be the caretaker of the pipe stand when provided.
[107] PRAAD-Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks, Wells; PRAAD-Accra, CSO 11/1/ 212 (1932-33) Medical and Sanitation Department Annual Report, 1932-1933.
[108] PRAAD-Cape Coast, ADM 23/ 1/ 658 (1927-44) Saltpond Improvement and Sanitation; PRAAD-Cape Coast, ADM 23/ 1/ 2424 (1929-32) Provincial Health Board. Earlier on in 1932, the Saltpond Sanitary Committee had partitioned the Provincial Health Board for pipe-borne water supply. However, it was not until 1936 that this was done. From Cape Coast, the pipe trucks passed through villages like Ekon, Moree, Yamoransa, Akatakyiwa, Biriwa, Anomabu, Abandzi and Kormantie until it finally reached Saltpond District. However, none of these villages or towns were connected to the pipe-borne water. The total cost of the project was £ 33, 300.

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provide their own water supply.[109] However, it was in 1936 that the extension of Cape Coast pipe-borne water supply to places like Elmina, Saltpond[110] and Asebu[111] commenced. As a result of the increasing extension of pipe-borne water supply into places, from the late 1930s therefore, the colonial government ordered for the disconnection of most rain water pipes, tanks and underground tanks and wells in the major towns in the Central Province, which were supplied with pipe-borne water. In the town of Winneba, it was suggested by the Public Works Department and the Medical Department that old underground tanks should be done away with by filling them up with sand and abandoned.[112] Some nine underground tanks in Cape Coast also were filled with sand and abandoned.[113] The rationale behind the order to bury the unused underground tanks and wells with sand was to prevent the breeding of mosquitoes in those tanks and wells.

On policies related to sanitation, the colonial government continued to provide facilities to support the Central Province in the quest to ensure public health. For examples, between 1929 and 1930, two 10-pan latrines and two incinerators were built at Winneba; additionally, two incinerators and a pan latrine were built at Swedru and Apam respectively.[114] By 1930, most large towns in the Central Province were comparatively clean with good layouts and

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[109] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 138.
[110] *Ibid*., p. 135.
[111] PRAAD-Cape Coast, ADM 23/ 1/2310 (1925-30) Cape Coast Water Works. The extension of the Cape Coast water supply to Asebu village was considered mainly because Messers L. Rose and Company had established a lime-producing factory at the village hence its consideration and not merely because the local community cried for it.
[112] PRAAD-Cape Coast, ADM 23/ 1/2429 (1929-32) Water Supply; PRAAD-Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks and Wells.
[113] PRAAD-Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks and Wells; PRAAD-Accra, CSO 11/14/ 132 Special Warrant for Yellow Fever Menace in Cape Coast.
[114] PRAAD-Cape Coast, ADM 23/ 1/ 4020 (1925-29) Sanitary Structures and Minor Sanitary Works.

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planning, they enjoyed conservancy, rubbish disposal and bush-clearing services. There was also the growing demand for environmental sanitation. Many indigenes started to collaborate amicably with sanitary officials in their work to ensure good sanitary practices among the people.[115]

As underscored, the colonial government was financially challenged during the world economic depression of the 1930s, hence, it became difficult for the government to make, pursue and implement public health and sanitation policies alone. Thus, the colonial government realized that it was much prudent to pass on the responsibility of sanitation to local authorities or Native Authorities. In 1932, through the instrumentality of the Native Administration Revenue Ordinance, Governor Sir R. Slater tried to empower local authorities to raise revenue to pay the salaries of their sanitary officials and to inaugurate schemes for development.[116] By this policy, it was expected that sanitary works like maintaining communal latrines, emptying latrines, maintaining incinerators, protecting water supply from contamination from mosquitoes, managing refuse dumps, clearing bushes, sweeping market and streets would be carried out by local authorities.[117] Consequently, government sanitary gangs were to be disbanded and their use discontinued. The government asked the chiefs to send their own people to medical officers in their districts, to be formally trained so that they could execute health and sanitation duties

[115] Addae, *Medical Histories from Primitive to Modern Medicine,* pp. 122-123.
[116] By this ordinance, the colonial government was introducing a form of direct taxation into the local areas, a policy which many people including some chiefs, protested against. It is said that apart from Nana Sir Ofori Atta and Nana Ayirebi Acquah, the *Omanhene* of Akyim Abuakwa and Winneba respectively, who gladly supported the ordinance, the greater masses objected to it. See Metcalfe, *Great Britain and Ghana,* pp. 632-633; Gocking, *The History of Ghana*, p. 64; PRAAD-Cape Coast, ADM 23/ 1/ 4289 (1932-34) Village Sanitary Board; PRAAD-Cape Coast, ADM 23/ 1/ 777 (1930-40) Establishment of Dispensaries in Cape Coast.
[117] PRAAD-Cape Coast, ADM 23/ 1/ 777 (1930-40) Establishment of Dispensaries in Cape Coast.

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efficiently in their towns. However, the cost of their training was the responsibility of the local authorities. They were to pay £ 2 per month for the trainee's food, lodging and clothes during the period of the training.[118] The scheme was not accepted by the chiefs.

Consequently, the colonial government promulgated the Labour Regulation Ordinance in October 1935. The colonial government used this ordinance to exact labour that it termed as "minor communal services" from the local people who were between the ages of 18 and 45.[119] This minor communal service was similar to what the Gold Coast indigenous people used to do for the development of their communities before colonial rule. The Colonial Secretary believed that such a regulation was necessary because of inadequate government funds to support public projects related to health and sanitation. He said to the Provincial Commissioner that:

> It is obvious that for financial reasons Government cannot undertake minor sanitary services in local areas, even if such a course was desirable… and that this responsibility must of necessity fall upon the people themselves.[120]

It appears that the colonial government was rather not willing to spend its resources which it had exploited from the Gold Coast African's land on the remote areas of the province where no European had settled. Thus, as far as

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[118] *Ibid.*

[119] PRAAD-Cape Coast, ADM 23/ 1/ 904 (1935-36) Sanitation of Rural Areas and Mining Villages. Some of the minor communal service that the ordinance stipulated were maintaining and clearing of roads and paths, the digging and construction of wells; the maintaining of native buildings and general sanitary measures.

[120] *Ibid.* The provincial commissioner was instructed to inform all the district commissioners of the province to carry out this regulation so that better sanitary practices could be observed. In fact, governor Sir R. Slater had remarked in the legislative council in March 1932 that central government cannot possibly continue to finance all projects and that local development must either practically cease, or be financed from local funds. See Metcalfe, *Great Britain and Ghana*, p. 632.

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public health and sanitation were concerned, the Gold Coast Africans residing in the rural areas were largely to take their destinies into their own hands, although at times government-initiated policies to facilitate their efforts and aided them half way.[121]

The period 1929 and 1939 also saw massive and tremendous construction of structures to improve sanitation in the Central Province. Between 1930 and 1939 there was the construction of two septic latrines to replace the pan latrines at Winneba and Swedru,[122] there was also the construction of latrines and bath houses at Hausa Zongo, Kotokuraba, as well as in Aboom, Prospect Hill, Siwdu and Idan beach road all in Cape Coast District.[123]

Epidemiology Policies

From 1929 onwards, the world economic slump brought about a drastic curtailment of social and economic development in the Gold Coast.[124] By 1930 most of the non-official Europeans had learnt their lesson from not living in residential areas offered them as a way of preventing malaria and yellow fever. Thus, there was little difference in the death and invalidity rate of European officials who resided in residential areas and non-officials who dwelled in the Gold Coast Africans' communities.[125] Residential Segregation used by colonial

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[121] *Ibid.*
[122] PRAAD-Cape Coast, ADM 23/ 1/ 659 (1927-39) Sanitation Structure- Winneba. These sanitary structures were built based on the recommendation and approval of the Winneba local health board.
[123] PRAAD-Cape Coast, ADM 23/ 1/ 765 (1930-37) Sanitation Structure- Cape Coast. Those sanitary developments were based on the Ten-Year sanitary program of the Cape Coast District.
[124] Kimble, *A Political History of Ghana,* p. 122.
[125] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 45. By early 1930s, the health of the European population had vastly improved and, in many instances, the death rate was as low as or lower than, what was recorded in the United Kingdom. See also PRAAD-Accra, CSO 11/1/ 371 (1934) Sanitation and Medical Facilities in the Gold Coast.

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governments to regulate the activities of officials but were generally unable to force European merchants from living in quarters, which were often located on trading premises in the heart of local communities in districts. Mining companies, merchants and missionaries resisted residential segregation, largely because of the high cost of building bungalows on an approved plan which was issued by the Public Works Department. Hence, it was easier for the colonial government to pursue this policy as regards to government officials but less on the non-officials. The majority of European non-officials lived on their business premises which were situated in the heart of local towns and the consequent effect was that they suffered far more severely from common diseases like malaria and yellow fever because such communities were prone to these diseases.[126]

From the second half of 1930, the Central Province experienced frequent outbreaks of small pox and yellow fever.[127] In July 1930, Dr. J. H. Owen-Flood, the Medical Officer of Health in Cape Coast, circulated a communique to all Europeans in the residential areas. The document outlined six measures that Europeans had to observe to prevent them from yellow fever and malaria. They were advised to ensure that all African stewards and cooks were mustered and checked by the bungalow occupier at 6: 00 pm and given strict orders not to leave the residential area until 6 am. Additionally, no other Gold Coast African were to be allowed into the residential area between 6 pm and 6 am, and that all Europeans should remain in the residential area from 6 pm to 6 am.

[126] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 45; Raymond E. Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", *Journal African Studies*, Vol. 1, No.2 (1968), pp. 153-197, p. 172.
[127] PRAAD-Cape Coast, ADM 23/ 1/632 (1926-45) Yellow Fever Outbreak.

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Furthermore, residents were told that when a European was visiting the town in the day time, long trousers, mosquito boots and coats were to be worn to prevent exposed parts of the body to mosquito bites. Quinine was also to be taken regularly every morning to avoid malaria and, lastly, any case of sickness had to be reported immediately to the health officer.[128] Following the frequent out breaks of yellow fever in 1932, the Provincial Commissioner of Cape Coast, H. Bleasdell, extended a free invitation to all Europeans living outside Cape Coast to come and reside temporarily in the European residential areas. The Swiss African Trade Company responded.[129] This shows that colonial officials were serious about protecting Europeans.

There was an outbreak of small pox in many places in the Central Province like Saltpond, Kankanbom, Anomabu, Dunkwa and Mankessim between 1929 and 1939. The epidemic claimed the lives of many of the Gold Coast Africans and Europeans. However, in most cases the total number of victims were not known or reported on. In the case of Saltpond out of 89 known and reported cases, 20 deaths were confirmed in October 1939 alone.[130] The epidemic was devastating. The colonial government responded to the epidemic, first, with the usual vaccination of infected people and, second, the fumigation and disinfection of the dwelling places of the victims and places which had been declared as infected areas. Accordingly, for example, about 5, 982 people which constituted about 96.9 per cent of the total population of Mankessim, were vaccinated against small pox and over 9, 300 people were vaccinated at Dunkwa

[128] *Ibid.*
[129] PRAAD-Cape Coast, ADM 23/ 1/2755 (1946-47) Plague and Yellow Fever; PRAAD-Cape Coast, ADM 23/ 1/632 (1926-45) Yellow Fever Outbreak.
[130] PRAAD-Cape Coast, ADM 23/ 1/ 176 (1909-45) Small Pox Infection Disease. The records did not specify the number of the victims who were Gold Coast Africans and those who were Europeans.

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and its surrounding villages in 1939.[131] Consequently, frequent directives were given that Europeans coming to West Africa and those residing in the Gold Coast colony and the Gold Coast Africans particularly, officials, should be vaccinated or inoculated against yellow fever and typhoid.[132] In addition to the vaccination and other means of disease prevention, the colonial government also continued with its health education programme.

Health Education

Health education for the masses was still in use as health propaganda in 1929. However, it took root in this decade under discussion. One of the pamphlets that offered health and sanitation education to the masses was Major Herman's *Village Health: A Pamphlet for Teachers*.[133] The pamphlet highlighted the role that teachers, pupils and the village dwellers had to play to prevent diseases through ensuring hygienic and sanitation practices in village communities. The pamphlet discusses themes like: "The Teacher and the Community," "Village Sanitation," "Water supply," "Health and Hygiene," "Village water Supply" and "The Village Layout." This pamphlet recognized the need to ensure reasonably the good health of the Gold Coast African

[131] *Ibid.*
[132] PRAAD-Cape Coast, ADM 23/ 1/ 359 (1920-33) Deficiency Diseases; PRAAD-Cape Coast, ADM 23/ 1/ 176 (1909-45) Small Pox Infection Disease; PRAAD-Cape Coast, ADM 23/ 1/632 (1926-45) Yellow Fever Outbreak. The directive required the wives as well as those taking appointments in the Gold Coast to be inoculated against these diseases before or just after arriving in the colony.
[133] Major Herman, *Village Health: A Pamphlet for Teachers,* (Accra-Gold Coast: Government Printing Office, 1930). Major Herman was once the Director of Education in the Gold Coast and he wrote this work in cooperation with the Medical Department. About a thousand copies were printed and distributed throughout the Gold Coast to senior officers of the department of education, the health branch of the Medical Department, provincial commissioners, schools, missions and even members of the legislative council. See PRAAD-Accra, CSO 11/14/128 (1931-35) Pamphlet on Village Health.

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communities. This pamphlet was widely used in primary schools in the Gold Coast.

Other agencies also added their efforts to health education in the Gold Coast. The most important consequence of the Maternal and Child Welfare Services was the intensification of the level of sanitation and health consciousness in African homes.[134] In the 1930s, the Gold Coast Branch of the British Red Cross Society (G.C.B.B.R.C.S.) published a number of pamphlets on various topics in health and sanitation which were distributed to not only schools, but also to the general reading population. Some of the pamphlets were titled "Tuberculosis or Consumption," "Water," "Food," "Baby Feeding Bottles," "Air", "Malaria" and "Night-Soil Disposal."[135] The G.C.B.B.R.C.S. had branches in all the provinces and districts of the Gold Coast. A junior arm of the Red Cross Society was created and they also helped to propagate the health knowledge. They helped to spread health knowledge among the youth in schools, in the communities and the outskirts of towns.[136] In the late 1930s, medical officers of health were duty bound to disseminate across all sections of the community, the message of sanitation and hygiene and hence, they gave lectures on health and sanitation.[137]

Health Week celebration was also avenues through which health education was carried out in the Central Province. For example, at one of the Dunkwa sanitary committee meetings, on 15th December, 1931, it was agreed

[134] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 33.
[135] For the content and copies of those pamphlets see PRAAD-Cape Coast, ADM 23/ 1/ 176 (1909-45) Small Pox Infection Disease.
[136] PRAAD-Cape Coast, ADM 23/ 1/2636 Red Cross Society.
[137] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 146. These activities preceded the introduction of radio, cinema and other means of mass media propaganda in the late 1930s.

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that "Health Week will be marked in the area once a month on which a special effort on the part of households, children among others will clean up rubbish in the town."[138] Winneba District also started celebrating the occasion in 1931.[139] The observance of the health week continued in the Central Province throughout the period under discussion and beyond.[140]

Different media were used by the Medical Department to promote and spread health education. For example, newspapers, radio broadcast and pamphlets were used. For example, there was a radio broadcast on health talk on the topic "Quinine and Malaria: A short talk to African Mothers" at 8 pm on 1st July 1936 on Gold Coast radio. The talk was delivered by Dr. Duff, the Director of Medical Service for the Gold Coast.[141] Dr. Duff educated the masses in the colony about the cause of malaria and debunked the notion that attributed it to malevolent spirits. He encouraged people to use quinine against the disease and added that:

> Quinine can save the lives of your children and it is good to know that children can take it easily and safely. Every mother in Africa ought to know this and to remember it. And give your child a little quinine every day during the rainy season.[142]

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[138] PRAAD-Cape Coast, ADM 23/ 1/1953 (1929-34) Sanitary Committee. Due to active participation of school children, it became prudent that the celebration of the health week be held only during months that school was opened since it was very difficult to get teachers and pupils during vacation experientially since mid-1933.

[139] PRAAD-Cape Coast, ADM 23/ 1/ 2422 (1929-31) Winneba Sanitary Committee Minutes.

[140] PRAAD-Cape Coast, ADM 23/ 1/ 2513 (1935-38) Winneba Health Board. In 1935 Health Week Celebration, it was found out that tins and other nuisances were thrown about at football field, hence, it was suggested that a box be placed in each compound in Winneba but emptied each day by sanitary inspectors.

[141] PRAAD-Cape Coast, ADM 23/ 1/ 2088 (1915-48) Medical Department. Dr. Duff mentioned how malaria is called in the Ga language and some Akan languages as a way of making his audience if not all most to know the exact disease that he was talking about.

[142] Duff did mention where quinine could be obtained in the colony. Thus, Hospitals, dispensaries, clinics, drug stores and post offices and postal agents. The quinine was pink in colour and it was sold at 6 d. The wrapper on each of the quinine tube contained directions in six languages- English, Twi, Fanti, Ga, Ewe and Hausa. Pregnant women were encouraged to take quinine to prevent dangerous miscarriage and perhaps death. See PRAAD-Cape Coast,

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Furthermore, Dr. Duff encouraged parents to teach their words about how they can sleep in their own mosquito nets.[143]

Gold Coast Africans' Initiative and Response to the Colonial Health Policies, 1919-39

By the beginning of the second decade of the twentieth century, the doctrines of racism of the late nineteenth century was reinforced by the colonial government in its policy formulation.[144] Thus, the erroneous idea that European race was superior to Africans became a component of colonial government's medical policies. Consequently, the Gold Coast Africans responded to it in different ways. The demonstration of dissatisfaction by the African professional elites, particularly the local medical doctors to this colonial bigotry which discriminated against Africans in the appointment and promotion of doctors, became well-coordinated when the National Congress of British West Africa (NCBWA) was formed in the Gold Coast in 1920 and came to an end in 1930. The NCBWA was a nationalist movement made up of educated professionals of the four British West African colonies who came together to demand for changes in the social, economic and political administration of British West Africa.

In 1920, the NCBWA petitioned the colonial office and made some demands, among other things, that the medical service should be thrown open to Africans without reservations since the large African population needed their service and that there should be general improvement of the sanitation in the

ADM 23/ 1/ 2088 (1915-48) Medical Department; PRAAD-Kumasi, ARG 1/14/23 (1935) Quinine Distribution Scheme.

[143] PRAAD-Cape Coast, ADM 23/ 1/ 2088 (1915-48) Medical Department.

[144] Gocking, *The History of Ghana,* p. 53.

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colonies.[145] It was with the coordinated effort of the NCBWA against the exclusion of the African doctors in the medical service that was why the colonial government began to consider the African medical doctors for employment into the service. For instance, by the effort of the NCBWA, in 1926, Dr. Edward Tagoe was posted to Dunkwa, a sub-district in the Central Province.[146] Based on the success of the NCBWA, the re-entry of African medical doctors into the medical service of Gold Coast was gradually heeded to by the colonial government in its policy direction. It must be pointed out here that the inclusion of African medical doctors in the colonial public health service did not end the stereotype, prejudice and discrimination that most Europeans had against Africans in this profession. For instance, the European community, minority

[145] The Congress was against segregation and, therefore, demanded that the colonial government should undertake improvement in "the general conditions of a community than spending time and substance upon a fanciful theory" of segregation of Europeans. The West African intelligentsia had the support of the Colonial Office which proposed that "government's policies should also be executed to improve "native" towns for good health in order to conserve the lives of the working population." In the Gold Coast, the intelligentsia had the support of governor Hodson who argued that the policy had outlived its days by the 1930s. For other demands made by the Congress, see Kimble, *A Political History of Ghana*, p. 97 and 107; Metcalfe, *Great Britain and Ghana*, pp. 583-585; Amenumey, *Ghana: A Concise History* p. 192; F.K. Buah, *A History of Ghana*, (Malaysia: Macmillan Publishers Ltd., 1980), p. 145; Addae, *Medical Histories from Primitive to Modern Medicine,* p. 46; Gocking, *The History of Ghana*, p. 56; Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century,* pp. 126-130; Kwabena O. Akurang-Parry & Isaac Indome, "Colonialism and African Migration", Toyin Falola & Martin S. Shanguhyia (eds.), *The Palgrave Handbook of African Colonial and Postcolonial History,* (New York: Palgrave Macmillan, 2018), p. 382; Martin Kilson, "The National Congress of British West African, 1918-1935", Robert Rutberg & Ali A. Mazrui (eds.), *Protest and Power in Black Africa*, (New York Oxford University Press, 1970), pp. 571-588; Crowder, *West Africa Under Colonial Rule,* pp. 426-428; Boahen, *African Perspectives on Colonialism,* p. 82.

[146] The gradual employment of the Gold Coast medical doctors in public service had come about due to the colonial scheme of 1925 where it was made as a policy that required the Gold Coast African medical doctors to have a clinical experience at the Korle Bu Hospital before formally employed into the public health service. Dr. Edward Tagoe was the first Gold Coast African to be put into the scheme. He was also the first one to complete his course as a Junior Medical Officer in Gold Coast. See Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 14; Kimble, *A Political History of Ghana*, p. 109; Amenumey, *Ghana: A Concise History,* p. 187; Addae, *Medical Histories from Primitive to Modern Medicine,* p. 216. In fact, the far-reaching impact and influence of the Congress on the colonial government's health policy formulation was so great that even in Nigeria, the number of the African medical officers rose from 6 in 1925 to 12 in 1934. See PRAAD-Accra, CSO 11/1/375 (1938) African Medical Practitioners-Employment of.

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group in Dunkwa openly objected to being attended to by Dr. Edward Tagoe; they even accused him of professional incompetence.[147] Regardless of how some Europeans perceived and reacted to African medical doctors, the policy of inclusion of African medical doctors into the public health service came to stay. Gradually their numbers increased in this profession from the 1930s. In all, the NCBWA demanded in early 1920 that the colonial government should establish municipal corporation "with full power of local self-government" in each of the principal towns.[148] Noteworthy, demands by the NCBWA pressured the colonial government to enact the 1927 Native Administration Ordinance.[149]

It must be noted that racial discrimination in government policies did not only manifest in the medical profession but in the general public health sector. When the pipe-borne water supply system began in the Central Province, there was open discrimination against African officials. It all began when in 1926 a General Order from the Executive Council moved that local officials were not to be given free supply of pipe-borne water because the rate at which pipe-borne water was sold was a cheap one.[150] The police magistrate at Winneba, Alexander Hutton Mills, was a Gold Coast African and he was

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[147] Dunkwa was with a population of about 2000 Africans and some 20 Europeans. The European community requested for Dr. Edward Tagoe's removal from Dunkwa. However, both Dr. Hungerford, the Director of Medical Service and Governor Guggisberg, refused to do so but suggested that any European who objected to being attended to by Dr. Tagoe was free to go to the nearest station for treatment. See Addae, *Medical Histories from Primitive to Modern Medicine,* pp. 216- 217 and Patterson*, Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 14.
[148] Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century*, p. 128.
[149] PRAAD-Cape Coast, ADM 23/ 1/ 777 (1930-40) Establishment of Dispensaries in Cape Coast.
[150] PRAAD-Cape Coast, ADM 23/ 1/2382 (1927-29) Winneba Water Supply and Maintenance. See also PRAAD-Cape Coast, ADM 23/ 1/2429 (1929-32) Water Supply. In other words, the local officials were from 1926 to pay for the water that they used in either their homes or in the government bungalows. It is important to note that the 1926 General Order was deliberately issued to nullify the General Order of 1907 edition No. 108 to 113 and the 1924 edition, General Order 27 to 30 Chapter XIII (C) which stipulated that water supply to government officials should be made free. See PRAAD-Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks and Wells.

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affected by this discriminatory practice in 1928.[151] The fate of the police magistrate was the same as that of other follow Gold Coast African officials who served in the Cape Coast District.[152] The only consideration that the colonial government gave to the local officials was a free supply of rain water which, to a large extent, was a source of water borne diseases.[153] Clearly, the European colonial regime was essentially built on racial bigotry and was therefore not respectful and fair to the exploited African in general.

In the Central Province, the Gold Coast intelligentsia criticized the colonial government on the use of the term "Segregated Area" for residential areas of Europeans, both officials and non-officials. The term was racially prejudicial and insulting to the Gold Coasters. Consequently, a circular from the Colonial Secretary's office on 12th May, 1922 read that the "term 'segregated area' as applied to those areas set apart for the residence of Europeans officials" be substituted for "Government Residential Areas."[154]

Another powerful group that influenced government's policies in this period was the Gold Coast Youth Conference (G.C.Y.C.). The G.C.Y.C made demands and inspired changes to occur within the public health, medical and sanitation of the colony. At its second conference, which was held in

[151] PRAAD-Cape Coast, ADM 23/ 1/2429 (1929-32) Water Supply. Alexander was a class A officer. All efforts by the Inspector General of Police to convince the Winneba District Engineer and the Public Works Department to supply the police officer with pipe-borne water for free yielded no positive results.
[152] By 1931, the police magistrate at Cape Coast castle; the two superintendents of police at the district police barracks, the Cape Coast hospital dispenser and the keeper of lighthouse were all non-Europeans who were required to pay for the pipe-borne water supply. PRAAD-Cape Coast, ADM 23/ 1/2429 (1929-32) Water Supply. See also PRAAD-Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks and Wells.
[153] PRAAD-Cape Coast, ADM 23/ 1/149 (1908-36) Water Supply from Government Tanks and Wells.
[154] PRAAD-Cape Coast, ADM 23/ 1/ 323 (1919-27) Winneba Government Segregated Area. One may argue that the change of the name meant nothing as it did not change the reality of the purpose of the so called "Segregated Areas" however, the racist word like segregation was forbidden in all government reports and circulars.

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Mfantsipim School in Cape Coast in 1938, it added to its resolutions that the colonial government should expand the health and sanitation facilities in not only the Central Province but the entire colony.[155] Hence, most, if not all, the public health and sanitation policies that the colonial government introduced or initiated from the 1920s to the start of the fourth decade of the century were largely as a result of the demands and resolutions of the Gold Coast intelligentsia.

Other responses emerged from some chiefs and private individuals against other colonial polices such as the demolition of some buildings. For instance, in response to the incessant demolition of perceived insanitary buildings based on the Building Regulations of 1921, Nana Kwa Atta, the Tufuhene (a sub-chief) of Gomoa Abosso, instructed his people in 1938 to rebuild any building that had been demolished in his jurisdiction by the building inspectors.[156] The Winneba District Commissioner, G. P. H. Brewes warned the chief in March 1939 that "you have no power to tell your people to rebuild the unauthorized buildings which were demolished. No one should alter or erect any building in Abosso without a permit, any building wrongly erected will be demolished at the expense of the builder."[157] The chief's action was because he and other chiefs and the people were not well informed about the regulations before it was implemented.[158] The policy never stipulated the specific time in

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[155] Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century,* p. 140.
[156] PRAAD-Cape Coast, ADM 23/ 1/ 2878 (11/1/1948- 8/5/1948) Layout and Sanitation of Villages and Towns.
[157] *Ibid.*
[158] PRAAD-Cape Coast, ADM 23/ 1/ 639 (1926-41) Building Regulations. Although the regulation was passed in 1921, it was in May 1933 that the District Commissioner of Winneba requested from the Provincial Commissioner ten copies of the Regulation, intended for distribution among the chiefs of his district who complained of their ignorance as far as the Building Regulation was concern.

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which if the so called "dangerous buildings" were not rebuilt, they would be demolished.[159]

It is interesting to mention here that when the colonial government assumed the responsibility of cleaning up streets and communities with the use of the sanitary workers in 1920s, some of the local communities and individuals saw it as the time to stop cleaning up their immediate surroundings. For instance, it was observed by the District Commissioner of Western Akyem that in places where the colonial government's sanitary workers existed and worked, the people made "big mess" as they thought that government sanitary workers will come and clean it up.[160] Thus, the presence of a group of sanitary workers made some of the local people show less regard for their personal sanitary environment, an act that was not overt in the period when the colonial government had not taken up the duty of cleaning streets and communities.

Conclusion

This chapter sought to discuss the colonial public health and sanitation policies that manifested within the Central Province of the Gold Coast in the inter-war years. Health and health facilities, water and sanitation, epidemiology and, lastly, health education were themes that were discussed. Gold Coast African response and initiatives to the public health and sanitation policies were discussed. The chapter has systematically articulated the various public health

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[159] *Ibid.*

[160] PRAAD-Cape Coast, ADM 23/ 1/ 359 (1920-33) Deficiency Diseases. In August 1932, the District Commissioner, therefore, suggested that the actual cleaning of towns be handed over to the chiefs and that government supply inspectors only to see that the places are kept clean. And also, that all sanitary offences against health laws be dealt with by government officers and not the chiefs.

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and sanitation policies that were formulated, pursued and implemented in the Central Province of the Gold Coast between 1919 and 1939.

It was from the 1920s onwards that general and real public health and sanitation policies were formulated and perused in the Gold Coast. The fact is that it was from this period that the colonial government responded to the pressure and demands made by the Gold Coast intelligentsia for the inclusion of the local people in the formulation and implementation of the health and sanitation policies.[161] Governor Guggisberg's government was the first to enunciate in clear terms, a public health policy, one that was both comprehensive and fairly well executed. Hence, from the mid-1920s, colonial health policies that were executed made the Central Province a welfare province. That notwithstanding, government also motivated the Gold Coast Africans to build their own dispensaries, clinics and hospitals without a corresponding policy of training enough health officers locally to meet the increasing demand for western medical care. Consequentially, when the economic depression of the 1930s started, the colonial government as well as the local people were faced with the challenge of closing down some dispensaries due to lack of health officers and also medicines. By 1939, there were a number of hospitals, clinics and dispensaries built in the Central Province. However, it must be emphasized that all these developments were in the towns and a large number of rural areas were neglected. Thus, the economic depression of 1930s directly affected the public health and sanitation policies of

[161] By 1920s, improvements in the medical department, advances in scientific knowledge and awareness of local health conditions, a growing sense of responsibility toward the Gold Coast African population, and increase public acceptance of an alien medical system were other facts that caused the gradual inclusion of the Gold Coast Africans in the public health and sanitation policies that were formulated and implemented in the Gold Coast in general. See Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 11.

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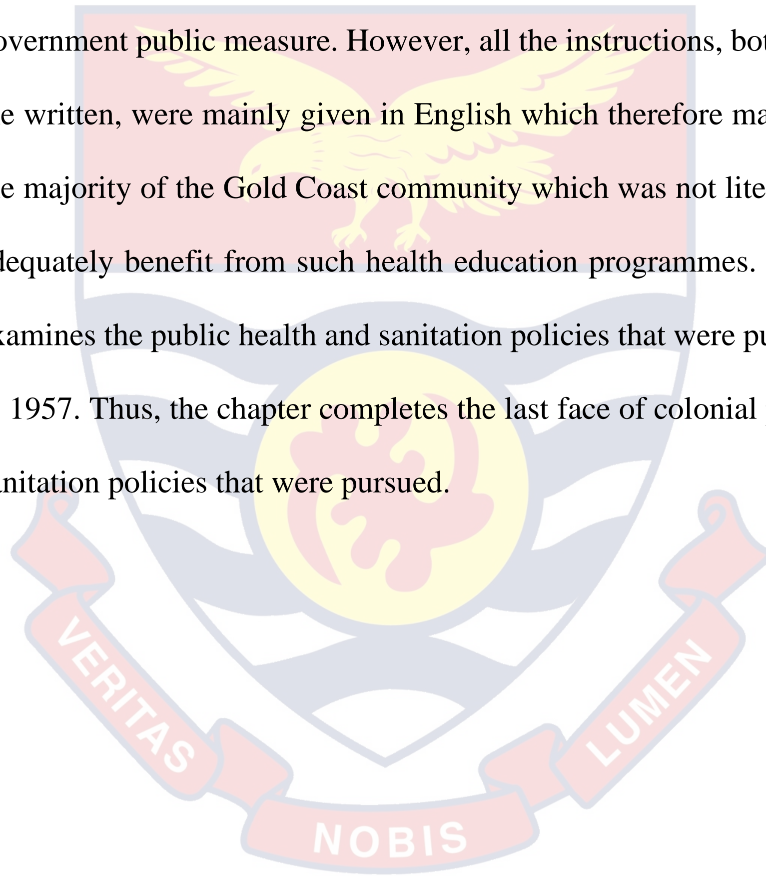
the colonial government. The colonial government relied on the support of the chiefs to pursue some of its public health and sanitation policies in the rural areas. One of such supports was the chief's mobilization and coordination of their people to engage in traditional practice of communal labour system. The initiative of the Gold Coast educated elites in no small way influenced colonial health and sanitation policies. Thus, it has become clear in this chapter some of the key roles that European and Gold Coast groups played to shape or determine government public measure. However, all the instructions, both the spoken and the written, were mainly given in English which therefore made it difficult for the majority of the Gold Coast community which was not literate in English to adequately benefit from such health education programmes. The next chapter examines the public health and sanitation policies that were pursued from 1939 to 1957. Thus, the chapter completes the last face of colonial public health and sanitation policies that were pursued.



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CHAPTER FIVE

PUBLIC HEALTH AND SANITATION POLICIES BETWEEN 1939 AND 1957

Introduction

The period between the outbreak of the Second World War in 1939 and the attainment of independence of the Gold Coast in 1957 witnessed a lot of government health and sanitation policies which were mostly unfavourable to the Gold Coasters particularly, those that were formulated and pursued during the war time. At the outbreak of the Second World War, the British colonial government was in a dilemma of pursuing a policy of ensuring the good health of the working population, defending the colony from possible invasion or employing all possible measures to win the War against measures to maintain health. Consequently, some unpopular health policies were pursued. These policies were often detrimental to public health in the colony. Even after the War, the colonial government continued with those unfavourable health policies, a situation which in no small way contributed to the various socio-political and socio-economic agitations of the day by the Gold Coast Africans.[1] These agitations eventually led to the demand for independence by the Gold

[1] Some of the grievances concerned the 1946 Burns Constitution which did not increase the number of Gold Coast Africans in the Legislative Council, the domination of the economy by foreign firms like the Association of West African Merchants (AWAM), the conditional sales, the swollen-shoot virus (CSSV) that affected cocoa trees, the general unemployment situation of both the youth and the ex-service men and other challenges and grievances of the Gold Coast Africans. The Gold Coast Africans demonstrated their social, economic and political grievances in the famous 1948 riots. For the grievances of the Gold Coast Africans against the colonial government in the post-Second World War Gold Coast, see Adu A. Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century,* (London: Longman Group Ltd., 2000), pp. 149-178; Michael Crowder, *West Africa Under Colonial Rule,* (London: Hutchinson & Co. Publishers Ltd., 1968), pp. 492-506; Devine E. K. Amenumey, *Ghana: A Concise History,* (Accra: Sankofa publications, 2000), pp. 202- 214; Roger S. Gocking, *The History of Ghana*, (London: Greenwood Press, 2005), pp. 77-87; F. K. Buah, *A History of Ghana*, (Malaysia: Macmillan Publishers Ltd., 1980), pp. 149-158.

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Coast Africans. This chapter attempts to discuss the colonial public health and sanitation policies in the Central Province between 1939 and 1957. The whole period under discussion will be divided into two, 1939 to 1945 and 1946 to 1957. In each period, the themes that will be discussed are health and health facilities, water and sanitation, epidemiology and, lastly, health education. Although these themes are treated separately, there was no sharp dichotomy. Rather, there is, as the evidence suggests, a connection in the public health and sanitation policies concerning health and health facilities, water and sanitation, epidemiology and health education. The Chapter will also examine the responses and initiative of the people of the Central Province to these colonial policies.

War Time Public Health, Sanitation Policies and Health Facilities, 1939-45

The Second World War reduced the number of British doctors that were sent to serve in the colony. There was, therefore, generally a shortage of medical officers in the Gold Coast. As a result of the shortage of medical officers during the War, there was a policy of frequently changing, rotating and shifting the limited number of medical officers in the colony so that at least each province, district or town could benefit from the services of a medical officer of health.[2] This was exemplified in Cape Coast, the capital of the Central Province. In spite of the already limited number of medical officers in the hospitals, the Deputy Director of health services pointed out to Mr. A F. E Fieldgate, the Provincial Commissioner, that the Medical Department had no option than to transfer Dr.

[2] PRAAD-Cape Coast, ADM 23/ 1/ 435 (1922-45) Sanitary Department.

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Ramsay, who was the only medical officer in the district, to Kumasi in October 1943.[3] Dr. Ramsay was brought back to Cape Coast in March 1944 to resume his duties. However, in less than two months he was transferred again to Tamale to relieve Dr. V. E. Whiteman, who was destined for Sierra Leone.[4] In 1940 alone, more than eight doctors had worked in the Cape Coast hospital on rotational basis because of the shortage of medical officers of health during the war time.[5] The constant transfer and change of medical officers of health during the war time was a real challenge to public health because there was no consistence in health service delivery to the people.

One of the health care policies that was a product of the War was implemented in January 1942 when the government, through the director of the Medical Department, called on the districts to form a voluntary visiting committee that was to visit the so called "more important African Hospitals"[6] at the various districts. The committee was expected to pay the visit twice in a year to observe the challenges of the hospitals and then report them to the Provincial Commissioner. In the Central Province, this policy was initially applied to Cape Coast, Dunkwa-on-Offin, Winneba and Western Akyem districts. Based on the policy, the committee would be made up of six members with the District Commissioner as its chairman.[7] The Provincial Commissioner

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[3] PRAAD-Cape Coast, ADM 23/ 1/ 435 (1922-45) Sanitary Department. Dr. Ramsay was to hand over his post to Mr. Forbes, the Sanitary Superintendent who, from October 1943 to March 1944 acted as the medical officer of health for the district. Dr. Ramsay was to relieve one Dobbin in Kumasi.

[4] *Ibid.*

[5] *Ibid.*

[6] PRAAD-Cape Coast, ADM 23/ 1/ 1058 (1942-48) Visiting Committee for the More Important African Hospitals.

[7] *Ibid.* The number of the membership depended on the size and the importance of the hospital. The membership of the committee included any African of higher repute in the district and Europeans, both official and non-official.

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had to forward the reports received from the various districts in the province to the Director of the Medical Department in Accra.[8]

Accordingly, the various committees in the Central Province proposed a general guideline for their activities. It was proposed that any member of the committee could visit the "more important African hospital" between 8 am and 6 pm before the committee makes any collective visit. The members could inspect the wards, other divisions of the hospital and were to check the hospital's records to know the complains of patients.[9] Also, the committees agreed to keep a book called "the Board of Visitors' Book" in each hospital and it was in it that complaints and observations made by members of the committee were recorded.[10] It was through such visitations and reports by the various committees that challenges like limited ward facilities, ambulance service, air-condition units in theaters, as well as lack of junior staff quarters, shortage of drugs, laundry services and employment of cooks for patients. Also, challenges like fencing of hospital compounds, water supply issues, mosquito proofing of hospitals and insufficient beds were brought to the attention of the colonial government.[11] It can be inferred from the hospital visitation policy that the rationale behind it was to make government aware of the challenges that the neglected African hospitals faced, especially, during the War time.

Another War time health care policy was proposed by Balfour Kirk, the Director of the Medical Department to solve some of the challenges of that

[8] *Ibid.*
[9] PRAAD-Cape Coast, ADM 23/ 1/ 1058 (1942-48) Visiting Committee for the More Important African Hospitals.
[10] *Ibid.*
[11] For some of the reports, works and members of the committee for the various districts in the Central Province from 1942 to 1950s, see PRAAD-Cape Coast, ADM 23/ 1/ 1058 (1942-48) Visiting Committee for the More Important African Hospitals; PRAAD-Cape Coast, ADM 23/ 1/ 2398 (1928-48) Winneba Native Hospital; PRAAD-Cape Coast, R.G. 1/ 9/ 2 (1952-64) Report of Hospital Visiting Board.

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department in what he called "rural health scheme." This policy was deemed as a solution to some of the challenges that the department faced. In 1943, he proposed the establishment of a network of several health centres in small communities around every major hospital.[12] Rural health centres were tasked to provide health care for local people and those referred from village dispensaries. The treatment of minor complaints was to be done by the health centres. However, patients whose cases or conditions required intensive health care were to be referred to the nearest district hospitals. The rural health centres were given the task to educate the public on the causes and prevention of common diseases.[13] During the War period there were some district hospitals which had no doctors. Hence, the rural health scheme became a white elephant because there was a limited number of doctors to visit the rural health care facility, the district hospitals.[14]

The operations of health care centres were affected by the Second World War because the colonial government placed much premium on the War than real measures to ensure public health. In May 1944, the European hospital in the Winneba District ceased to function because it was converted into a recuperative rest house for the military.[15] One of the reasons that the colonial

[12] David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* (Los Angeles: Crossroad Press, 1981), p. 17 and Stephen Addae, *Medical Histories from Primitive to Modern Medicine*, *1850-2000,* Vol. 1, (Accra: Durham Academic Press Ltd., 2012), p. 77.

[13] Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 17 and Addae, *Medical Histories from Primitive to Modern Medicine,* p. 86. By 1950, therefore, both Burn's hospital expansion scheme and Kirk's rural health scheme were being carried out.

[14] Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* p. 18.

[15] PRAAD-Cape Coast, ADM 23/ 1/ 3909 (1/5/1948-19/11/1948) European Hospital-Winneba; PRAAD-Accra, ADM 5/1/ 228 (1913-21) Gold Coast Colony Report on the Medical Department, 1944. The Winneba hospital was a concrete building with two consulting rooms, a dining room and two boys' quarters, among other facilities. From 1944 till 1948, the hospital remained as a rest house for the military who were stationed in this district. It is also worth noting that there was no construction of any special health facility for the military in the Central

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government gave in support of this measure was that the road network between Accra and Winneba was greatly improved hence Europeans in Winneba could access health care in Accra while the hospital in Winneba was used to aid the military in the War.[16] Additionally, the Saltpond hospital was also closed down during the War mainly because of shortage of doctors in the Central Province and the Gold Coast at large.[17] According to Stephen Addae, the War shunted away about 25 per cent of the medical staff to war time duties and also one of the constant features of war time was great shortage of medical officers of health and medicine to keep medical service running.[18]

Due to the shortage of medical officers of health during the War, hospitals which were without a resident doctor were visited occasionally by a doctor from districts or province which had one and also when arrangements were made during times of emergency.[19] The shortage of medical officers of health during the War time made the colonial government deem it necessary to leave some hospitals temporarily without permanent or resident medical officers.[20] Nurse-dispensers were therefore put in-charge of hospitals, clinics or dispensaries where there was no resident medical officer, largely because of the

Province. Till the Second World War, no special hospital existed for military personnel. However, because the colonial government gave much importance to the War, during the War, the Public Works Department was tasked to build hospitals in the colony. This led to the completion of the military general hospital (37th General Hospital) in July 1941 in Accra and, in the same year, the 52nd General Hospital of the British Empire was also opened in Takoradi. See Addae, *Medical Histories from Primitive to Modern Medicine*, p. 110.

[16] PRAAD-Cape Coast, ADM 23/ 1/ 3909 (1/5/1948-19/11/1948) European Hospital-Winneba; PRAAD-Accra, ADM 5/1/ 228 (1913-21) Gold Coast Colony Report on the Medical Department, 1944.

[17] PRAAD-Accra, ADM 5/1/ 228 (1913-21) Gold Coast Colony Report on the Medical Department, 1944. The people of the Saltpond District were required to visit the Cape Coast hospital for any medical care.

[18] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 206.

[19] PRAAD-Accra, ADM 5/1/ 228 (1913-21) Gold Coast Colony Report on the Medical Department, 1944. Due to the shortage of medical officers of health during the war time, long tours of service were the general rule. It was after a medical officer of health had served for two years that a leave was granted to the medical officer of health.

[20] *Ibid.*

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shortage of medical officers. Consequently, several rural dispensaries were closed, however, this was done only in rural areas where the total number of attendants to the health facility had been so low. In such cases, the dispensers were transferred to rural areas where their services were needed most.[21] This was a real challenge to the health of the Gold Coast Africans who dwelled in rural areas. Most Gold Coast Africans in both urban and some rural areas were induced by the colonial government through its policies to accept and patronize western medicine and medical care in the early 1930s. Some local authorities were encouraged to build their own health facilities and a non-resident medical officer of health visited patients at least once a week to attend to the health needs of the people in the area. However, the sudden shortage of medicine, medical officers and the eventual close-down of some health facilities demonstrated a retrogression of the colonial government's public health policies. These challenges also affected the colonial government's desire to supplant indigenous medicine and medical system with a European one.

The Second World War was the main factor for the challenges that engulfed the Medical Department in the first half of the 1940s. When the Medical Department realized that the War was not ending and many of its staff were constantly conscripted as non-combatants of the War, the Department took measures to train auxiliary health care workers in the Gold Coast. In October 1944, the Director of the Medical Department, Dr. Balfour Kirk, issued a communique calling on all Native Authorities who were desirous to train their own dispensers and nurses to send their "boys" names to a health training centre

[21] PRAAD-Accra, ADM 5/1/ 271 (1942) Medical Department Report, 1942.

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in Tamale or Kumasi for health training.[22] The nominee was to have educational background that was equivalent to elementary school standard 5. The duration for the health training was 18 months and some of the courses that were taught included wound dressing, nursing, administering of simple medicines for common ailments and first aid.[23] With this measure, the colonial government wanted to help local authorities to have their own "medical staff" in the ranks of dispensers, nurses and dressers.[24] Therefore, by way of solving the issue of shortage of medical staff and also preventing local health centres or facilities from total collapse, the colonial government took to the training of auxiliary local health staff to manage their own local health facilities. In addition to this intervention, government had to also make provision for water and sanitary facilities during the war period.

Water and Sanitation Policies

By 1939 and in the early years of 1940s, almost all the district capitals in the Central Province were connected to portable drinking water. On the contrary, many rural parts of the province were without pipe-borne water or any safe drinking water.[25] In the colonial government's quest to solve the water supply issues in the rural areas, a Temporary Water Supply Department was formed in 1943 and was tasked with the responsibility for the supply of water

[22] *Ibid.* see also Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, pp. 16-17.
[23] Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 17. PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries. The Akyem Kotoku state in the Oda-Western Akyem District nominated Messrs J. Ampabeng and I. A. Adjei for the said medical training in Tamale in 1946.
[24] *Ibid.*
[25] PRAAD-Cape Coast, ADM 23/ 1/ 2625 (1945) Temporary Water Supply Department.

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to villages and rural communities.[26] However, nothing much was really achieved by this department in the Central Province.

In the area of sanitation, few sanitary facilities were constructed during the War time period. The colonial government was constrained financially and so could not finance many sanitary projects in the Central Province. The sanitary facilities that were provided were those that the government deemed very necessary to better its position in the Second World War. For instance, in 1943 the colonial government established a Naval base at Komenda.[27] This naval base stimulated a measure of development in the town as the colonial government sought to provide sanitary facilities in the town for people. Thus, by the establishment of the admiralty in Komenda, it meant a possible increase in the number of people into the area which would increase the pressure on the limited sanitary facilities. Owing to this, the colonial government provided eleven sanitary sites on which a market, slaughter houses, latrines and incinerators in Komenda and its surrounding towns.[28] The local authority in Komenda gave land for free for the various sanitary structures that were provided for the town to aid the admiralty in the War.[29] Disease prevention and control was another area of concern to the colonial government during the War period.

VERITAS LUMEN NOBIS

[26] *Ibid.* Governor Burns had already been concerned about rural water supplies and had, despite wartime shortages, create a Temporary Water Supply Department. It was expected of the department to tour the colony and its rural areas to assess the water supply needed by the people in order of priority. In 1944, the Temporary Water Supply Department was changed to the Department of Rural Water Development. It was responsible for the many water supply in the rural areas. In the 1950s, the department was grouped with the others under the Ministry of Agriculture and Natural Resources. See Addae, *Medical Histories from Primitive to Modern Medicine,* p. 135 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 61.
[27] PRAAD-Cape Coast, ADM 23/ 1/ 933 (1936-44) Sanitary Structure-Dunkwa.
[28] PRAAD-Cape Coast, ADM 23/ 1/ 1069 (1942-43) Sanitary Structure-Komenda. The provision of all these public health and sanitation facilities were done based on the Defense Regulations was promulgated during the outbreak of the War.
[29] *Ibid.*

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Epidemiology Policies

No new epidemiological measures were introduced during the War period hence the old measures like vaccination and the use of residential segregation were still pursued in the combat against the spread and control of diseases. It is worth mentioning here that the method of segregation that had been used by the colonial regime to protect Europeans from malaria and yellow fever continued in the Central Province. For instance, between 1942 and 1944, the colonial government acquired land from the Kwonna Family at Saltpond to extend the European Residential Area.[30] The objective of this project was not only to safeguard the health of the official members in the district but it was to meet the increasing demand for officers due to the outbreak of the War.[31] Thus, the Second World War gave impulse to the extension of some of the existing residential areas in most of the districts in the Central Province. However, because the building of bungalows was capital-intensive, the colonial government could not finance such projects in addition to the cost of fighting the War.[32]

Another epidemiological measure that persisted through this period was vaccination against both communicable and non-communicable diseases such as small pox, yaws and yellow fever. In the early 1940s, the Gold Coast in general experienced periodic outbreak of small pox.[33] In 1941, the Central Province as a whole recorded about 343 cases of small pox of which 106 deaths

[30] PRAAD-Cape Coast, ADM 23/ 1/ 276 (1916-47) Segregated Areas-Saltpond.
[31] *Ibid.*
[32] *Ibid.*
[33] PRAAD-Accra, ADM 5/1/ 279 (1941) Gold Coast Colony Report on the Medical Department for the Year 1941. According to David Scott, during the twelve years from 1941 to 1952, Gold Coast experienced a series of epidemics of small pox which had been taking place gradually. David Scott, *Epidemic Disease in Ghana, 1901-1960*, (London: Oxford University Press, 1965), p. 74.

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cases were recorded on.[34] In 1942 there was outbreak of small pox at Dunkwa and Akatakyi, but in the case of the latter it became an epidemic, and hence an isolation camp where victims were vaccinated was built.[35] Between 1942 and 1945, there were regular reports on the outbreak of small pox at Assin Manso, Cape Coast, Akyinasu and the Winneba Districts.[36] There were frequent outbreaks of small pox in various parts of the Central Province. The colonial government responded to the epidemic by calling on the general public to be vaccinated; accordingly, vaccination centres were made assessable to the public.[37]

Malaria control in the Central Province was not effective enough to protect the average people hence in 1945, it was reported that yellow fever and malaria were the dominant diseases in the Province during the War time.[38] Generally, most of the health care centres and facilities were deprived of permanent medical staff hence anti-epidemic measures necessary in the rural areas as well as in the large health centers were ignored during the War time.[39] It is, therefore, clear that colonial government had its War effort as priority and neglected the basic health needs of the masses in the Central Province in particular and the Gold Coast in general. Apart from efforts that were made and

[34] PRAAD-Accra, ADM 5/1/ 279 (1941) Gold Coast Colony Report on the Medical Department for the Year 1941. According to David Scott, in 1941, the mortality rate for small pox in the Central Province was 30 per cent in 240 cases recorded in the Province. His projected number of cases for the Province within the said year is less than what the colonial report gives. However, the vital information is that, the Province recorded high cases of small pox than most of the other provinces in 1941. Scott, *Epidemic Disease in Ghana, 1901-1960*, p. 81.
[35] PRAAD-Cape Coast, ADM 23/ 1/ 176 (1909-45) Small Pox Infection Disease; PRAAD-Accra, ADM 5/1/ 271 (1942) Medical Department Report, 1942. The building of the isolation camp was based on the Quarantine Ordinance of 1873.
[36] PRAAD-Cape Coast, ADM 23/ 1/ 2755 (1946-47) Plague and Yellow Fever; PRAAD-Accra, ADM 5/1/ 228 (1913-21) Gold Coast Colony Report on the Medical Department, 1944.
[37] PRAAD-Cape Coast, ADM 23/ 1/ 2755 (1946-47) Plague and Yellow Fever; PRAAD-Accra, ADM 5/1/ 228 (1913-21) Gold Coast Colony Report on the Medical Department, 1944.
[38] PRAAD-Accra, ADM 5/1/ 227 (1945) Gold Coast Colony Report on the Medical Department, 1945.
[39] *Ibid.*

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challenges that were faced in the area of epidemiology, health education became one area that also saw government intervention. What was the relevance of health education? What was the nature, extent, and outcome of such intervention?

Health Education

One of the effective ways of disease prevention and control was the use of health education to create awareness amongst the public on some diseases. Health education was still employed as a prophylactic measure to eradicate, control and manage a number of diseases in the Central Province. Health education which manifested through conduits like the celebration of health week, printing and distribution of books and pamphlets, the teaching of hygiene and sanitation in schools persisted in this period. For instance, in November 1940, Dr. L. G. Eddey, the Medical Officer in the Cape Coast District started a weekly series on health lectures and discussions. These activities occurred during Monday evenings, at about 7 p. m, in the Town Hall (Hamilton Hall) at Cape Coast.[40] It was opened to all interested Gold Coasters self-employed, professionals, government workers and the general public. Between November and December 1940, some of the topics debated or spoken on included, "Flies and Fevers"; "That the Common Housefly is a worse menace to the Gold Coast African than is the mosquito"; "Healthy Feeding"; "Healthy Drinking" and "Water is a more health-giving beverage than alcohol."[41] The far reaching impact of this form of health education on the Gold Coast Africans in the

[40] PRAAD-Cape Coast, ADM 23/ 1/ 435 (1922-45) Sanitary Department.
[41] *Ibid.*

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Central Province cannot be quantified here as there are no records to show the effects of this form of health education; nevertheless, it was largely the so-called educated Gold Coast Africans who largely participated in such talks and therefore must have taken beneficial health tips from this important form of health education before the end of the Second World War. Nevertheless, the health needs and challenges of the people persisted after the end of the War in 1945. This situation, which needed to be tackled, invited governmental and non-governmental initiatives and interventions.

Post-War and the First African Government's Initiatives, 1946- 57

This period under discussion, 1946 to 1957, marks the turning point or watershed between colonialism and decolonization of Gold Coast. The colonial government took measures to prepare the people of Gold Coast for self-determination so that the Gold Coasters could manage their own political, health and sanitation after independence. Consequently, there was the training of the Gold Coasters in health care delivery, water management techniques and the preparation of the first African leader in political administration. This section discusses the public health and sanitation policies that falls under health and health facilities, water and sanitation and epidemiology within the period 1945 and 1957.

Health and Health Facilities

The financial challenges that the colonial government faced in the pre-War period worsened immediately after the Second World War, therefore, it was still incapable in the provision of health facilities for the colony. The Gold

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Coast Branch of the British Red Cross Society (G.C.B.B.R.C.S.) continued to render services to the general public on behalf of the colonial government.[42] The Society also helped local authorities in constructing health centres. For instance, by 7th May, 1946, the Society had helped the people of Komenda to complete a child welfare clinic at the cost of £ 600 and the Native Authority was to pay for the cost of the project in monthly instalment basis.[43] Also, in 1947, Nana Ababio III, the *Omanhene* (Paramount Chief) of Abura petitioned the secretary of G.C.B.B.R.C.S. in Cape Coast to station a nurse and a dispenser at Abakrampa where the state of Abura had almost completed the construction of its own clinic.[44] While the G.C.B.B.R.C.S. played such a vital role in the provision of health services and facilities in the Central Province to support the work of the colonial government, it largely focused on the provision of maternal and child health care.[45]

Unable to increase the number of health facilities and staff and funds in the Gold Coast, the colonial government allowed both Gold Coast Africans and Europeans to use the same limited health facilities together. Thus, the very weak financial position of the colonial government must have contributed to bringing

[42] PRAAD-Cape Coast, ADM 23/ 1/ 777 (1930-40) Establishment of Dispensaries in Cape Coast.
[43] *Ibid.* The clinic had antenatal as well as postnatal care, a dispensary, waiting room, office for the staff and two cement water tanks. On the opening day the Komenda Native Authority requested to employ the services of one Mrs. Gertrude Banson, a midwife, to work at the welfare clinic. Although the chiefs gave the land for the construction of the health facility, they were to pay for the total cost of the facility. Hence, the people of Komenda built their own child welfare clinic.
[44] PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries. Abura is about 13 kilometers from Cape Coast, the capital of the province, however, as at this time it had no clinic and this was affecting the pregnant women and children who had to journey to far distance for antenatal and post-natal care.
[45] In the Cape Coast District, the Junior arm of the G.C.B.B.R.C. Society at the Wesley Girls' High School was also known as Link Number 14. It was very philanthropical to the Cape Coast government hospital. Between December 1939 and December 1943, this junior arm had donated an amount of £ 53 toward the maintenance of beds in the Cape Coast hospital. The beds in the hospital were accordingly named after the association. See PRAAD-Accra, CSO 11/1/ 574 (1943) Maternity Block of the New Government Hospital, Cape Coast- Gift for naming a Bed.

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an end to the provision of separate health facilities for Gold Coast Africans and Europeans in the Gold Coast. By 1946, European hospitals were no longer exclusively for Europeans and the name "European Hospital" was abolished as those Gold Coast Africans who could afford admission into such health facilities were allowed to do so.[46] The use of the expression "European Hospital" was taken out of government reports from 1946 onwards.[47] It can, therefore, be said that the long perceived and jealously guarded, albeit erroneous, superiority of Europeans over Gold Coast Africans which had led to the provision of separate health care facilities and health officers for the two races, which was a component of the colonial government's public health policies, started to disintegrate immediately the War ended. It is also possible that the very weak financial position of the colonial government following the end of the War may be a factor that brought about an end to the provision of separate health facilities for Gold Coast Africans and Europeans in the Gold Coast.

Although the colonial government was not in a strong financial position to employ more medical officers of health in the service of the Gold Coast, the government was committed in assisting local authorities in the training of local medical staff as auxiliary health officials. In March 1947, the Medical Department published a pamphlet bearing the title "Policy with Regard to the Development of Medical Service in the Rural Areas."[48] It stipulated the mode of training of the Gold Coast Africans nominated by their local authority for a medical course either in Tamale or Kumasi.[49] It was required that the nominee

[46] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 76.
[47] *Ibid.*
[48] PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries.
[49] *Ibid.*

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pass an interview before the nominee was sent to the training centre. Such interviews were to be conducted by the medical officer of health in the district that the nominee was coming from. The purpose of the training was based on the fact that government realized that "it will probably always be impossible to provide in the rural areas a complete medical services owing to widely dispersed population living at low economic levels, but it is generally agreed that a service of some kind is essential in order to relieve suffering."[50] In areas where there existed no dispensary or dressing stations, the local authorities in that area were encouraged by the colonial government to build one for themselves and were also to make plans to pay for the service of their own health staff.[51] In 1948, the Medical Officer in the Cape Coast District interviewed and approved some four nominees representing Agona, Gomoa Assin, the Denkyira Confederation of states and the Assin Confederation of states for training.[52] These states promised to pay a monthly stipend of £ 3 to their respective nominee during the training period. Based on the policy of training auxiliary local health staff, it could be said that from the start of the second half of the twentieth century, most of the rural communities in the Central Province had their own medical auxiliaries and nurses who offered biomedical health care service to such communities. Consequently, western medicine and medical care had impact on large areas in the interior part of the Central Province through the work of such

[50] *Ibid.*
[51] *Ibid.* See also PRAAD-Cape Coast, ADM 23/ 1/ 3117 (1945-52) Dispensaries- Native Authority; PRAAD-Cape Coast, ADM 23/ 1/ 3190 (1948-49) Dispensaries; PRAAD-Cape Coast, ADM 23/ 1/ 1299 (1948-50) Village Dispensaries and Clinic.
[52] PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries. See also PRAAD-Cape Coast, ADM 23/ 1/ 3117 (1945-52) Dispensaries- Native Authority; PRAAD-Cape Coast, ADM 23/ 1/ 3190 (1948-49) Dispensaries; PRAAD-Cape Coast, ADM 23/ 1/ 1299 (1948-50) Village Dispensaries and Clinic.

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health care workers.[53] Although the colonial government was faced with financial challenges which made it incapable of financing the cost of training of local medical staff, it strove to provide a health facility for the treatment of lepers in the Central Province.

It was in the late 1940s that the colonial government decided to build a leprosarium for lepers in the Central Province.[54] The Medical Department decided to help in the treatment of this infectious disease in the Central Province hence in 1948, the colonial government took steps to build a health facility for lepers at Ankaful, a town sandwiched between Cape Coast and Elmina.[55] On 14th November, 1953, the official opening of the Ankaful leprosarium took place.[56] Therefore, from the late 1953, there was a segregated community for lepers in the Central Province and all lepers were sent from all parts of the province to the health facility at Ankaful for treatment. The leprosarium was made to accommodate a total of about 450 patients and was designed to serve

[53] John Middleton & Joseph C. Miller, *New Encyclopedia of Africa,* (New York: Charles Scribner's Sons, 2008), p. 543.
[54] By 1941, there were leper settlements in most part of the Gold Coast like Ho, Accra, Kumasi, Yendi and Sekondi but the Central Province did not have one although lepers lived in the Central Province. See PRAAD-Accra, ADM 5/1/ 279 (1941) Gold Coast Colony Report on the Medical Department for the Year 1941; PRAAD-Accra, CSO 11/9/ 9 Leper Settlement in the Northern Territories. See also Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 74.
[55] It was in August 1950 that a committee made up of the Chief Commissioner, Director of Agriculture, Provincial Engineer and Medical Officer of Health decided on the site for the leprosarium. They decided to have a soil scientist to test the fertility of the soil since it was planned that the leprosarium would have its own farm. This initiative was under the leadership of Dr. A. McKelvie, an experienced leprosy doctor who had successfully managed a segregated village for the treatment of lepers in Nigeria and was committed to manage a leprosarium in the Central Province. See PRAAD-Cape Coast, ADM 23/ 1/1348 (1950-55) Ankaful Leper Settlement; PRAAD-Cape Coast, ADM 23/ 1/ 2088 (1915-48) Medical Department; PRAAD-Cape Coast, ADM 23/ 1/ 311 (17/10/1918-27/11/1918) Leprosy; PRAAD-Cape Coast, ADM 23/ 1/ 1403 (1951-52) Leprosy Clinic in the Central Province.
[56] PRAAD-Cape Coast, ADM 23/ 1/ 1348 (1950-55) Ankanful Leper Settlement; PRAAD-Cape Coast, ADM 23/ 1/ 2088 (1915-48) Medical Department; PRAAD-Cape Coast, ADM 23/ 1/ 311 (17/10/1918-27/11/1918) Leprosy.

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as a leper settlement for the treatment of infectious leprosy as well as a hospital that could receive and treat referral cases.[57]

It is worth noting the political development in the Gold Coast that influenced public health and sanitation policies. In the Gold Coast, in general, from 1951 there was internal semi-political independence when Kwame Nkrumah became the "Leader of Government Business" and subsequently the Prime Minister.[58] Therefore, from the late-1951, a Gold Coast African was to continue with the already existing colonial public health and sanitation policies. The new government was also in charge of the formulation and implementation of public health and sanitation policies. Based on the 1951 constitution of the Gold Coast, Town Councils were substituted for Urban and Local Councils. Thus, at the urban level, the Urban Council took charge of the responsibility of the former Town Council and at the rural areas, the Local Council also did the same. Following this internal political arrangements, the colonial government's initial policy of passing on its responsibility of providing the health needs of the Gold Coasters onto the local government began to manifest.[59] So far as public health and sanitation were concerned, the functions of the Local Council

[57] PRAAD-Accra, ADM 5/1/ 337 (1954) Report on the Ministry of Health, 1954.
[58] Roger, *The History of Ghana,* pp. 98-99; Boahen, *Ghana: Evolution and Change,* p. 177; Buah, *A History of Ghana,* p. 160; Amenumey, *Ghana: A Concise History,* p. 209 and Kwame Osei Kwarteng & Mary Owusu, "Opposition to Kwame Nkrumah and the Convention Peoples Party, 1951-1960", Bea Lundt & Christoph Marx (eds.) *Kwame Nkrumah, 1909- 1972: A Controversial African Visionary*, (Stuttgart: Franz Steiner Verlag, 2016), pp. 67-88, p. 73.
[59] Based on the 1951 constitution, the whole of the Gold Coast was administered together as one colony. Therefore, there were changes in the political administrative machinery. There was the appearance of Regional Commissioners in place of the Provincial Commissioners. Four regions were created, Ashanti, Northern, Eastern and Western Region (amalgamation of the former Central and Western Provinces). Cape Coast was made the administrative capital of the Western Region. The administration at the regional level was divided into two main units, the Municipal and District Councils. Each District Council was made up of Urban and Local Councils. See PRAAD-Cape Coast, ADM 23/ 1/ 1792 (1951-52) Local Government. It is also important to note here that for the purpose of consistency and continuity, the use of the term "Central Province" is hitherto used in reference to the same or original territories and districts that constituted the Central Province at the beginning of the colonial period and not to include the former Western Province.

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included but not limited to establishing, maintaining and controlling of drains, public lavatories and wash places, public water supply, safeguarding and promoting public health, sanitary services for the removal and destruction of night soil, refuse collection and also the prevention of pollution of water bodies.[60] The 1951 constitution of the Gold Coast also created the Ministry of Health and Labour in place of the Medical Department with Mr. K. A. Gbedemah, a Gold Coast African of the Convention People's Party, as the head.[61]

Following the internal political changes, from July 1951, the local authorities of Cape Coast, Saltpond and Komenda appealed to the Ministry of Health and Labour to give their local dispensers license to enable the dispensers to inject patience with yaws.[62] This demand was precipitated by the fact that the government's doctors had stopped their weekly visit to the local clinics and dispensaries.[63] Hence, the supervision of the activities of the local dispensers by government doctors had also not been done in the absence of government doctors.[64] It was the government's doctors who supervised the activities of the locally trained medical auxiliaries in the dispensaries and clinics.

Furthermore, the first Gold Coast African government stopped providing the health care facilities needed by the rural population of the Central Province from early 1950s. Partly due to the support of the Roman Catholic

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[60] PRAAD-Cape Coast, ADM 23/ 1/ 1792 (1951-52) Local Government. See also Addae, *Medical Histories from Primitive to Modern Medicine*, p. 124. The provision, maintenance and the management of slaughter houses was also the duty of the local authorities.
[61] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 83; P. A. Twumasi, *Social Foundations of the Interplay between Traditional and Modern Medical Systems,* (Accra: Ghana University Press, 1988), p. 18. In 1953, the Ministry of Health and Labour was simple called the Ministry of Health.
[62] PRAAD-Cape Coast, ADM 23/ 1/ 1372 (1950-54) Village Dispensaries and Clinics.
[63] *Ibid.*
[64] *Ibid.* There was also a shortage of drugs to this local clinic.

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mission and other non-governmental bodies to such rural areas. For instance, the Roman Catholic mission enabled the Assin Confederation of States to be able to build a health centre at Foso in 1951.[65] Also, in June 1952 a maternity block whose building was financed by the local authority without government's assistance was added to the Fante Yankumasi dispensary with one Mrs. Enchills as the first midwife of the maternity unit.[66] The Gold Coast African government went further to withdraw the services of some of its health officials who were stationed in some of the rural areas in the Province. In November, 1953, the Assin Confederation vehemently opposed the decision of the Ministry of Health to withdraw the service of the only government dispenser at Fante Yankumasi dispensary.[67] This decision was a manifestation of the government's plan to put to an end its responsibility of providing for the health needs of the people in the rural areas. The Assin Confederation was unsuccessful in its protest and in all its efforts to maintain the dispenser, and hence, the government dispenser was removed from the Yankumasi dispensary.[68] However, in December 1953, the Assin Confederation treasury employed one A. W. Asamoah, a nurse who came from Assin but was trained at Kintampo health school, to take over from the

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[65] It was opened on 14th December, 1951 and the treatment of leprosy was given attention as victims of the disease were treated on Tuesdays and Fridays. See PRAAD-Cape Coast, ADM 23/ 1/ 1403 (1951-52) Leprosy Clinic in the Central Province. It is worth mentioning here that the Assin Confederation of States was an amalgamation of the two Assin paramount stools of Assin Apemanim and Assin Attandanso. See PRAAD-Cape Coast, ADM 23/ 1/ 1372 (1950-54) Village Dispensaries and Clinics; PRAAD-Cape Coast, ADM 23/ 1/ 1187 (1945-46) Native Authority Assin Apimanim and Assin Atandanso Confederacy; PRAAD-Cape Coast, ADM 23/ 1/ 1164 (1945-46) Assin Confederacy Native Authority.

[66] PRAAD-Cape Coast, ADM 23/ 1/ 1372 (1950-54) Village Dispensaries and Clinics. This maternity block was highly patronized by the people as was reported by Reginal Matron that in October of 1952, the total attendance was 1045.

[67] The Confederation was joined by the Assin Attandanso Youth Association (AAYA), the youth wing of the Confederation, in protesting against the removal of the government dispenser and also the general shortage of drugs in the dispensary. See PRAAD-Cape Coast, ADM 23/ 1/ 1372 (1950-54) Village Dispensaries and Clinics.

[68] *Ibid*

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government dispenser who was due to leave the dispensary in January of 1954.[69] The discontent that was demonstrated towards the government by the various local authorities and the youth associations in the Central Province who were affected by the unpopular health policies of the colonial government after the Second World War contributed to the demand for independence of the Gold Coast.

The colonial government's decision to withdraw the services of its health staff in most of the rural areas and in some cases the urban centres in the early 1950s raises a lot of questions. For instance, was the colonial government preparing the Gold Coast Africans to take charge of their own health and manage their health care facilities with their own local health officials like midwives, nurses, nurse-dispensers and dispensers? Could such a plan have been necessitated by the post-War financial standing of the colonial government or a method to prepare the country for independence? The fact is that the end of the Second World War marked a watershed between colonization and decolonization.[70] Therefore, by way of drawing a historical parallel, that aside the financial consideration, socially, it is reasonable to conclude that the colonial government took those decisions as a way of preparing the local people of the country to be formally in charge of the provision and management of their health care needs since political power was gradually shifting to the Gold Coast African nationalist leaders. The financial challenges that prevented government from taking full responsibility in the provision of health staff and health

[69] *Ibid.*
[70] Crowder, *West Africa Under Colonial Rule,* p. 19. See also Boahen, *Ghana: Evolution and Change,* p. 149.

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facilities for the people, also affected it in the provision of water and sanitation in the Central Province.

Water and Sanitation Policies

Concerning water and sanitation, the colonial government pursued a policy that was very similar to that of the health and health facilities. The government trained some of the Gold Coast Africans in water supply for them to manage their own water supply issues. In 1946, two independent departments were created out of the Medical and Sanitation Departments. These were the Housing and Town Planning and Labour and Water Supplies Departments.[71] In March 1948, the colonial government set up a geological survey team to investigate and map out how water supply could be extended to, or provided, for the rural areas of the Gold Coast. The survey done by the team assisted in providing wells for the rural areas. It was from the survey that Asebu, Komenda, Assin Atandanso, Assin Kumasi, Ajumako, Damang, Asamang, Tumfokro, Amoabin and other rural areas in the Central Province became beneficiaries of the government-dug wells.[72] Water was a real necessity for most of the rural areas in the Central Province at this time. The increasing need for safe and clean water supply for the rural areas was regularly reported on. For instance, in March 1948, the chairman of the Dunkwa Social Welfare Committee pointed out to the Provincial Commissioner of the Central Province that the Committee had resolved in 1948 that the "provision of pipe-borne water for Dunkwa should

[71] Addae, *Medical Histories from Primitive to Modern Medicine,* p. 149.

[72] PRAAD-Cape Coast, ADM 23/ 1/ 799 (1930-48) Water Supply-Towns and Villages in Central Province. This form of water supply was largely lacking in the interior as the old wells and some of the nearby streams were drying up, hence, the need for deep wells in such areas. The Geological Survey Department went about inspecting the possible areas within a town or village where wells could be dug for the people.

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take priority over the supply of electricity" and that "Dunkwa is one of the towns due to be provided with water supply."[73] The problem of shortage of staff at the Public Works Department and, particularly, the Temporary Water Supply Department who were responsible for the drilling of wells also made it difficult for the drilling of enough wells in the Gold Coast.[74]

In 1948, the colonial government made it a policy to train Gold Coast Africans in the methods of construction and maintenance of dams, wells, ponds and any good source of water supply for the public or a locality[75] as a way of solving the issues of both shortage of staff of the Public Works Department and the frequent shortage of water supply in most rural areas. Based on this policy each local authority in the Central Province was directed to nominate a person who had skills in masonry for such training. In all, by the end of 1948, a total of 30 persons were nominated from the Central Province for training in Tamale.[76] Like the training of the Gold Coast Africans as auxiliary medical staff for their service in their own traditional area, it was hoped that upon completion of the training in water supply management, the trainee would be employed by the Temporary Water Supply Department in the trainee's own traditional area.

In 1951, Kwame Nkrumah, the "Leader of Government Business" drew a Five-Year Development Plan for the colony. It was due to this development plan that health services were improved, the provision of good drinking water in the rural areas through the boring of water holes and the construction of new

[73] PRAAD-Cape Coast, ADM 23/ 1/ 2625 (1945) Temporary Water Supply Department.
[74] *Ibid.*
[75] *Ibid.* The water supply training school for the whole of the Gold Coast was stationed at Tamale.
[76] PRAAD-Cape Coast, ADM 23/ 1/ 2625 (1945) Temporary Water Supply Department.

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reservoirs were increased.[77] In all, by the end of 1954, a total of 227 wells had been drilled in the rural areas of the Central Province.[78] The existing water-supply facilities in the districts in the Central Province were also expanded. Between 1954 and 1957, an increasing demand for and supply of pipe-borne water into a number of households, individuals' homes, churches or mission houses, public bath houses and schools in the major towns of the Central Province made this increase necessary.[79]

Concerning sanitation, the Building Regulation of 1921 was still operational by 1951. Therefore, the issuing of building permits before any form of building could be constructed by private individuals and institutions was still enforced.[80] However, after three decades of its enactment, in 1951, the Building Regulation was amended to meet changing circumstances. Thus, two important clauses were added to it. The first clause that was added to the Building Regulation made it mandatory for every household to have its own pan-latrine.[81] The number of pan-latrines that each household was to have was calculated on a ratio of one pan-latrine to every four living rooms in a household.[82] The second clause empowered the Public Works Department to authorize the installation of water flushed urinals in urban centres and towns and water closets in place of

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[77] Boahen, *Ghana: Evolution and Change*, p. 177; Amenumey, *Ghana: A Concise History*, p. 210.
[78] PRAAD-Accra, ADM 5/1/ 234 (1954) Department of Rural Water Development Annual Report, 1953-1954.
[79] For the list of the institutions and some private homes that requested for pipe-born water supply to their homes see PRAAD-Cape Coast, ADM 23/ 1/ 3464 (1954-57) Water Supply Cape Coast.
[80] PRAAD-Cape Coast, ADM 23/ 1/ 2594 (1941-49) Building Permits and Plans. In the 1940s, the various District Commissioners and Engineers in the province issued building permits to a number of individuals and most educational institutions for the construction of dormitories and classroom blocks as well as to churches and firms in the province.
[81] PRAAD-Cape Coast, ADM 23/ 1/ 2594 (1941-49) Building Permits and Plans.
[82] *Ibid.*

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the pan-latrine for both public and private latrines.[83] In the same year that the amendment was made, the Public Works Department in the Central Province received 6 water closets from the colonial government for installation in Cape Coast and Winneba.[84] The Public Works Department was also empowered to ensure that properly constructed sewage systems were constructed for the public in the Province.[85] The rationale behind these clauses was to reduce the pressure on single pan-latrine in households and also to prevent the possibility of an individual using the bush as a private latrine due to the limited number of pan-latrines in a home. It is vital to mention here that from the 1950s, government considered the responsibility of ensuring better sanitation to be one of the duties of the local authorities largely because the provision of sanitary facilities was capital-intensive.[86]

On 20th March, 1953, the Ministry of Local Government and Housing published the government's policy on housing. The Housing Department was reorganized into three units- Urban Housing Department, Rural Housing Department and the Assisting Housing Division.[87] The Central Province was a beneficiary of the housing scheme that Nkrumah's CPP-led government launched as a way of ensuring a better layout and sanitary environment. For instance, 4 three roomed cottages, 36 two-roomed cottages, 180 single rooms

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[83] These regulations were added to section 81A sub-section 2 of the 1921 Building Regulations. Prior to the amendment of the building regulation for the whole of the Gold Coast, part of the Western and Eastern regions had already introduced in their jurisdiction the above-mentioned clauses into the Building Regulation. See PRAAD-Cape Coast, ADM 23/ 1/ 2036 (1949-51) Building Regulations.

[84] PRAAD-Cape Coast, ADM 23/ 1/ 2658 (1945-52) Septic Tank Latrines. Four of the 6 water closets were installed in Cape Coast and two in Winneba.

[85] PRAAD-Cape Coast, ADM 23/ 1/ 2036 (1949-51) Building Regulations.

[86] PRAAD-Cape Coast, ADM 23/ 1/ 1792 (1951-52) Local Government.

[87] PRAAD-Cape Coast, ADM 23/ 1/ 3154 (1952-53) Housing- Dunkwa. Through the Traditional Council of Dunkwa a passionate call was made on the government to consider Dunkwa in the housing scheme as the area was engulfed in severe flood that destroyed 13 houses and rendered about 500 people homeless in September 1952.

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with ancillary buildings of 26 two-roomed cottages and 140 single rooms were built at Swedru Estate Housing based on the government's housing policy.[88] This measure was one of the ways that the African government employed to ensure sanitary and better layout of settlements. Disease prevention and management was also another concern to the colonial government after the Second World War.

Epidemiology Policies

The epidemiological measures taken to prevent, manage and control the spread of diseases since the commencement of colonial rule in the Gold Coast was still used during this period. However, new diseases and health conditions required new dimensions of preventions, controlling and managing diseases. In July 1946, the government doctor at Winneba detected the outbreak of canine rabies in the district. Between August and September of 1946, a total of 91 dogs were destroyed in the Winneba District for the safety of the public health as enshrined in the Disease Animal Ordnance.[89] In September 1946, the government doctor in Winneba issued a communique calling on the public to keep their dogs tethered throughout the day and night until further instruction was given. It was also added that every dog that was found outside would be considered a stray dog and, therefore, would be destroyed.[90] The government doctor requested that owners of dogs must register their dogs and have them

[88] PRAAD-Accra, ADM 5/1/ 35 (1947) Annual Report, Gold Coast 1947.
[89] PRAAD-Cape Coast, ADM 23/ 1/ 2755 (1946-47) Plague and Yellow Fever. The killing of stray dogs was based on the Disease Animal Ordnance section 10 which stipulated that "A veterinary authority may, if he shall consider that such destruction is necessary in the interest of the Public Health, destroyed or causes to be destroyed."
[90] This communique was read in three local languages- Fante, Twi and Ga- in the districts. See PRAAD-Cape Coast, ADM 23/ 1/ 2755 (1946-47) Plague and Yellow Fever; PRAAD-Cape Coast, ADM 23/ 1/ 897 Diseases of Animals.

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examined in the hospital. All these measures were issued to ensure the health and safety of the public.

Also, in September 1952, there was outbreak of small pox at Dunkwa-on-Offin and the nature of the epidemic compelled the government to construct an isolation camp at Atekyem where victims of the disease were quarantined for vaccination.[91] For the safety of the general public, the Ministry of Health and Labour made the vaccination against small pox free for the people of Dunkwa-on-offin and the vaccination exercise was done in public places like markets, church premises and at hospitals.[92] In 1954, the Central Province was named one of the areas in the Gold Coast that recorded the highest cases of typhoid and paratyphoid fevers.[93] Based on official report, the most affected areas in the Central Province were Cape Coast, Oda, Dunkwa-on-Offin and Winneba with the number of cases being 36, 37, 7 and 19 respectively.[94] Indeed the absence of a comprehensive public health ordinance in the Central Province and the Gold Coast in general after the Second World War was the reason for this epidemic in the colony as no disease control measures were effectively employed in 1954.[95]

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[91] PRAAD-Cape Coast, ADM 23/ 1/ 3334 (1930-53) Disease General. Atekyem is about half a mile from Dunkwa town.
[92] *Ibid.*
[93] PRAAD-Accra, ADM 5/1/ 337 (1954) Report on the Ministry of Health, 1954.
[94] *Ibid.*
[95] One of the possible reasons that accounted for this high number of fever cases in the Central Province in 1954 could also be attributed to the fact that as at 1954, the local authorities were not equipped to assume full control of public health activities in their districts. The constitutional reforms of 1951 had not been implemented to its fullness hence the various local governments could not perform their duties so far as public health services was concerned. See PRAAD-Accra, ADM 5/1/ 337 (1954) Repot on the Ministry of Health, 1954.

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Gold Coast Africans' Initiatives and Response to the Public Health and Sanitation Policies, 1939-57

It is worth mentioning here that some of the public health and sanitation policies negatively affected the economic activities and the source of livelihood of some of the peoples of the Central Province. For instance, in the colonial government's quest to minimize the cost of water chlorination and purification, in 1940, through an Order in Council, the colonial government outlawed some human activities that were carried out near water bodies or along river banks. Some of those activities included fishing, washing of clothes, swimming or bathing, farming and the use of canoes on a water body on which a dam had been constructed.[96] It was perceived by the Public Works Department and the Medical Department that those activities resulted in the pollution of the water body with water borne diseases like ancylostomiasis, dracontiasis and schistosomiasis which made the purification process of the water body very difficult and expensive to carry out.[97]

On 9th November 1940, the *Omanhene* of Asebu, Nana Amanfi III, disclosed the far-reaching impact of the Order on his people. He noted that the people of Srodorfu and Abasa were affected by the Order in Council that banned the people from performing any activity on or around the Kakum River.[98] By the Order, the economic activities of the people like transportation of lime fruits by means of canoe across the Kakum River from Srodorfu and Abasa to Apewosika was affected.[99] In fact, as a result of the ban, farmers could not

[96] PRAAD, Cape Coast, ADM 23/ 1/ 2585 (1940-43) Cape Coast Water Works- Brimsu Water Purification.
[97] *Ibid.*
[98] *Ibid.*
[99] It was only after the farmers have been able to cross the Kakum River to Apewosika that the farmers could have access to a motorable road to transport their fruits to Asebu where a lime

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transport their produce to the Asebu lime firm. Lime fruit farming was the mainstay of the people of Srodorfu and Abasa largely because of the ready market of it. In early 1941, Nana Amanfi III passionately appealed to the Public Works Department and A. F.E. Fieldgate, the Provincial Commissioner to allow his people to transport their lime fruits across the Kakum River.[100] In fact, neither the Provincial Commissioner nor the Director of Public Works Department really paid attention to this request.[101] The colonial government's officials were determined to enforce the dictates of the Orders that protected the river bodies regardless of the adverse effects of the Orders on the economic activities of the people.

When sanitary inspection was extended to the rural areas in the 1940s, some chiefs whose jurisdiction had never experienced such "police form of inspection and arrest," rose against the inspections in their area. In 1944, the chief of Gomoa Assin, Nana Kuso Edu XV, suggested to the *Adontenhene*, Nana Kojo Anuakwa of Agona Dunkwa, to use his powers and office to stop the sanitary inspectors from inspecting the rural areas.[102] In fact, Nana Kuso Edu XV argued that the "sanitary inspectors have gone far to all villages around Dunkwa" and that "the sanitary rules do not particularly apply to such poor

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factory had been built. It was pointed out that the quantity of lime fruits produced by five farmers was 100 bags hence, the Orders was a real challenge to the lime fruits farmers. In fact, that ban was rigidly enforced that in the same year one Opanin Kofi Ntsin of Sordrofu had his canoe seized for using it on the Kakum River. See PRAAD, Cape Coast, ADM 23/ 1/ 2585 (1940-43) Cape Coast Water Works- Brimsu Water Purification.

[100] PRAAD, Cape Coast, ADM 23/ 1/ 2585 (1940-43) Cape Coast Water Works- Brimsu Water Purification.

[101] *Ibid*. By September 1941 this request by Nana Amanfi III was still not granted. By 1948, this request by the chief and his people had not been granted by neither the Provincial Commissioner nor the Public Works Department.

[102] PRAAD-Cape Coast, ADM 23/ 1/ 2878 (11/1/1948-8/5/1948) Layout and Sanitation of Villages and Towns.

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villages who are simply workmen."[103] The *Adontenhene* obviously did not have such power to obstruct sanitary inspectors from doing their work and pointed out to the Gomoa Assin chief that "when sickness or disease break out in the villages it spreads to the cities due to trade and migration hence the need for the better sanitary environment in the villages as well."[104] It can be inferred from the argument that Nana Kuso Edu XV gave in support of his request for the curtailment of the activities of the sanitary inspectors in his jurisdiction that, by the later part of the twentieth century, some Gold Coasters had not come to accept fully the benefits that they would derive from sanitary inspection. Whatever the reason may be, Nana Kuso Edu XV had acted or made the request as a reaction to the complains that he had received from his people regarding fines and court summons by the sanitary inspectors when their homes were found to be insanitary.[105]

Aside the situation pointed out above, there is evidence that many Gold Coast Africans kept on using their indigenous medicine and medical systems regardless of the formalization and institutionalization of western medicine in the Gold Coast. The cost of treatment at hospitals and other health care centres was expensive to many of the Gold Coast Africans. As at 1940, the colonial government had not been able to reduce hospital fees in the colony.[106] The high

[103] Nana Kuso Edu XV added that the rural people were always busy with their wives and children on their cocoa farms and, therefore, they did not spend much time at home. Hence, there was no need for such inspection and fines imposed on those whose houses were found to be insanitary. See PRAAD-Cape Coast, ADM 23/ 1/ 2878 (11/1/1948-8/5/1948) Layout and Sanitation of Villages and Towns.
[104] *Ibid.* It should be mentioned here that the reverse of the argument put forth the *Adontenhene* is also valid since disease could also spread from the cities or towns into the villages. Thus, diseases maintained in the crowded slums could easily be transmitted to the countryside. See Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 6.
[105] PRAAD-Cape Coast, ADM 23/ 1/ 2878 (11/1/1948-8/5/1948) Layout and Sanitation of Villages and Towns.
[106] PRAAD-Accra, CSO 11/3/ 32 (1940) Cape Coast African Hospital-Administration.

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cost of the use of hospital or health care facility was one of the factors that discouraged some of the Gold Coast Africans from patronizing western medical care and medicine.[107] In the whole of August 1940, the African hospital at Fosu-Ekyir was not visited or patronized by the local people in the area because exorbitant fees were demanded from patients upon their discharge from the hospital.[108] Another situation that drew the local people closer to their indigenous medicine and medical system was the shortage of some essential western medicine and medical officers of health to serve the health needs of the local people during the Second World War and even after the war. The Medical Department in 1945 reported on how Gold Coast Africans had abandoned hospitals to use their indigenous medicine and medical care.

> It is surprising and not a little disappointing to find that, in this centre (Central Province) of so much education and enlightenment, there still exists a desire among Africans to take their sickness to local fetish or herbalist while right in his town there exists a fine modern hospital. It is notably so with maternity cases who receive the most extraordinarily cruel and primitive treatment before being brought to hospital. Such cases are not confined to village, but many come from the town itself.[109]

During the Second World War, essential equipment and drugs were brought into the colony in quantities that were far less than what was really needed, however, the prices were high and uncertain and often considerable delay ensued before they finally got into the Gold Coast and the hands of patients.[110] It was, therefore, not news that the Gold Coast Africans in the Central Province

[107] *Ibid.*
[108] *Ibid.* The high cost of hospital fees was very serious that a fee of 10 shillings and six pence was usually charged for school boys who accessed the health facility.
[109] PRAAD-Accra, ADM 5/1/ 227 (1945) Gold Coast Colony Report on the Medical Department, 1945.
[110] *Ibid.*

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continued to use their indigenous medicine and medical systems regardless of the availability of the western medical facilities in their towns. It is therefore obvious that western medicine and medical care was unsuccessful in assimilating totally the indigenous one in the Central Province and the Gold Coast as a whole.

On the contrary, from the 1950s the Gold Coast Africans demanded for the reopening of hospitals that were closed down. They initiated the reopening of all the hospitals that were closed down during the Second World War. On 22nd January, 1951 the Saltpond Youth Association petitioned the colonial government to immediately re-open the Saltpond hospital that was closed down.[111] This Youth Association also demanded that government should station a resident doctor at the Saltpond hospital like it was in the pre-War period and that sufficient medical equipment should be supplied to facilitate the efficient running of the hospital.[112] Government did not grant the wish of the Youth Association until the Convention Peoples' Party's executive in Saltpond added its voice to the call by articulating the instances of imminent and fatal loss of lives at Saltpond due to the absence of a health facility and medical staff.[113] Hence in December 1951, the Public Works Department and the Medical Department took steps to renovate the old hospital as well as getting it a new doctor and nurses to operate it. Following this success, in 1952, Dr. M. A. Barnor, a Gold Coast African, who was transferred to Cape Coast was given the

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[111] PRAAD-Cape Coast, R.G. 1/ 9/ 4 (1946-74) Saltpond Hospitals. In the 1940s, all efforts made by the Fante Confederation under the leadership of Nana Aduku Ababio to vehemently oppose government's decision to close down the hospital proved unsuccessful. Saltpond by then had a population of about 124, 200 yet the only hospital in the district capital was closed due to the outbreak of the Second World War and the general shortage of medical staff to run the hospital. The people of Saltpond were required to travel to Cape Coast to access medical care.
[112] PRAAD-Cape Coast, R.G. 1/ 9/ 4 (1946-74) Saltpond Hospitals.
[113] *Ibid.*

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responsibility of managing the hospital at Saltpond. However, in 1956, he was transferred to the Winneba Hospital.[114] In fact if the people of Saltpond had not pressured government the only hospital that they had would not have been reopened even after the War.

Conclusion

This chapter attempted to discuss the colonial public health and sanitation policies that were formulated and pursued in the Central Province between the period of the outbreak of the Second World War and the attainment of independence of the Gold Coast in 1957. It discussed policies that sought to solve problems of health and health facilities, water and sanitation, epidemiology and health education as the main themes of the chapter. The chapter has pointed out that the Second World War caused shortage of medical staff and western medicine in the Gold Coast, a situation which resulted in the constant transfer of medical doctors from one district and province to the other. This situation caused the Gold Coast Africans to rely mostly on their indigenous medicine and medical care. The colonial government neglected measures that were essential to ensure public health during the war time. The post-Second World War period, 1945 to 1950s marked the watershed between colonization and decolonization of the Gold Coast. Therefore, the late 1940s witnessed the colonial government adopting policies and systematic processes which sought to prepare the Gold Coast Africans to take full responsibility for the facilities and institutions that were responsible for ensuring public health and sanitation.

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[114] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 219. Dr. Barnor was the first African medical doctor to work at the Winneba hospital.

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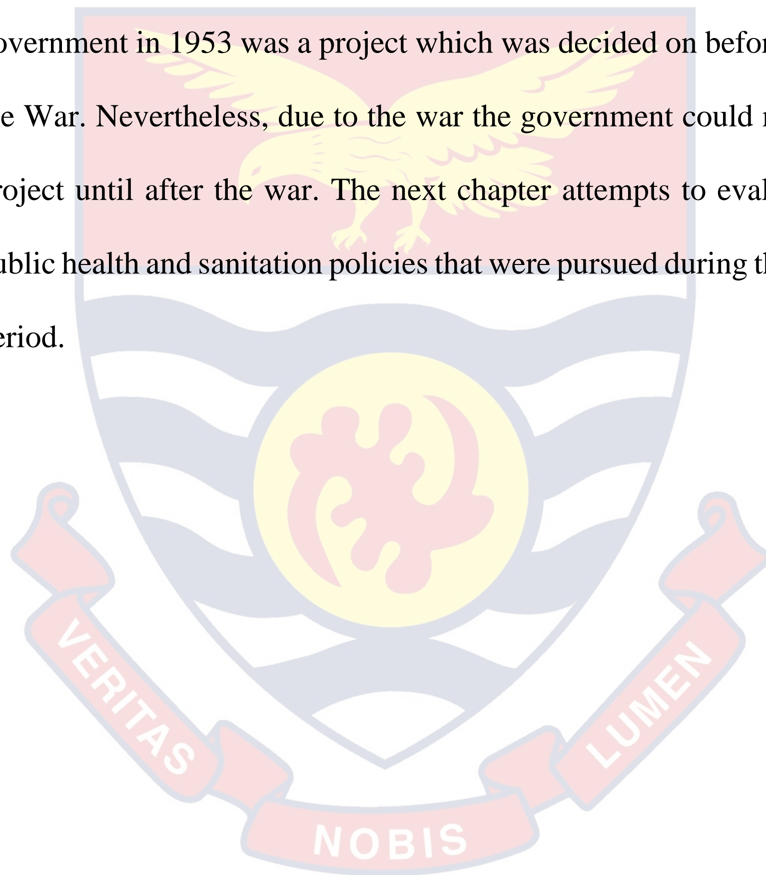
The training of local people to become health professionals like midwives, nurses, nurse-dispensers and instructions that some of the Gold Coast Africans had in the methods of water treatment and supply was clear manifestations of the preparation of the people for self-determination. The post-Second World War period, i.e. from 1945 marked the colonial government's deliberate policy not to build any health facilities in the Central Province. However, the Ankaful leprosarium, which was financed by the colonial government in 1953 was a project which was decided on before the outbreak of the War. Nevertheless, due to the war the government could not undertake the project until after the war. The next chapter attempts to evaluate the colonial public health and sanitation policies that were pursued during the whole colonial period.



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CHAPTER SIX

EVALUATION OF COLONIAL PUBLIC HEALTH AND SANITATION POLICIES IN THE CENTRAL PROVINCE OF THE GOLD COAST

Introduction

Western allopathic medicine is a cultural import arriving on the Gold Coast from Europe since Africans first contact with Europeans in the late fifteenth century. Western allopathic medicine entered most parts of Africa with European global expansion of the late fifteenth century, conquest, and colonization particularly in the late nineteenth century. Since its inception in the Gold Coast and elsewhere in Africa, a sick person was offered at least three alternative forms of medical aid and care,[1] Gold Coast indigenous medicine, Arabo-Islamic medicine and the western allopathic one. The competition that Gold Coast indigenous medicine faced with the arrival of Arabo-Islamic medicine and western medicine and medical systems pre-dated the formal colonization of the Gold Coast in 1874. Western allopathic medicine and medical systems were deemed to be culturally neutral by Europeans and by contrast, indigenous practices were viewed as superstitious, and a hindrance to European progress in the Gold Coast.[2] Therefore, the British colonial government endeavoured to institutionalize western medicine and medical care in the Gold Coast. Accordingly, various forms of colonial public health and

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[1] P. A. Twumasi, *Medical System in Ghana: A Study in Medical Sociology,* (Accra: Ghana Publishing Corporation, 1975), p. 62.

[2] Sandra M. Tomkins, "Colonial Administration in British Africa during the Influenza Epidemic of 1918-19", *Canadian Journal of African Studies / Revue Canadienne des Études Africaines,* Vol. 28, No. 1 (1994), pp. 60-83, p. 61. It is worth noting here that due to the civilization mission of the various European imperialists, they considered indigenous African cultural ways as uncivilized and outmoded.

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sanitation policies were formulated, pursued and implemented in the Gold Coast in general and the Central Province in particular by the colonial government through mainly the Medical and Sanitary Departments. What was the general pattern and the purpose of the public health and sanitation policies? Who were the beneficiaries of the public health and sanitation policies? Also, to what extent was the colonial government successful in its attempt to allow western medicine and medical care to supplant the indigenous one? This chapter evaluates the colonial public health and sanitation policies that were pursued and implemented in the Central Province of the Gold Coast.

The General Pattern and Features of the Colonial Public Health and Sanitation Policies in the Central Province

The unfolding of the colonial public health and sanitation policies of the Gold Coast from 1874 to 1957 can be put into four periods: 1874-1910s, the 1920s, the 1930s, and 1940-1957. The period from 1874 to 1919, witnessed a policy that could be termed as European-centered health and sanitation policies. This is because the policies tended to focus on Europeans rather than the Gold Coast Africans or the general public. For this reason, most of the health facilities were located only at the towns with larger European population, particularly, the district capitals and some major towns of the Central Province.[3] The larger population of the Gold Coast Africans in the interior of the province were ignored in this era. This era was when the colonial government introduced what has been discussed in chapter three of this thesis as Segregated Health Care

[3] D. E. K. Amenumey, *Ghana: A Concise History,* (Accra: Sankofa publications, 2000), p. 181.

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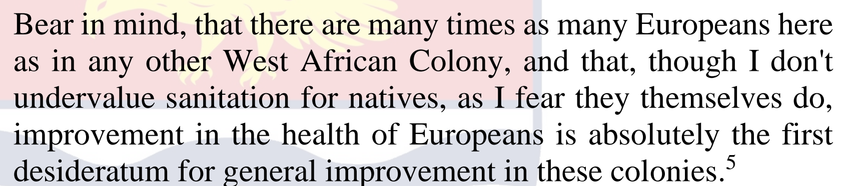
policy.[4] The rationale behind the policy, which included the building of residential areas to separate Europeans from African communities, was to protect Europeans from malaria, yellow fever and other tropical diseases. It was not a policy that sought the health interest and wellbeing of Gold Coast Africans. In the era under discussion, the colonial government made it emphatic that the health policies were designed to be primary in the service of Europeans. For instance, Major M. Nathan, the Governor of Gold Coast from December, 1900 to July, 1902 vividly and explicitly stated in 1901 that;



> Bear in mind, that there are many times as many Europeans here as in any other West African Colony, and that, though I don't undervalue sanitation for natives, as I fear they themselves do, improvement in the health of Europeans is absolutely the first desideratum for general improvement in these colonies.[5]

Sir Hugh Clifford, Governor of Gold Coast from December, 1912 to May, 1914 also stated in a dispatch to his contemporary in Sierra Leone in 1913 that his "Medical Establishment was maintained almost exclusively for the benefit of

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[4] Robert Boyce, "History of Yellow Fever in West Africa (Concluded)", *The British Medical Journal*, Vol. 1, No. 2615 (Feb. 1911), pp. 301-306, p. 305. See also John W. Cell, "Anglo-Indian Medical Theories and the Origin of Segregation in West Africa", *The American Historical Review*, Vol. 91, No. 3 (1986), pp. 307-335, Raymond E. Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", *African Historical Studies*, Vol. 1, No. 2 (1968), pp. 153-197; Thomas S. Gale, "Segregation in British West Africa", *Cahiers de' etudes Africanines,* Vol. 80 (1980), pp. 495-508; Stephen Addae, *Medical Histories from Primitive to Modern Medicine 1850-2000,* (Accra: Durham Academic Press Ltd., 2012), pp. 40-41.

[5] In a letter from Governor Nathan to Roland Ross on 30 Nov. 1901. Cited in Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910," p. 170. See also, Michael Crowder, *West Africa Under Colonial Rule,* (London: Hutchinson & Co. Publishers Ltd., 1968), p. 326. It is worth mentioning here that it was not only the colonial governors Like General Nathan, who initially pursued a policy of excluding the Gold Coast Africans from the public health and sanitation policies, but also the committee that was charged in early 1908 with the re-organization of the West African Medical Service also had the same policy. See David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* (Los Angeles: Crossroad Press, 1981), p. 12.

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the European population."[6] In the area of water distribution, it was also largely Europeans who received free water supply from government tanks and wells in the early years of the colonial period. This policy of catering for the health needs of Europeans was one of the colonial schemes adopted by imperial Britain in the Gold Coast and elsewhere in Africa. This scheme had been pursued by Britain in its colonies in Africa,[7] Asia[8] and the Caribbean.[9] With this historical parallelism of the British colonial policies that were formulated and pursued in British spheres of influence, it was therefore the policy of the British Colonial Office to first satisfy the health needs of British nationals and other Europeans, before those of the colonist. The medical officers who were employed by the British were given the responsibility to care for the health needs of senior administrative officers working in the civil service of the colonial government.[10] The discriminatory form of health and sanitation policies were really against the philosophy and principles of public health care which are built on equality and justice in ensuring universal access to health care resources and coverage in

[6] Crowder, *West Africa Under Colonial Rule*, p. 326.
[7] For the British West African colonies see for example, Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910" and Amenumey, *Ghana: A Concise History,* p. 181.
[8] For Asia, particularly, India see Cell, "Anglo-Indian Medical Theories and the Origin of Segregation in West Africa", p. 321 and Thomas S. Gale, "The Struggle against Diseases in the Gold Coast: Early Attempt at Urban Sanitary Reform", *Transactions of the Historical Society of Ghana,* Vol. 16. New Series No. 1 (1995), p. 186.
[9] In the British Caribbean, public health policies were aimed at protecting European troops in the initial stage of colonization. However, due to outbreaks of disease in the Caribbean, the various European imperialists extended the health and sanitation measures to the indigenous people of the Islands. See Juanita De Barros & Sean Stilwell, "Introduction: Public Health and the Imperial Project", *Colonialism and Health in the Tropics,* Vol. 49, No. 4, (2003), pp. 1-11, p. 2. For instance, in the British Caribbean, during the epidemic of the early 1830s, the British Government advised the colonies to institute boards of health and quarantine protocols, isolate the sick and, generally, clean up the towns. Similar health boards were formed in the Gold Coast for the same purpose of ensuring the health of the colonized.
[10] Twumasi, *Social Foundations of the Interplay between Traditional and Modern Medical Systems*, p. 15. See also Gale, "The Struggle against Diseases in the Gold Coast: Early Attempt at Urban Sanitary Reform", p. 199.

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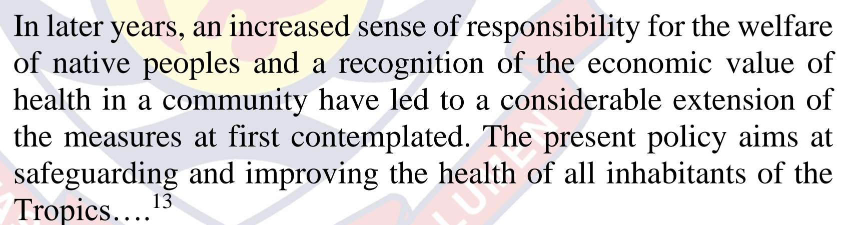
relation to the needs of people.[11] However, the British colonial government overlooked such philosophies and principles.

The 1920s marked the extension of public health and sanitation facilities into the indigenous communities of the Gold Coast in general and the Central Province in particular. The decade experienced the beginning of the implementation of public health and sanitation policies in the Gold Coast, because the colonial government practically endeavoured to extend the health and sanitation measures to the wider population of Gold Coast Africans. In 1927, the Chief Medical Adviser to the Secretary of State, indicated the new direction of the colonial public health and sanitation policies when he remarked that although the initial colonial medical policy had been directed primarily to safeguard the health of Europeans, however, from the 1920s this was no longer its sole aim.[12] He added that:



> In later years, an increased sense of responsibility for the welfare of native peoples and a recognition of the economic value of health in a community have led to a considerable extension of the measures at first contemplated. The present policy aims at safeguarding and improving the health of all inhabitants of the Tropics….[13]

British colonial officials saw that the better health conditions of Gold Coast Africans would inevitably bring about the desired improvement of health of Europeans, economy and administration of the colony at large. Due to the change in the policies, facilities and staff at the main government hospitals in

[11] George Pitckett & John J. Hanlon, *Public Health Administration and Practice*, Ninth Ed. (New York: The McGraw-Hill Companies, Inc., 1990) and George Rasen, *A History of Public Health,* (New York, 1958).
[12] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 72.
[13] *Ibid.*

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the Gold Coast were gradually expanded, and the inclusion of the rural areas in the administration of the province also led to the establishment of small dispensaries at some outstations.[14]

The extension and implementation of an inclusive public health and sanitation agenda that catered for the needs of the indigenous peoples was because of the exigencies of the period, thus, the vehement demands of the indigenes for the health and sanitation services that were impartial; the outbreak of epidemic or endemic diseases, and the deliberate effort of the colonizers to conserve the lives of the working population.[15] The European merchants, an interest group, also pressured the colonial government to extend health and sanitation facilities to Gold Coast Africans.[16] Two reasons could have been responsible for this. First, most of the employees of the merchants lived in the heart of the indigenous communities, hence, it followed that with the extension of health and sanitation policies to include the indigenous communities, their European employees would also benefit and live healthy in the colony.[17] Second, European merchants saw a direct link between health and wealth creation. Hence, they called for the extension of public health and sanitation policies into the indigenous communities so that there would be a general healthy people and environment for economic development. For instance, the Liverpool Chamber of Commerce, one of the leading critics of the colonial policies resolved in the 1920s that, "good health on the coast is even more

[14] Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910," p. 173.
[15] PRAAD-Accra, CSO 11/1/ 371 (1934) Sanitation and Medical Facilities in the Gold Coast.
[16] Gale, "The Struggle against Diseases in the Gold Coast: Early Attempt at Urban Sanitary Reform", p. 193.
[17] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 45 and Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 172.

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important than good trade."[18] The merchants were interested in their business of exploiting the economic wealth of the colony through a labour force of healthy workers, that is, Gold Coast Africans; thus, the health of the local worker became a concern to most of them. Therefore, the colonial government began to gradually include the Gold Coast Africans in its public health and sanitation policies from the 1920s.

From the 1930s, the colonial government sought to provide the necessary support for the Gold Coast Africans to build their own health care facilities. This era saw the issuing of grants-in-aid for the construction of dispensaries and clinics. Local authorities who were encouraged by their colonial administrators, and also enticed with the aid of subsidized building materials like roofing sheets, drugs, dressing and cash support of about £ 100, strove to build their own dispensaries according to the approved plan.[19] In fact, several rural areas and some urban centres in the Central Province where hitherto health care facilities were absent, were able to build their own dispensaries and clinics by the close of the third decade of the twentieth century. Some of those rural areas included the Asebu state, Fante Nyankomasi and Moree.[20] This policy of supporting local communities to provide their own health care facilities had come about as a result of the colonial government's quest to entice the indigenous population to patronize western medicine and medical care as against their indigenous one. The colonial government had

[18] Gale, "The Struggle against Diseases in the Gold Coast: Early Attempt at Urban Sanitary Reform," p. 193.
[19] This was based on a communique from P. S. Selwyn Clarke, the Director of Medical Service to the Provincial Commissioners. The building materials for the project were to be obtained from the Public Works Department in the province or nearby district. PRAAD-Cape Coast, ADM 23/ 1/ 777 (1930-40) Establishment of Dispensaries in Cape Coast; PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries.
[20] *Ibid.*

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employed such scheme as a reaction to a conference held in November 1929 in Sierra Leone whose outcome proved that indigenous African medicine was very effective and highly regarded.[21] Therefore, the rationale behind the provision of western health care facilities in the Gold Coast African communities were to make them accept and patronize western medical care.

It was with the increasing desire of the colonial government to entice the colonized Gold Coast Africans to build their own dispensaries and clinics, which most local authorities did, that has been misconstrued by some scholars that Africans had accepted western medicine and medical care although with some suspicions and resistances by 1920s or 1930s. For instance, Stephen Addae intimated that "many [African] villages, in the 1920s, began to apply for dispensaries and hospitals" thus, he asserted that "the Africans' confidence in modern medicine had been won by 1930."[22] However, most Gold Coast Africans in the Central Province had not had total confidence in western medicine although some visited hospitals and dispensaries because it had been brought nearer to them. Yet, many still visited and used their indigenous medicine. Hence, "the African confidence in modern medicine" does not mean their total acceptance of western medicine as against their patronage of indigenous medicine and medical care.[23] As it shall be discussed later, there are pieces of evidence to prove that several factors turned colonized Gold Coast off from the western medicine and medical care. If "many villages" applied for dispensaries, it was all because through subterfuge, the colonial government had

[21] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses. See chapter four of this work for details.
[22] Addae, *Medical Histories from Primitive to Modern Medicine*, p. 69.
[23] According to David Scott, "…there was little confidence in western medicine….". David Scott, *Epidemic Disease in Ghana, 1901-1960*, (London: Oxford University Press, 1965), p. ix.

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proposed to give and gave material and monetary support to local authorities to build their own dispensaries. It is, therefore, reasonable to view the aid as part of the colonial regime's effort to encourage the local authorities to build their own health facilities and by so doing the colonial government aimed at turning the people's mind from their indigenous medicine to the western one. This is part of the colonial design of control. In this context, it aims at establishing in the minds of colonized that, western medicine and medical care was superior to the indigenous one to affirm the erroneous notion of European superiority over Africans, a notion that also guaranteed and shelled colonization of the continent was true.

The time from the 1940s to the attainment of independence, was the era which can be called the preparation of the Gold Coast Africans for self-determination in the provision and management of public health and sanitation facilities. The widespread preparation took the form of education and training of the Gold Coast Africans for them to become nurses, midwives, dispensers and also water supply technicians.[24] The development manifested in parts of the Central Province too. When the Second World War took the services of most of the staff of the Medical and Sanitation Department, the colonial government started to train Gold Coast Africans as auxiliary health care workers in the Gold Coast to fill labour gap created by the staff that had been conscripted.[25] It must be established here that this policy contributed in making agents to perpetuate the use of western medical care in the country. Thus, such auxiliary health and

[24] PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries. See also, PRAAD-Cape Coast, ADM 23/ 1/ 3117 (1945-52) Dispensaries- Native Authority; PRAAD-Cape Coast, ADM 23/ 1/ 3190 (1948-49) Dispensaries; PRAAD-Cape Coast, ADM 23/ 1/ 1299 (1948-50) Village Dispensaries and Clinic; PRAAD-Cape Coast, ADM 23/ 1/ 2625 (1945) Temporary Water Supply Department.
[25] PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries.

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sanitation workers became pioneering agents for the continuation of a public health and sanitation tradition that was birthed from colonialism in post-colonial Gold Coast.

Aside the above-mentioned general patterns that the colonial public health and sanitation policies followed, there were some specific features of the policies that were pursued. One of the features of the colonial public health and sanitation policies was the adaptation of an inter-sectoral or multi-departmental approach in pursuit of the policies. Although, the Medical and Sanitation Department was the main department tasked to ensure public health and sanitation, the unit worked hand-in-hand with other departments including that of Education, Geological Survey, Agriculture, Public Works and the Police. This was an effective and integrated approach to implement public health policies. Such approach confirms the fact that public health involves the application of biological, social and behavioural sciences for the well-being of human population and it is therefore intensely multi-disciplinary.[26]

It is also worth noting that the application of western medicine and public health legislation increased state intervention into the lives of the Gold Coast Africans and enhanced colonial control over the people. The issuing of medical passports, use of medical examinations and sanitation regulations were some of the ways that the colonial government used to supposedly fight epidemic diseases but, in reality, as can be reasonably deduced from the perspective of Juanita De Barros and Sean Stilwell on the nexus between public health and colonialism and imperialism in the Tropics, they were colonial

[26] Samuel Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health,* (Accra: Page links Publishers, 2005), p. 137.

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attempts to regulate the lives of the colonized in the Gold Coast.[27] For instance, the Building Regulations Act of 1921 were not really a means to ensure a public health and sanitation goal; it was a way to acculturate the indigenous African architectural art by forcing the people to build European proto-type homes with European building materials.[28] Also, the amendment of the Building Regulation of 1921 in 1951 to include clauses that required the fixing of water closets in homes[29] was a means to acculturate the indigenous people to patronize European culture. Most of the public health and sanitation policies that were pursued were means to ensure health of the people for wealth creation by the colonial government. Thus, by way of ensuring the health of the active population in economic potential areas, it will invariably facilitate the exploitation of the area. This explains why the European-dominated areas in the Central Province became the focal point of a robust health and sanitation policy while the rural areas were initially left on their own to provide for their health needs until the 1920s when they had little government support and attention.

Another feature of colonial public health and sanitation policies was discrimination against the colonized. As mentioned earlier in this chapter, the period between 1874 and 1919 was an era of European-Centered Public Health Policies. There was open racial discrimination against the Gold Coast medical officers of health.[30] By 1902 a pamphlet drawn up for the newly created West African Medical Service stated that applicants must be of "European" parentage. As well, an unpublished note also made it clear that this was designed

[27] Juanita De Barros & Sean Stilwell, "Introduction: Public Health and the Imperial Project", p. 6.
[28] PRAAD-Cape Coast, ADM 23/ 1/ 2594 (1941-49) Building Permits and Plans.
[29] *Ibid.*
[30] PRAAD-Accra, CSO 11/1/ 375 (1938) African Medical Practitioners-Employment of.

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to exclude Africans and Asians from the service.[31] Based on this policy, African doctors in the Gold Coast with the same degrees like European doctors could not gain admission to the medical service as doctors.[32] The Gold Coast intelligentsia vehemently opposed this discriminatory practice. In 1911, Thomas Hutton-Mills, a Gold Coast African complained of discrimination against qualified African doctors, which did not exist in Southern Nigeria and Sierra Leone. European patients objected to being taken care of by the African doctors and J. E. Casely Hayford described the policy of discrimination against the African doctors in the Gold Coast as "nothing short of a scandal".[33] The Gold Coast African taxpayer paid for the provision of the health facilities, yet they were discriminated against in the provision and also employment into the medical service. The protest of the Gold Coast African intelligentsia made the colonial administration to allow the gradual inclusion of African doctors into the medical service and their promotion to higher ranks like the European doctors.[34] To the issue of racial discrimination in the Gold Coast, J. E. Casely Hayford remarked that "until we knocked and knocked and knocked at the time, that West African Medical Staff was a closed door: they did not want us to get

[31] Kimble, *A Political History of Ghana,* p. 98.

[32] Matthew M. Heaton, "Health and Medicine in Colonial Society", Martin S. Shanguhyia & Toyin Falola (eds.), *The Palgrave Handbook of African Colonial and Post-Colonial History,* (New York: Springer Nature Publishers, 2018), p. 311; Crowder, *West Africa Under Colonial Rule*, p. 199; Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,*p. 13 and p. 326; Amenumey, *Ghana: A Concise History*, p. 186. Even in the vital and understaffed medical services, the Gold Coast African doctors with good qualifications were refused appointment. For instance, in 1913 Dr. R. A Savage, Medical Health Officer to the Cape Coast Municipality since 1907, lost his job when his post came under Gold Coast government control. See Crowder, *West Africa Under Colonial Rule*, p. 427.

[33] Kimble, *A Political History of Ghana,* p. 100.

[34] It was through the instrumentality of the National Congress of British West Africa that the employment and promotion of African Medical officers were considered in the medical service. The coordinated effort of some Gold Coast Africans in the Legislative Council and the Provincial Council of Chiefs that made the colonial government heed to the call from the people to include them in the employment of medical officers of health. See PRAAD-Accra, CSO 11/1/ 375 (1938) African Medical Practitioners-Employment of.

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in. It was a question whether we were ever going to get in all."[35] Discriminatory intentions underpinned public health and sanitation policies in the early years of colonization; the Gold Coast Africans never failed to vehemently oppose such intentions by speaking against them.

Furthermore, the colonial public health policies pursued by the colonial government exhibited a total disregard for indigenous medicine and the customary system and practitioners that sustained it. Throughout the colonial period, there were no laws or policies that sought to legalize the activities of the Gold Coast indigenous medical practitioners as well as the medicines that they gave to the Gold Coast Africans. Since the formalization of colonization in the Gold Coast in 1874 and the eventual institutionalization of western medicine and medical systems in the Gold Coast, the colonial government considered the open practice of indigenous medicine and medical system as illegal. Hence, licenses were not issued for the indigenous medical practitioners and their medicines. All efforts made by the Provincial Council of Chiefs in the Central Province to persuade the colonial government to grant the indigenous medical practitioners license to legalize their activities yielded no results.[36] Through the agency of the Medical and the Police Departments and other colonial agencies, the colonial government pursued a policy of great hostility towards indigenous medicine and its practitioners. For instance, on 14th February, 1931, the

[35] Kimble, *A Political History of Ghana,* p. 109. The Congress demanded that discrimination should be avoided and appointments made be based on merit and not on colour, race and creed. It also insisted that the Medical Service should be open to Africans without reservation since the large African population needed their services, and regardless of the views of European.

[36] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses. It is worth of note that not only in the Gold Coasters in the Central Province who spoke against for the legalization and regularization of indigenous medicine and its practitioners but also individuals like J. B. Danquah, Nana Sir Ofori Atta and G. L. Christian, the Legislative Council member for the Western Province all spoke against the practice. The same was done in Ashanti through its Confederation Council. See Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, pp. 29-30.

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Criminal Investigation Department (CID) of the Central Province reported to the Commander of the Police in Cape Coast that from its several enquires, there was a herbalist headquarters at Sekondi where a herbalist association had been established.[37] The C.I.D. ordered the Commander of the Police to send police men to the area to disband the association.[38]

Similarly, on 7th March, 1939, the colonial government warned one Hadji Mohammed Ameen, an indigenous medical practitioner based in Cape Coast, to stop advertising in local newspapers that he had remedy for cataract.[39] Clearly, the colonial government tolerated western medicine but did not tolerate the promotion of indigenous medicine as a viable alternative or complement. The persecution of indigenous medical practitioners was a deliberate act by the colonial government to institutionalize and perpetuate the bigoted notion of the myth of superiority of western medicine and medical system over the indigenous one.[40] However, this did not materialize totally in the Gold Coast as some factors acted as a catalyst that kept Gold Coast Africans to their indigenous medicine and medical system even as they also complementarily

[37] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses. The C.I.D added that their investigations revealed that medicine men sent women with some medicines in bottles to Cape Coast for sale, a practice that was illegal. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955,* pp. 29-30.
[38] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses. It is worth mentioning here that indigenous healers were not allowed during this colonial era to sell or dispense any products that were deemed useful in "European" medicine, even if they were products that indigenous healers had used for a long time. See Heaton, "Health and Medicine in Colonial Society", p. 311.
[39] PRAAD-Cape Coast, ADM 23/ 1/ 441 (1922-47) Native Medicine-Practitioners and Licenses.
[40] Due to the negative impact of colonial health policies on indigenous medicine and medical system, after independence, Kwame Nkrumah suggested in 1960, the formation of an Association of Indigenous Healers in his effort to encourage and promote the practice of indigenous medicine in Ghana in the period after colonial rule. As a result, a body known as "The Ghana Psychic and Traditional Healing Association" was established in 1960. See Evans-Anfom E., *Traditional Medicine in Ghana: Practices, Problems and Prospects,* (Accra: Academy of Art and Sciences, 1986), p. 45.

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used western medicine[41] when and where necessary in a pluralistic health care manner.

Factors that drew the Gold Coast Africans toward their Indigenous Medical System

Throughout the colonial period indigenous medicine and its practitioners survived. The indigenous medical cosmology was different from western medical system and explanation to disease causation. Indigenous medical systems hold the view of natural and supernatural causation of illness and diseases.[42] To establish a new medical practice, one of a colonizing power, in the Gold Coast, it followed that certain changes, at least in the belief system, needed to be made before it could become the dominant medical practice that the indigenous people will accept.[43] Hence, the colonial government devoted effort to establish western medicine and medical system as the only legally accepted one in the Gold Coast. In spite of the colonial government's effort to supplant the Gold Coast indigenous medicine and medical system with the western one, Gold Coast Africans did not jettison their indigenous medicine and medical system. The British imperial regime and colonial government was however unsuccessful in totally alienating Gold Coast Africans, whether literate or illiterate,[44] from their indigenous medicine and medical system rooted in

[41] The Gold Coasters consulted the native medical practitioners and the colonial medical physician simultaneously or, more likely, go to the clinic after the village healer had failed. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 28.
[42] Twumasi, *Medical System in Ghana: A Study in Medical Sociology*, p. 63. Indigenous African cosmology holds that causal factors between events are not only one of natural world but of the supernatural also.
[43] *Ibid.*, p. 64.
[44] PRAAD-Accra, ADM 5/1/ 227 (1945) Gold Coast Colony Report on the Medical Department, 1945.

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their culture.[45] The fact is that most of the colonized resorted to western medicine and health facilities as a complement to their indigenous medicine and medical care.

Noteworthy, the high charges that the colonized paid for using or visiting a western health care facility also made many to stick to their indigenous medicine. For example, in 1899 Dr. B.W. Quartey-Papafio, who worked at Saltpond and Anomabo hospital, explained that a large number of Gold Coast Africans in the Central Province relied on the services of indigenous medical practitioners and healers in spite of the western health care facility.[46] In fact, Gold Coast Africans wanted affordable, fast, easily available and accessible public health system which the colonial government seemingly was not in a position to provide.

Furthermore, the limited number of health care centres, facilities, medical staff[47] and medicine[48] brought inconveniencies and inconsistence in health service delivery. This also made Gold Coast Africans lose trust and confidence in the western medicine and medical system. As mentioned in chapter three of this work, from 1874 to 1910, there were a smaller number of European medical officers of health in the colony. The limited number of

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[45] Ofosu-Amaah, *Health and Disease in Ghana: The Origin of Disease and the Future of our Health*, pp. 106-107; John S. Mbiti, *African Religions and Philosophy,* Second Edition, (New York: Heinemann Educational Publishers, 1989); E. Evans-Anfom, *Traditional Medicine in Ghana: Practices, Problems and Prospects,* (Accra: Academy of Art and Sciences, 1986), pp. 14-15; C. A. Dime, *African Traditional Medicine: Peculiarities*, (Ekpoma: Edo State University Press, 1995), p. 28 and Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 28.

[46] PRAAD-Accra, ADM 5/1/55 (1899) Government of Gold Coast Departmental Report 1899. The reason that the people gave for turning away the health facilities was the high hospital charges demanded from them.

[47] PRAAD-Accra, ADM 5/1/ 56 (1901) Government of Gold Coast Departmental Report 1901, Medical and Sanitation Department, p. 13.

[48] PRAAD-Accra, ADM 5/1/ 228 (1913-21) Gold Coast Colony Report on the Medical Department, 1944.

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medical officers of health available were also tasked to satisfy the health needs of the European colonial officials and administrators. In this period, an insignificant number of Gold Coast Africans resorted to western medicine and medical care and those were those who lived in urban centres which were populated by Europeans. The two World Wars which pulled a larger number of medical officers of health to war duties further reduced the already limited number of medical officers.[49] The long-term effect of these developments was that it reduced further the already smaller number of European medical officers of health in the Gold Coast.[50] Hence, this also turned most of the Gold Coast Africans off from using the western health care facilities due to the inconsistencies in the availability of health staff and medications at such facilities.

Lastly, the presence of male medical officers of health in the health centres also turned some of the Gold Coast Africans, particularly, the female patients from using western health care facilities. This was observed and reported by the acting Governor Sir A. Ransford Slater and his wife in 1927 and also by the District Commissioner of Dunkwa, I. L. Phillips in 1932 that most female Gold Coast Africans refuse to be taken care of by male medical officers and therefore have turned away from the health care facilities.[51] Similar

[49] PRAAD-Accra, ADM 5/1/ 227 (1945) Gold Coast Colony Report on the Medical Department, 1945.
[50] See chapter five of this work for the effect of the Second World War on public health.
[51] PRAAD-Cape Coast, ADM 23/ 1/ 2331 (1925-47) Medical and Sanitary. Both the Governor and the District Commissioner reported that the Gold Coast women prefer female medical officers or nurses to male nurses especially, in child bearing. Gold Coast Africans, therefore, requested for female medical officers of health or nurse. See also PRAAD-Cape Coast, ADM 23/ 1/ 658 (1927-44) Saltpond Improvement. In a petition to the District Commissioner of Saltpond by the chiefs of Saltpond in 1935, the chiefs requested for female medical officers of health or female nurses as a way of bringing female patients into the hospitals. For similar reasons expressed for the rejection of western medical care by the Gold Coast Africans in the Central Province, see PRAAD-Cape Coast, ADM 23/ 1/ 976 (1939-47) Infant Welfare Clinic-Central Province; PRAAD-Accra, CSO 11/3/ 13 (1935) Hospital Accommodation at Saltpond.

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observations were also made in Ho, Tarkwa and Saltpond.[52] In the Gold Coast, in general, the majority of practicing nurses were men up until a nursing college was opened at Kumasi in 1948 to train more female nurses and, by 1953, about four hundred midwives and nurses had been trained.[53] Thus, most Gold Coast Africans turned away from the hospitals and health care centres because they were being staffed with male medical officers. Whatever the reasons that made the western health care facilities unattractive to the Gold Coast African, the question is who financed the cost of the health and sanitation facilities that were provided out of the colonial policies?

Financing the Public Health and Sanitation Policies

Although the colonial western medicine, health centres and sanitation policies were primarily controlled by the colonizers, it was largely the financial gains that were made from the exploitation of the resources of the Gold Coast and the African's labour that the colonial regime mainly used to finance the cost of almost all the health and sanitation facilities in the Gold Coast. During the pre-colonial era, Britain took all measures to ensure that the Gold Coast Africans themselves will pay for the health facilities that were provided in the coastal areas.[54] For instance, the promulgation of the Poll Tax Ordinance in April 1852 was a measure to raise taxes so that, among other things, Britain could provide medical, sanitation and educational facilities for the Gold Coast

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According to David K. Patterson, females were probably more reluctant to submit to examinations by male doctors, particularly alien ones. Hence, females probably had greater fears about western medicine and that they resorted to quacks. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 20.

[52] *Ibid.*

[53] John Middleton & Joseph C. Miller, *New Encyclopedia of Africa,* (New York: Charles Scribner's Sons, 2008), p. 546

[54] David K. Patterson, "The Influenza Epidemic of 1918-1919 in the Gold Coast", *Journal of African History* Cambridge, Vol. 24, No. 4 (1983), p. 206.

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Africans living within the British protectorate.[55] Although the whole issue of direct taxation was a total failure, it can be inferred from the nature of the Poll Tax Ordinance that the British government was in no way ready to finance health and sanitation projects for the Gold Coast Africans. Thus, the Gold Coast Africans were to pay for and they did pay for any of such facilities that government deemed necessary for the general public in the pre-colonial time.

From 1874 onwards Gold Coast Africans continued to finance the implementation of public health and sanitation policies. They paid for the public health facilities through the direct or indirect taxes, revenue generated from export of the exploitation of the resources of the colony and some amount of free labour demanded from the people in the event of provision of health facilities.[56] Right from the colonization of Gold Coast to the outbreak of the Second World War, the Secretary of State for colonies held that the colonies should pay for their development from their own resources and that the British taxpayer had no responsibility in this direction.[57] For example, in 1883 a

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[55] The Secretary of State, Lord Grey, was very anxious to extend the provision of roads, schools, hospitals and dispensaries beyond the strict limits of the British forts and castles in the Gold Coast in the early years. However, he thought that such services should be provided out of local resources like custom duties or direct taxation. This precipitated the promulgation of the Poll Tax Ordinance. See Kimble, *A Political History of Ghana,* pp. 173-78; Amenumey, *Ghana: A Concise History*, p. 179; Adu A. Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century*, (London: Longman Group Ltd., 2000), pp. 40-43; Addae, *Medical Histories from Primitive to Modern Medicine*, p. 21; Roger S. Gocking, *The History of Ghana*, (London: Greenwood Press, 2005), p. 32; F. K. Buah, *A History of Ghana,* (Malaysia: Macmillan Publishers Ltd., 1980), pp. 82-83. Based on the 1858 amendment of the Poll Tax Ordinance by Governor Richard Pine, it was suggested that the taxes raised should be spent based on a formula: "Two-thirds on Medical Officers and Hospitals, on new Magistrates, and on Schools, and one-third on making Roads and Bridges, supplying tanks for water and the like matters." See Kimble, *A Political History of Ghana,* p. 185.

[56] Aside giving free land for the construction of pipe-borne water supply for Cape Coast, the people of Cape Coast, Saltpond, and Elmina also provided free labour for the project. When the project was completed, the people were made to pay for the water that was supplied to them. The Labour Regulation of 1935 also demanded a measure of free labour from the Gold Coast Africans whenever a project was undertaken in any vicinity. See PRAAD-Cape Coast, ADM 23/ 1/ 2310 (1925-30) Cape Coast Water Works; PRAAD-Cape Coast, ADM 23/ 1/904 (1935-36) Sanitation of Rural Areas and Mining Villages.

[57] Crowder, *West Africa Under Colonial Rule*, p. 309. It is worth noting here that even the "Ten-Year Plan" that was proposed by Sir Frederick Guggisberg as the framework for the

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deputation from London and Manchester, who due to their trade and commence in the Gold Coast became interested in the affairs of the colony, complained to the Secretary of State that the increased revenue by the 4 per cent duty had not led to any improvement in roads, sanitation, or conditions of the towns in the colony and that duties should be increased.[58] Logically, some of the proceeds from the taxes and duties that were used in the provision of health and sanitation facilities were needed in the colony. The Gold Coast Africans also paid for the upkeep and cost of training of the auxiliary health care providers as well as those trained in water supply management.[59] Gold Coast Africans financed all the health and sanitation facilities that were provided for them or those which they later came to enjoy directly or indirectly.

From the beginning of the twentieth century, various governors of the Gold Coast strove to provide infrastructure that would help the colony to increase its revenue because the colony was left to finance the cost of the provision of the public health and sanitation facilities. Therefore, the motive behind the infrastructural development programmes was partly to help the colony to raise its revenue for its internal development. As Governor Guggisberg himself stated, the real object of the developmental programme was to give the colony "sufficient revenue to carry out the educational and sanitary reforms necessary in this country and to make that revenue a permanent one."[60]

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development of all sectors of the Gold Coast was financed entirely by the Gold Coasters. There was no contribution on the part of the metropolitan government. All the two loans raised in London in aid of the program were all paid by the Gold Coast Africans.

[58] Kimble, *A Political History of Ghana*, p. 308. In 1887 the Manchester merchants returned to the attack.

[59] PRAAD-Accra, ADM 5/1/ 271 (1942) Medical Department Report, 1942; PRAAD-Cape Coast, ADM 23/ 1/ 868 (1934-48) Village Dispensaries.

[60] Kimble, *A Political History of Ghana*, p. 58. See also Boahen, *Ghana: Evolution and Change*, p. 113 and Amenumey, *Ghana: A Concise History*, p. 186. Guggisberg used part of the revenue from agriculture to provide social amenities like schools and medical facilities. He emphasized the provision of health and educational facilities and actually considered all the works he did in

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Metropolitan Britain did not pay for any of the infrastructure that were provided in the Gold Coast. Whatever financial support that the colony received from Britain to undertake developmental projects came in the form of loans and those loans were not really used to provide water and electricity, sanitation, health and educational facilities alone, but also for railways and other infrastructure that facilitated the exploitation of the natural resources of the colony.[61] In the Gold Coast, the colonial governors often gave loans to local authorities to build sanitary facilities. For instance, on 13th April, 1945, the colonial secretary, H. L. G. Gurney issued a communique that;

> To be able to construct septic tank latrines, Town Councils and in approved cases Native Authorities would be able to borrow from government loans sufficient to cover their share of capital expenditure, repayment over 20 years with interest at 3 per cent per annum. Native Authorities which would not be eligible for loans should be advised to finance their share of the capital expenditure from their Native Treasury.[62]

It is worth noting here that the financing of the researches conducted into tropical diseases were partly paid for by the colonized. The London School of Hygiene and Tropical Medicine was tasked to train some of the European medical officers to work in the service of the British colonies and also conduct research into a wider variety of tropical diseases throughout the British Empire.[63] Initially, the Imperial government subsidized only the London

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the economic field as directed towards making it possible to provide schools, health and sanitation facilities.

[61] Crowder, *West Africa Under Colonial Rule,* pp. 310- 311. In the Gold Coast for instance, up to 1936, the British government had spent £ 12, 961 as loan to the colony and £ 401 as grants in aid but a total of £ 100 in the loans and grants by the Colonial Development Fund.

[62] PRAAD-Cape Coast, ADM 23/ 1/ 2658 (1945-52) Septic Tank Latrines.

[63] PRAAD-Accra, CSO 11/1/ 263 (1931-38) London School of Hygiene and Tropical Medicine. See also, Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 163.

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School, but in 1901, Joseph Chamberlain asked the British government, the colonial government in India and all tropical Crown Colonies to contribute to the "Tropical Diseases Research Fund."[64] It was from this directive that the Gold Coast taxpayers contributed the amounts of £ 250, £ 2,000 and £ 200 to the London School in 1912, 1919 and 1935 respectively.[65] Hence, the colonies contributed to the medical researches that brought about some of the findings and solutions to the tropical diseases. If the resources of Africans in the Gold Coast directly and indirectly paid for the cost of the public health and sanitation policies, then the hospitals, the clinics, dispensaries, the segregated or residential bungalows were all financed and sustained with the monies extracted from the economic exploitation of the Gold Coast, even though such policies and infrastructure were not made with the altruistic intention to primarily benefit the colonized much. They were all part of the pistons that worked to move and conceal the insidious plan of an exploitative imperial and colonial system which was not established to give any benefit to the colonized African.

Some Factors that Hindered the Successful Implementation of the Colonial Public Health Policies

The introduction of western medicine did not have a smooth beginning in the Gold Coast. As with any new ideas from a different culture, initial opposition was expressed by the Gold Coast Africans toward the implementation of some

[64] It was in 1904 that the Tropical Diseases Research Fund was created and was administered by a Special Advisory Committee but was later in 1927 taken over by the Colonial Medical Research Committee. It was from this fund that grants were made available to London, the Liverpool, and other research institutes in the United Kingdom. See B. M. J., "The Colonial Medical Service", *The British Medical Journal*, Vol. 2, No. 3678 (1931), pp. 11-17, p. 13 and Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", p. 163.
[65] PRAAD-Accra, CSO 11/1/ 263 (1931-38) London School of Hygiene and Tropical Medicine.

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of the public health and sanitation policies. There were obvious difficulties as there were several factors that militated against the success and smooth implementation of some of the public health and sanitation policies in the Central Province. Thus, the indigenous population had to be given education on disease causation and basic methods of prevention so to make it easy for them to accept the new medical culture with its new social organization, and a new medical orientation.[66] However, on the contrary, there was generally high illiteracy rate in mostly the rural parts of the Central Province.[67] The predominant forms and modes of the health education: health lectures, health talks on radio, health week celebrations and even the classroom-based form of health education required some degree of literacy in English; thus they largely targeted and served the reading public. This means the bulk of the public who were illiterate in English language were excluded from the formal health education programmes, hence, their massive protest against the implementation of some of the health and sanitation policies. The teaching of hygiene in schools was improved by the adoption of practical methods agreed upon by both the education and medical departments. An important aspect of the cooperation consisted of the giving of regular courses or lectures by medical officers in communities where there were enough teachers to attend the lectures. On the contrary, the mass illiteracy of the Gold Coast Africans in the Central Province hindered the implementation of the public health and sanitation policies. On 25th July, 1932, the District Commissioner of Winneba pointed out to the Provincial Commissioner of Cape Coast, that:

[66] Twumasi, *Social Foundations of the Interplay between Traditional and Modern Medical Systems,* p. 16.
[67] PRAAD-Cape Coast, ADM 23/ 1/ 632 (1926-45) Yellow Fever Outbreak.

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> It is comparatively useless to try to educate a handful of old men in a village community in matters of hygiene, more particularly when the method adopted is a spasmodic visit by an officer who has not sufficient acquaintance with the local language to enable him to check the interpretation.[68]

The lack of sanitation, hygiene, education culture as well as language barrier constituted some of the challenges to the successful implementation of public health and sanitation in the Province and the colony at large.

Furthermore, the poor implementation of the public health and sanitation policies was due to the nature of the bureaucratic system in the administrative structure. The issue of bureaucratic bottlenecks particularly in land acquisition, for the construction of sanitary structures, also hindered the quick implementation of the public health and sanitation policies. Often, it took a long time for a plot of land to be acquired from individuals or families to undertake sanitary projects.[69] The procedures in land acquisition, whereby a health board or committee at the district level had to meet to decide on the place in a district where a health and sanitary facility should be built, were difficult and cumbersome. The decision and recommendation of the board or committee of the district had to be sent to the Provincial Health Board for further discussions and approval. The Provincial Health Board in turn had to forward its decision and recommendation on lands proposed for acquisition by the various District Health Boards to the colony's Central Health Board for final approval.[70] This

[68] PRAAD-Cape Coast, ADM 23/ 1/ 2088 (1915-48) Medical Department.
[69] For instance, in April 1937, the Elmina slaughter house was surveyed and mapped by the Survey Department. Owing to the bureaucratic nature of the colonial administration and the difficulty in acquiring land, it was not until October 1940 that the said project was completed. See PRAAD-Cape Coast, ADM 23/ 1/ 916 (1936-40) Slaughter House-Elmina.
[70] PRAAD-Cape Coast, ADM 23/ 1/ 1754 (1950-53) Agenda and Minutes of Colony Health Board Meetings. See chapter three for the duties of the health boards and the bureaucratic system that was to be followed in arriving at a decision.

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form of bureaucracy also slowed down the pace of the provision of a needed health or sanitary facilities in a district.

The financial constraint of the colony also limited the execution of public health and sanitation policies especially, from the early stage of colonization and during the post war periods of the two World Wars. The role of finance in ensuring better sanitation cannot be overstated. From 1890s, the colonial government relied on the pretext of lack of funds[71] and, the global economic depression to deny the Gold Coast Africans of some essential public health and sanitation facilities. This was exemplified in the delay in the provision of potable pipe-borne water supply in the Central Province. The pipe-borne water supply project was proposed in early1880s.[72] However, owing to financial constraints, it was rather provided in the late 1920s.[73] In fact, the same financial constraint prevented the colonial government from employing sufficient number of medical officers of health in the service of the colony. The financial issue explains why District Commissioners had to double as political administrators and at the same time medical-officers of health in their districts.[74] The financial issue also explains why in the early years of colonial rule; Gold Coast Africans were not the focus of the provision of public health facilities.

[71] PRAAD-Accra, CSO 11/1/ 371 (1934) Sanitation and Medical Facilities in the Gold Coast. In a petition to the colonial government in 1934, the joint delegation of the Gold Coast colony and Asante suggested to Governor Sir Arnold W. Hopson that "some portion of the surplus revenue which is usually invested abroad should be invested in the colony" to improve the health and well-being of the native population.
[72] In a dispatch to Lord Knutsford in 1891, Governor Griffith expressed the hope that in few years, if the revenue of the colony is maintained, it would be possible to supply pipe-borne water to Cape Coast. The pipe borne project did not materialize in the nineteenth century. See Addae, *Medical Histories from Primitive to Modern Medicine*, p. 132.
[73] PRAAD-Cape Coast, ADM 23/ 1/2310 (1925-30) Cape Coast Water Works.
The Cape Coast water supply scheme was proposed in January, 1924, but it was not until 1928 that the project was completed and operational.
[74] PRAAD-Cape Coast, ADM 23/ 1/ 275 (1916-37) Medical Officers as District Commissioners.

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The same financial constraint was given as the rationale behind the insufficient number of sanitary officers in the various districts in the colony.[75] In fact, the proper implementation and execution of public health and sanitation policies were dependent on the financial strength of the colony. The provision of public health facilities is very capital intensive and, hence, there is a direct relation between the implementation of health policies and the availability of funds of a polity.

Additionally, the attitude of some of the District Commissioners also worked against the implementation of the public health and sanitation policies. Some of the District Commissioners were not firm in the implementation of some of the health policies.[76] For instance, it was once reported that the District Commissioner of Western Akyem had relaxed the implementation of the Building Regulation of 1921.[77] The relaxation of the Building Regulation was due to the perceived hardship that the strict implementation of the regulation would bring to the lives of the Gold Coast Africans in the Oda District. Thus, some of the colonial authorities who were entrusted to implement and enforce public health and sanitation policies were weak and often corrupt. Some of the sanitary inspectors took bribes from people so as to overlook their violation of

[75] Between 1920 and the end of the first quarter of 1922, there were only 31 scavengers employed in the whole of the Central Province, a number which was very insufficient to help ensure the desired sanitary environment. See PRAAD-Accra, ADM 5/1/ 79 (1922-23) Government of Gold Coast Annual Report for 1922-1923.

[76] Dr. P. S. Selwyn-Clarke ever criticized the inadequacy of the health laws and the unwillingness of the chiefs or the political officers to enforce them or to levy substantial fines on those found guilty of volitions. Selwyn-Clarke therefore called on D.C.s to cooperate with the medical officers of health. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, p. 21.

[77] PRAAD-Cape Coast, ADM 23/ 1/ 639 (1926-41) Building Regulations.

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public health and sanitation regulations.[78] Such practices also hindered the smooth implementation of the policies.

The inadequacy of sensitization of the public on a health and sanitation policy before and after its enactment also affected the better means of ensuring public health and sanitation in the Central Province. Often the general public was not well informed and sensitized on some of the policies before they were implemented. For instance, some of the chiefs as well as their people were not better informed and sensitized on specific health policies and that was why some of the policies were opposed by them. This was exemplified when the people and chiefs of Gomoa Abosso traditional area rose up against the demolition of their dilapidated buildings which did not meet the requirement of the Building Regulation of 1921.[79] Although the Building Regulation was passed in 1921, it was in May 1933 that the District Commissioner of Winneba requested for ten copies of the Regulation from the Provincial Commissioner to distribute among the chiefs of his district, who had complained that they did not understand the clauses of the Building Regulation.[80] Also, the frequent acts of resistance to sanitary inspection of homes in both urban and rural areas by Gold Coast Africans were because many were not initially sensitized about the purpose of such an exercise.[81]

The poor road network in the Central Province and the Gold Coast colony in general also mitigated against the efforts of the Medical and Sanitation

[78] PRAAD-Cape Coast, ADM 23/ 1/ 435 (1922-45) Sanitary Department. See Chapter four of the work for examples of bribery and corruption engaged in by sanitary inspectors.
[79] PRAAD-Cape Coast, ADM 23/ 1/ 2878 (11/1/1948-8/5/1948) Layout and Sanitation of Villages and Towns.
[80] *Ibid.*
[81] PRAAD-Accra, ADM 5/1/ 57 (1902) Government of Gold Coast Departmental Report 1902, Medical Department.

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Department to ensure the desired level of public health and sanitation. The difficulty of access to most of the rural areas due to the poor nature of the roads during the rainy seasons made it difficult for medical officers to treat communicable and infectious diseases during outbreaks.[82]

Conclusion

This chapter evaluated the evaluation of colonial public health and sanitation policies in the Central Province of the Gold Coast from 1874 to the attainment of independence in 1957. The chapter therefore underscore the general pattern, features and purpose of public health and sanitation policies, those who financed the health and sanitation policies and some of the factors that militated against the successful implementation of public health and sanitation policies. Also, the question of who financed public health and sanitation policies was also answered here. The colonial public health and sanitation policies generally followed a pattern of exclusion of the Gold Coast Africans in the early phase of colonialism, however from the second decade of the twentieth century, there was a gradual extension and inclusion of the Gold Coast Africans in the policies. Discriminatory measures against the Gold Coast African was a feature in public health and sanitation policies. This notwithstanding, colonial public health and sanitation policies that were enacted and implemented in the Gold Coast confirmed the idea that, to ensure public health, there should be the employment of inter sectorial or inter- departmental action. Thus, health has multiple determinants hence, the use of a multi-sectoral

[82] PRAAD-Accra, ADM 5/1/ 147 (1951) Medical Department 1951 Report.

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approach by the colonial government to ensure public health and sanitation in the Central Province is commendable.

It could be inferred from the colonial public health and sanitation policies that the colonial government only arranged space and built structures in the Gold Coast to make it possible for western medicine and medical systems to gain root and dominate the indigenous medical systems. Following this, the colonial government restricted the work of indigenous medical practitioners as a way of causing extinction of the indigenous medicine and medical systems. However, the colonial system could not extinguish the flame of the indigenous medical systems in the Gold Coast which the people could not jettison because of their reverence for its usefulness.

It must be reiterated and remembered that it was the Gold Coast Africans in the Central Province who gave out the land on which health and sanitation facilities were built, and at the same time their money or resources financed the building of such facilities, hence the colonial government did not really selflessly and altruistically sponsor the provision of facilities and infrastructure for the maintenance of health in the Gold Coast. The next chapter gives the conclusion of the work. It highlights the core findings that the work underscores.

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CHAPTER SEVEN

CONCLUSION

This thesis was written with the basic objective of producing a history of colonial public health and sanitation policies in the Central Province of the Gold Coast from 1874 to 1957. The thesis first analyzed key concepts that underpinned indigenous African medical practices during the pre-colonial period. Second, it systematically examined the underlining reasons for the transfer of the colonial administrative capital of the Gold Coast from Cape Coast to Accra. Third, it examined the influence of the two World Wars on the colonial government's health policy direction and implementation. Forth, it traced the general pattern, features and nature of the colonial public health and sanitation policies that were formulated, pursued and implemented in the Central Province. Last, it highlighted the Gold Coast Africans' initiatives and response to the colonial public health and sanitation policies. Consequently, this thesis has offered a well textured analysis of the ideas, plans, implementation of laws promulgated to advance a public health and sanitary environment in the Central Province.

Until this study was undertaken, much of the literature on the history of the Gold Coast had focused on diverse aspects and topics of colonial regime in Gold Coast particularly, those of political administration, economics, religion and spread of western formal school education. Few works exist on the medical and health history of the Gold Coast. Relying on primary and secondary sources, the thesis has produced a history that provides a window into colonial public health and sanitation policies in the Central Province of the Gold Coast and the Gold Coast as a whole. Medical and health history is a large field of study;

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however, larger portion of the field has not been fully tilled so far as the history of the Gold Coast is concerned hence scholars should give attention to the study of the history of medicine and health of the Gold Coast and post-colonial Ghana.

In pursuing the task of unearthing and interrogating ideas and concepts in the indigenous African medicine and medical systems this thesis argues and reveals the fact that such systems are not a queer collection of superstitions and error, but rather it embodies therapeutic experiences and knowledge that deals with the whole human being in both his or her physical and spiritual dimensions in the process of healing.

Before the formal colonization of Africa, preventive and curative medicine, good hygiene and sanitation, nutrition, rituals, taboos and seeking protection from magic, sorcery and witchcraft through inoculation, sacrifices, the wearing of charms, amulets and talismans were generally the aspects of the African health systems. Enculturation and adaption of indigenous African medical systems to non-African medical cultural backgrounds happened through Arabo-Islamic cultural contact with Africa particularly from the seventh century and intrusion of European (western) cultural imperialism via the Atlantic Ocean from the fifteenth century onwards. The competition that Gold Coast indigenous medicine faced with the arrival of Arabo-Islamic medicine and western medicine and medical systems pre-dated the formal colonization of the Gold Coast by Britain in 1874. During the colonial period, the British colonial government aimed to put the indigenous healing methods and Arabo-Islamic medical systems on the periphery of society by endevouring to institutionalize western medicine and medical care in the Gold Coast as the dominant method of ensuring good health in the territory. This process was a

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success to an extent because the regime was able to insert western medical ways in the social space of the Gold Coast but it could not totally obliterate the interest of the indigenous people in their African and Arabo-Islamic medical methods. Consequently, the sick person was offered two main alternative forms of medical treatment and systems; these were the indigenous treatment and systems and the western treatment and systems. Although, the Arabo-Islamic medicine did not vanish, it was not prominent except among African Muslims who chose it. This means the formalization of western medical systems and facilities brought about a double consciousness in the social setting of the Gold Coast Africans. Thus, the Gold Coast African did not only know and used the indigenous treatment and systems but also the western treatment and systems.

At the beginning of colonial rule in the Gold Coast, the health and sanitation situation in the Central Province was very poor particularly the coastal towns. The transfer of the colonial capital from the Central Province to the Eastern Province in 1877 because the British colonial government perceived Cape Coast to be insanitary, however, this work reveals that the reason for the transfer was largely based on politico-economic factors. As revealed in chapter three of this thesis, the transfer of the capital to the Eastern Province was to enable the colonial government to effectively check smuggling of goods that was going on at the eastern boundary of the Gold Coast. The colonial government thus wanted to maximize its economic gains in that region. As revealed in chapter three of this thesis, the increasing threat from Germany and France for the boundary between Gold Coast and Togo was another factor that precipitated the transfer of the capital of the colony to the east of Cape Coast.

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After the transfer of the capital, the colonial government began to formulate and pursue public health and sanitation policies that will make the province reasonably clean however, the world wars had impact on colonial public health and sanitation policies as it limited the number of medical staff in the service of the colony. The Second World War caused shortage of medical staff and western medicine in the Gold Coast, a situation which resulted in the constant transfer of medical doctors from one district and province to the other. This situation, in no small way, caused the Gold Coast Africans to rely mostly on their indigenous medicine and medical care. Colonial government neglected measures that were essential to ensure public health during the war time. The post-Second World War period, that is, 1945 to 1950s marked the watershed between colonization and decolonization of the Gold Coast. Therefore, the late 1940s witnessed the colonial government adopting policies and systematic processes which sought to prepare the Gold Coast Africans to take full responsibility for the facilities and institutions that were responsible for ensuring public health and sanitation. The training of local people to become health professionals like midwives, nurses, nurse-dispensers and the instructions that some of the Gold Coast Africans had in the methods of water treatment and supply under the auspices of the colonial government were clear manifestations of the preparation of the people for self-determination. Thus, the general shortage of medical staff during the war stimulated the gradual training of the Gold Coast Africans to serve various governmental departments that were tasked to ensure public health and sanitation.

The unfolding of colonial public health and sanitation policies in the Central Province from 1874 to 1957 can be put into four periods: 1874-1910s,

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the 1920s, the 1930s, and 1940-1957. The period from 1874 to 1919, witnessed policies that could be termed as European-centered health and sanitation policies. The colonial government patronized European health interest in health and sanitation policies. This is because the policies tended to focus on Europeans rather than the Gold Coast Africans or the general public. On the contrary, the 1920s marked the extension of public health and sanitation facilities into the indigenous communities of the Gold Coast in general and the Central Province in particular. The decade experienced the beginning of the implementation of public health and sanitation policies in the Gold Coast because the colonial government practically endeavoured to extend the health and sanitation measures to the wider population of Gold Coast Africans. From the 1930s, the colonial government sought to provide the necessary support for the Gold Coast Africans to build their own health care facilities. This era saw the issuing of grants-in-aid for the construction of dispensaries and clinics in most of the interior parts of the Central Province. The time from the mid-1940 to the attainment of independence, was the era of the preparation of the Gold Coast Africans for self-determination in the provision and management of public health and sanitation facilities. The widespread preparation took the form of training of Gold Coast Africans for them to become nurses, midwives, dispensers and also in methods of water supply management.

The colonial government devoted efforts to establish western medicine and medical system as the only legally accepted one in the Gold Coast. In spite of the colonial government's effort to supplant the Gold Coast indigenous medicine and medical system with the western one, Gold Coast Africans did not jettison their indigenous medicine and medical system because of their

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reverence for its usefulness. There were some factors that drew the Africans closer to their indigenous medicine and medical systems. For instance, the high charges that the colonized paid for using or visiting a western health care facility made many to stick to their indigenous medicine. The limited number of health care centres, facilities, medical staff and, particularly, medicine which carried inconveniencies and inconsistence in health service delivery also made Gold Coast Africans lose trust and confidence in western medicine and medical system. The two world wars which pulled a larger number of medical officers of health to war duties further reduced the already limited number of medical officers and this made many Gold Coast Africans lost trust and confidence in western medical system. Since most hospitals were without doctors to attend to patience. Hence, the Gold Coast indigenous medicine and medical systems survived during the colonial period because the people did not relinquish it usage.

One of the unique features of the colonial public health and sanitation policies was that the British colonial government employed a multi-dimensional and multi-departmental approach in the quest to ensure reasonably good public health and sanitation in the Central Province. By multi-dimensional approach, the colonial government considered and paid attention to the clinical aspects of health promotion, that is, the provision of health care facilities like hospitals, dispensaries, clinics and the various health staff to work in them as well as the provision of preventive and curative medicines. Additionally, concerns for the environment was part of the multi-dimensional approach. With this, the colonial government strove to have the human settlement reasonably healthy for the prevention of diseases. The provision of public latrines, sewage and drainage

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systems and the planning of well laid out settlements were measures to ensure a clean and safe environment for the people. The third dimension was the people-centred approach. With this approach, the colonial government took interest in sensitizing the people on personal hygiene. This manifested in the conscientization of the people about issues related to health and hygiene, disease prevention and control through both the formal and informal mode of teaching and learning. The teaching of hygiene in schools, the use of health week celebration and the schooling of people on hygiene by sanitary officers upon their regular inspection of homes were the chief methods of the health edification that were given to the people. Thus, clinical, environmental and people-centred were the three approaches and aspects of the multi-dimensional approaches to the colonial public health and sanitation policies.

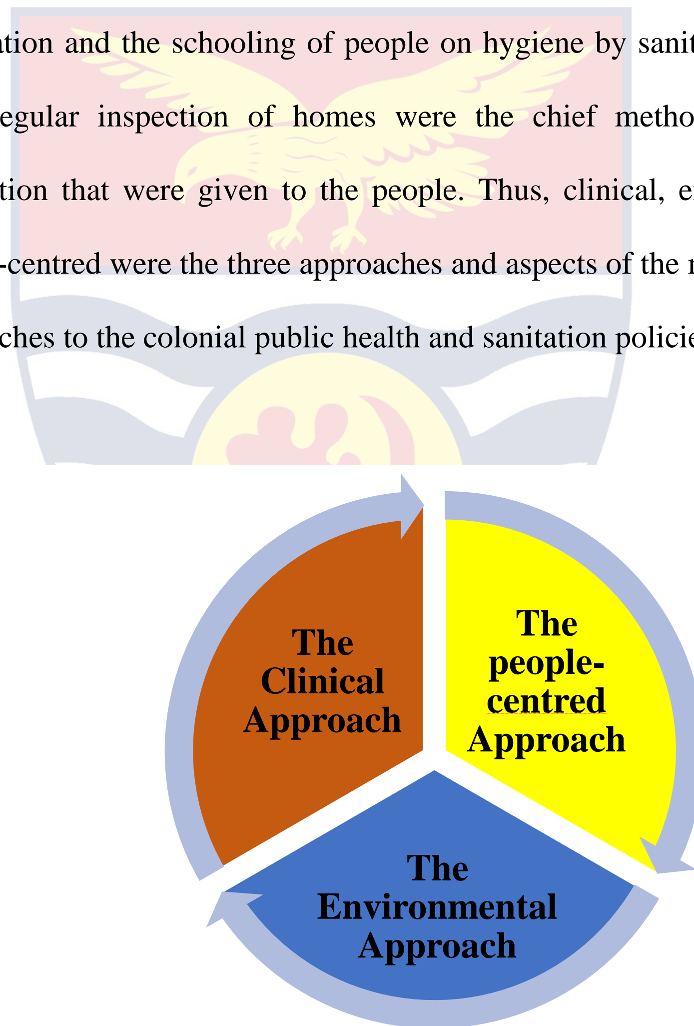

Diagram 1. *A diagram showing the multi-dimensional approach to public health and sanitation.*

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Health has multiple determinants; therefore, the colonial government's use of a multi-sectoral or departmental approach to ensure public health and sanitation in the Central Province is commendable. Although, the Medical and Sanitation Department was the main department tasked to ensure public health and sanitation, the unit worked hand-in-hand with other departments including that of Education, Geological Survey, Agriculture, the Public Works and the Police in implementing and enforcing the public health and sanitation policies. This was an effective and integrated approach to implement public health policies.

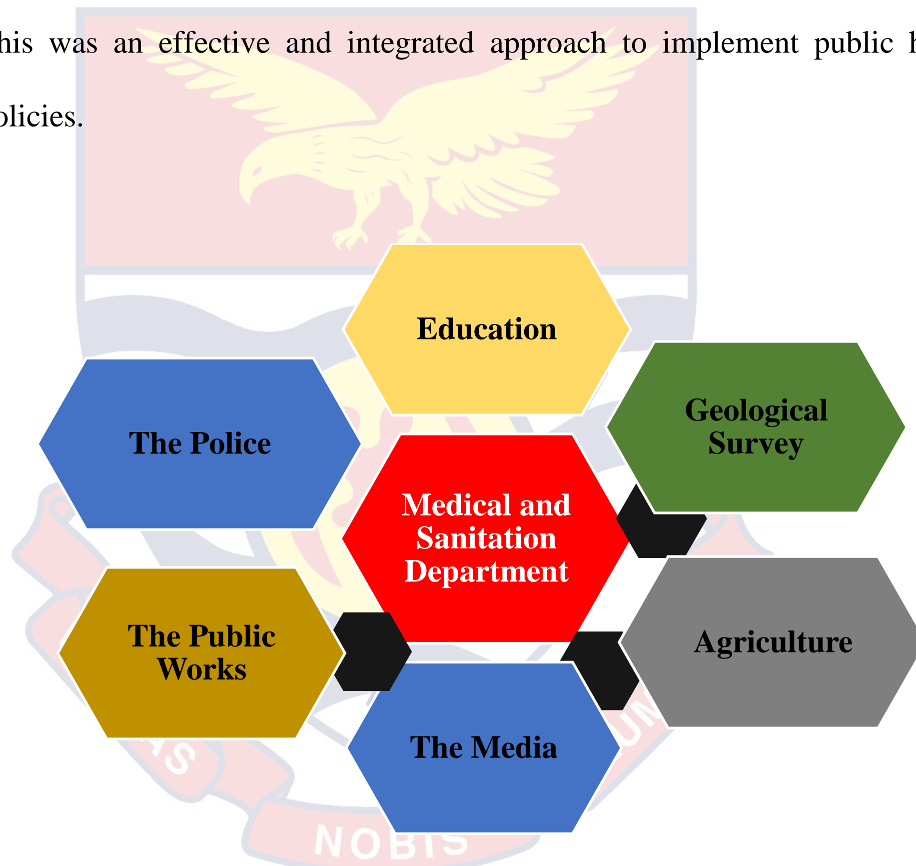

Diagram 2: *A diagram showing the multi-departmental approach to the public health and sanitation.*

Regarding the Gold Coast Africans' initiatives and responds to colonial public health and sanitation policies, it has been revealed in this thesis that Africans made some initiatives into the formulation and shaping of the policies. The initiatives and responses to the colonial public health and sanitation policies

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took the form of formation of organized groups by the Africans to demand for changes in the public health formulation or propose new directions to the pursuit of health and sanitation policies. For instance, in 1894 when the colonial government enacted the Town Council Ordinance, Cape Coast, the capital of the Central Province, vehemently opposed it because, first, the people were being compelled to pay a 5 per cent compulsory rate and, second, local government system was modeled after the British type.[1] The Gold Coast Africans raised objections to this ordinance on the grounds that "they wanted a genuine town council and not merely a board responsible for sanitation" they argued that they "paid enough indirect taxes to create surpluses in most years."[2] The protest from the Gold Coast Africans in the Central Province frustrated all efforts by the colonial government to generate interest in elective town councils. Accordingly, the colonial government's efforts to draw public support for the elective town councils failed due to the government's refusal to work through the existing indigenous organizations such as chieftaincy and the resistance of both chiefs and educated elite nationalist to any form of direct taxation.[3] It was

[1] The Town Council of 1894 was for Accra, Cape Coast and Sekondi. The Africans at Accra also opposed the election and implementation of the ordinance. Devine E. K. Amenumey, *Ghana: A Concise History*, (Accra: Sankofa publications, 2000), pp. 164-166; F. K. Buah, *A History of Ghana*, (Malaysia: Macmillan Publishers Ltd., 1980), pp. 104-105; David Kimble, *A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1928,* (Oxford: Clarendon Press, 1963), pp. 425-6; Adu A. Boahen, *Ghana: Evolution and Change in the Nineteenth and the Twentieth Century*, (London: Longman Group Ltd., 2000), p. 61; Roger S. Gocking, *The History of Ghana*, (London: Greenwood Press, 2005), pp. 51-54.

[2] The Gold Coast had a painful history of attempts by the British government to impose direct taxation on the inhabitants through local self-governing bodies. The Poll Tax of 1852 marked the introduction of direct taxation in the history of the Gold Coast and the people rose up against it. Kimble, *A Political History of Ghana,* pp. 169-185; Stephen Addae, *Medical Histories from Primitive to Modern Medicine, 1850-2000*, Vol. 1 (Accra: Durham Academic Press Ltd., 2012), p. 116; Boahen, *Ghana: Evolution and Change,* pp. 40-43; Thomas S. Gale, "The Struggle against Diseases in the Gold Coast: Early Attempt at Urban Sanitary Reform", *Transactions of the Historical Society of Ghana*, New Series 1, Vol. 16, No. 1 (1995), pp. 195-196.

[3] Raymond E. Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910", *African Historical Studies*, Vol. 1, No. 2 (1968), p. 169.

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not until 1908 that Cape Coast accepted the functioning of the Town Council Ordinance after the colonial government had made few modifications to the ordinance.[4] Hence, the Gold Coast Africans were able to initiate changes into the colonial public health and sanitation policies.

Additionally, the demonstration of dissatisfaction by the African professional elites, particularly the local medical doctors to colonial bigotry which discriminated against Africans in the appointment and promotion of doctors, became well-coordinated when the National Congress of British West Africa (NCBWA) was formed in the Gold Coast in 1920 and came to an end in 1930. It was with the coordinated effort of the NCBWA for the effective inclusion of the African doctors in the medical service that was why the colonial government took measures to systematically include the African doctors into the medical service of the Gold Coast from mid-1920. It must be mentioned here that the inclusion of African medical doctors in the medical service did not end the stereotype, prejudice and discrimination that most Europeans had against Africans in this profession.

In the Central Province, the Gold Coast intelligentsia criticized the colonial government on the use of the term "Segregated Area" as an expression for the residential areas of Europeans, both officials and non-officials. The term was racially prejudicial and insulting to the Gold Coast Africans. Consequently, a circular from the Colonial Secretary's office on 12th May, 1922 read that the "term 'segregated area' as applied to those areas set apart for the residence of Europeans officials" be substituted for "Government Residential Areas."[5]

[4] Amenumey, *Ghana: A Concise History,* p. 165 and Gocking, *The History of Ghana,* p. 53.
[5] PRAAD-Cape Coast, ADM 23/ 1/ 323 (1919-27) Winneba Government Segregated Area. One may argue that the change of the name meant nothing as it did not change the reality of the

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Additionally, when sanitary inspection was extended to the rural areas in the 1940s, some chiefs whose jurisdiction had never experienced such "police form of inspection and arrest," rose against the inspections in their area.[6] Gold Coast Africans responded to the domestic sanitary inspection by sanitary officers and scavengers with much agitation. The reason for this was because the sanitary inspectors represented the law as they had power to prosecute and they did prosecute people, often with zeal, when sanitary laws were broken.

Recommendations

Following the revelations of this work, it is highly recommended that government and stakeholders of health and sanitation should employ a multi-dimensional approach in pursuing, formulating and implementing public health and sanitation policies. This is because there are multiple determiners in health and sanitation. Also, government and stakeholders, should engage chiefs or traditional leaders in the implementation of sanitation policies. The colonial government realized the role of chiefs in ensuring sanitary environment at the local levels. Some measure of power and authority should be given to traditional political leaders to enable them to make sanitary bye-laws. Such power and authority should determine how they should enforce and punish (fine) persons that may violate the bye-laws. Thus, stakeholders should revive the pre-colonial communal labour system. In fact, the colonial government did that in 1883 when it promulgated the Native Jurisdiction Ordinance and also in 1935 with the

purpose of the so called "Segregated Areas" however, the racist word like segregation was forbidden in all government reports and circulars.

[6] PRAAD-Cape Coast, ADM 23/ 1/ 2878 (11/1/1948-8/5/1948) Layout and Sanitation of Villages and Towns.

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Labour Regulation Ordinance. The latter ordinance demanded for "minor communal service" from the people.

Furthermore, the Public Health Unit of the Ministry of Health should collaborate with the Ghana Education Service of Ministry of Education to introduce "Health Week Celebration" at all levels of education in Ghana particularly the basic school level. This policy that was practiced during the colonial regime would be very useful to the present generation in educating pupils and students on the practical aspect of ensuring the desired health and sanitation. This form of education should be activity-based and not classroom one. The implementation of health and sanitation policies requires a multi-departmental approach hence, the health sector or department should collaborate with other departments in their quest to ensure reasonably good health of the public. Again, government and health policy makers should build Contagious Disease Hospitals throughout the country and not just general and referral hospitals alone.

To historians and future scholars, the field of health and sanitation is wide and this work is not exhaustive on the topic of colonial public health and sanitation policies in the Gold Coast as the work was limited to the Central Province. Thus, other equally vital areas like the Northern Territories, Ashanti, Western and Easter Provinces have not been tilled. Research into those areas are very important since at one point in time, the administration of Gold Coast was not uniform, hence there would be relevant difference in the pursuit, formulation and implementation of the public health and sanitation policies.

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Oral Interviews

Agyemang, Christian. Age 68 years, C.E.O. of Taabea Herbal products, personal interview, 28th December, 2017 at Plot. 24 Blk. U, Aputuogya-Bosomtwi, Ashanti Region.

Asamoah, Clement. Age 93 years, herbalist and bone setter at Wassa Asikuma, personal interview, 3rd February, 2018, Wassa Asikuma at Asikuma in the Western Region.

Yorke, Dewood. Age 67 years, the owner of Kaabiwe Herbal Centre, personal interview, 14th February, 2018 at Wangara Line, Kotokuraba road opposite Aburaa Taxi station, Cape Coast.

Eshun, Efua Comfort. Age 61 years, Traditional priest and herbalist, personal interview, 12th February, 2018, house number A36/4 Idan, Cape Coast.

Francis, Christian. Age 49 years, owner of Aumabg Herbal Treatment Centre, Cape Coast, personal interview, at Debekus Wood Ventures, Apewosika, Cape Coast on 27th January, 2018.

Nkrumah-Gyimah, Juliana. Age 56 years, C.E.O., Adumtwumwa Herbal Industries Ltd., personal interview, 30th December, 2017 at Abuakwa-Manhyia, Kumasi. Adumtwumwaa Herbal industries have been producing medical products into the market for the past 30 years.

Ntim, Franklin. Age 65 years, personal interview, 4th February, 2018 at Wassa Asikuma in the Western Region.

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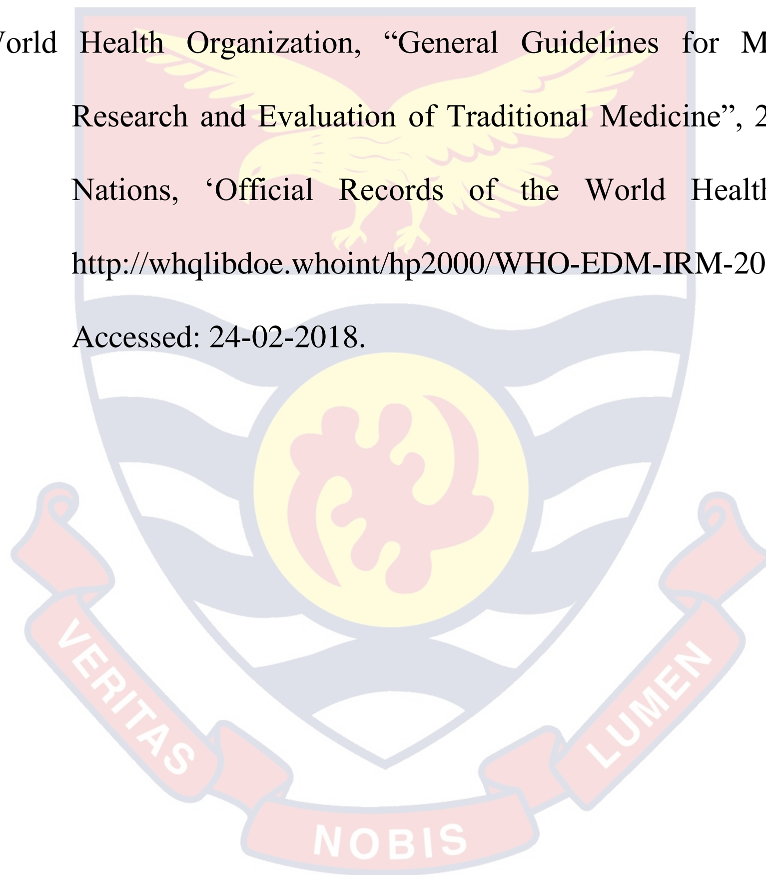

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APPENDICES

Table 4: LIST OF SOME MEDICAL OFFICERS OF THE CENTRAL PROVINCE

NAME	YEAR	DISTRICT
J. H. Owen-Flood	1932	Cape Coast
H. O. Hara May	1916	Cape Coast
G. M. Minifie	1941	Cape Coast
A. B. Monks	1929	Cape Coast
S.A. Maclean	1935	Cape Coast
H. C. Armstrong	1939	Cape Coast
N. A. Dyce Sharp	1936	Cape Coast
L.G. Eddy	1940	Cape Coast
W. N. Greer	1929	Saltpond
J. L. Brohier	1916	Saltpond
P. A.T. Sneath	1923	Saltpond
O. G. Wilde	1927	Winneba
Scott Johnson	1936	Winneba
Austin D. Cust	1937	Western Akyem (Oda)

Table 5: LIST OF SOME COLONIAL ADMINISTRATIVE WORKERS OF THE CENTRAL PROVINCE.

NAME	YEAR	PORTFOLIO/ DEPARTMENT
A.G. McPherson	1937	District Engineer, Dunkwa
J. B. Fallowfield	1915	Assistant Engineer, Cape Coast
R. M. Fisher	1930-6	District Engineer, Winneba
S. Gifford-Baggs	1915	Provincial Engineer, Cape Coast
G. C. Cuthbert	1928	Provincial Engineer, Cape Coast
Stanley Gifford	1930	Provincial Engineer, Cape Coast
Armstrong	1929	Maintains Engineer
J. W. Mcintyre	1929	Building Inspector, Cape Coast
D.O. Allotey Annan	1940	Building Inspector, Cape Coast
W. J. Bedemah	1916	Sanitary Inspector, Cape Coast
J. W. Stevenson	1927	PWD, Water Works, Winneba
E. J. Wood	1956	Water Works Superintendent

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Table 6: LIST OF SOME DISTRICT COMMISSIONERS WHO SERVED IN THE CENTRAL PROVINCE

NAME	YEAR	DISTRICT SERVED
J. L. Atterbury	1916-1924	Cape Coast
E. O. Rake	1929	Cape Coast
H. Bleasdell	1930	Cape Coast
V. J. Lynch	1931	Cape Coast
D. H. Strathairn	1931	Cape Coast
E. Norton Jonce	1933	Cape Coast
S. W. Saxton	1937	Cape Coast
A.F. E. Fieldgate	1937	Cape Coast
G. F. Mackay	1938	Cape Coast
L. W. Judd	1939	Cape Coast
A.J. Loveridge	1947	Cape Coast
R. G. Cooper	1950	Cape Coast
A.S. Jones	1953	Cape Coast
A.S. Watt	1921	Winneba
J. R. Dickinson	1925	Winneba
A.F. E. Fieldgate	1927	Winneba
G. P. H. Brews	1931	Winneba
M. G. Hewson	1944	Winneba
A.H. Murray	1949	Winneba
Hugh Thomas	1923	Saltpond
J. R. Dickinson	1924	Saltpond
G. J. Cumine	1929	Saltpond
W. E. Gilbert	1929	Saltpond
P. C. B. Shirreff	1930	Saltpond
H. S. Stovold	1939	Saltpond
P. W. Rutherford	1939	Saltpond
H. E. Decaux	1939	Saltpond
G. F. Nackay	1940	Saltpond
J. Eyre-Smith	1941	Saltpond
Tom Hindle	1945	Saltpond
J. H. West	1923	Western Akyem (Oda)
C. S. Masser	1929	Western Akyem (Oda)
I. L. Phillips	1937	Dunkwa

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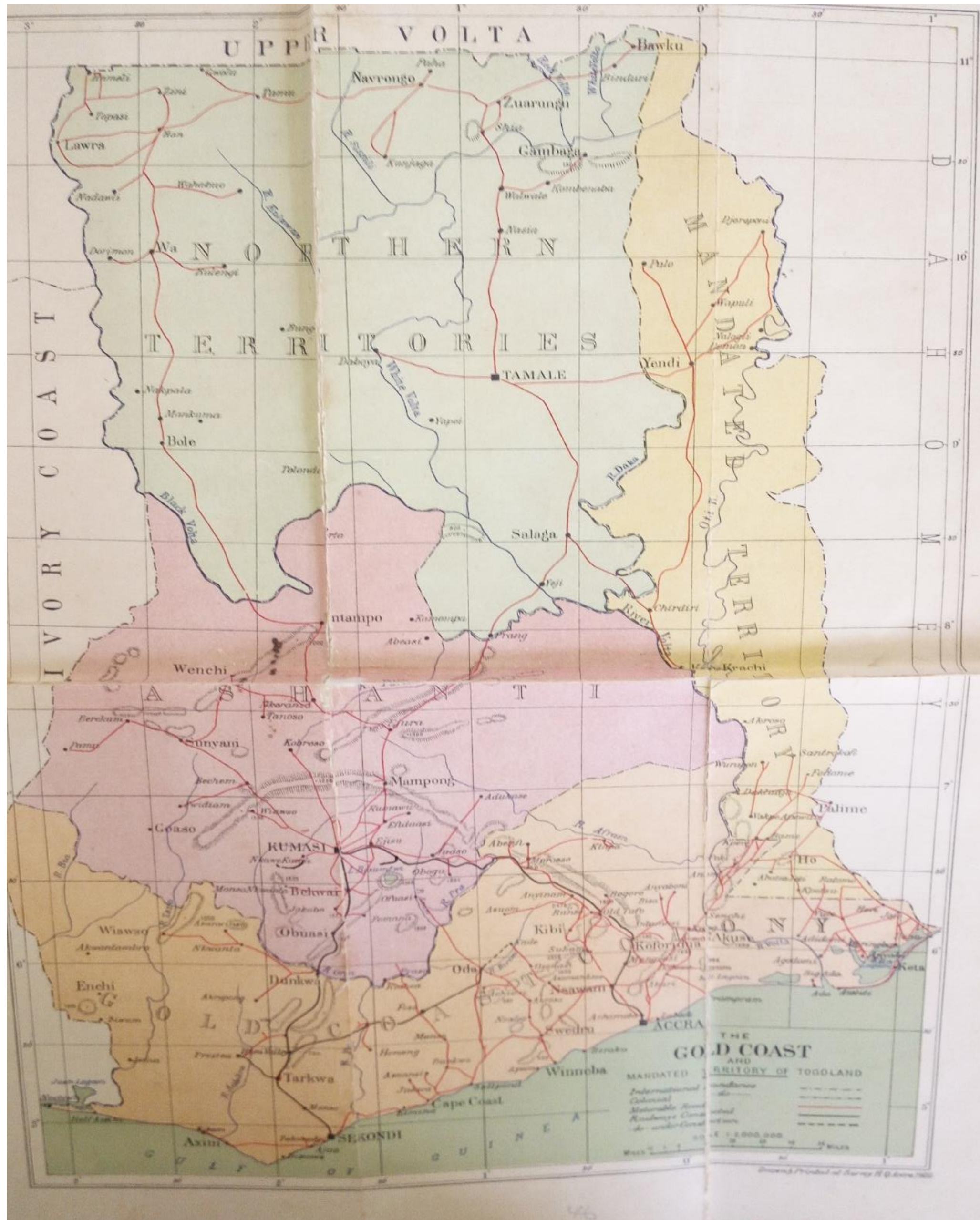

Figure 1. Map showing the administrative divisions of the Gold Coast Colony before independence.

Source: PRAAD- Accra, ADM 5/ 1/ 21 *Gold Coast Annual Report, 1925-1926.*

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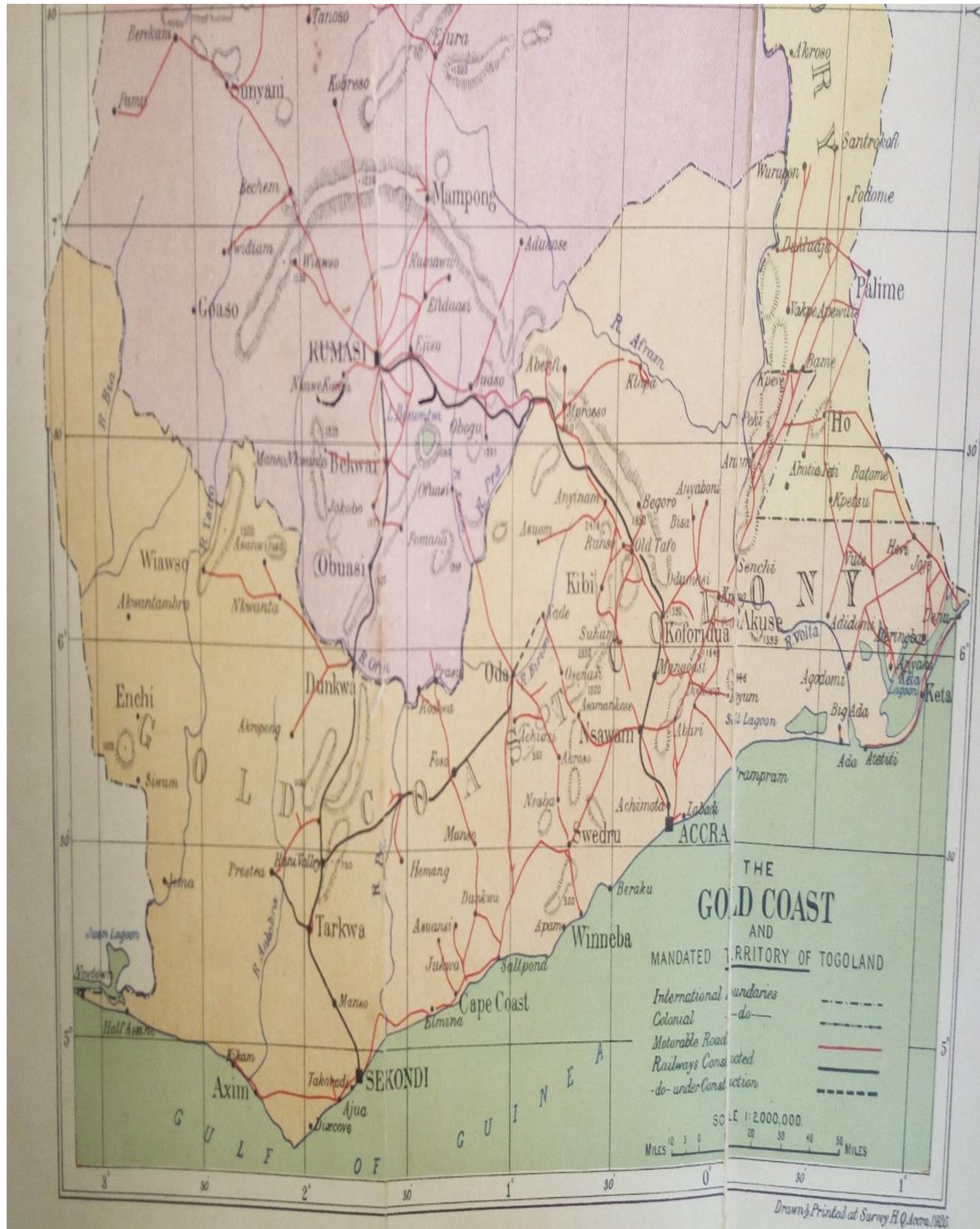

Fig. 2. Map showing the three main provinces in southern Gold Coast.
Source: PRAAD- Accra, ADM 5/ 1/ 21 *Gold Coast Annual Report, 1925-1926.*

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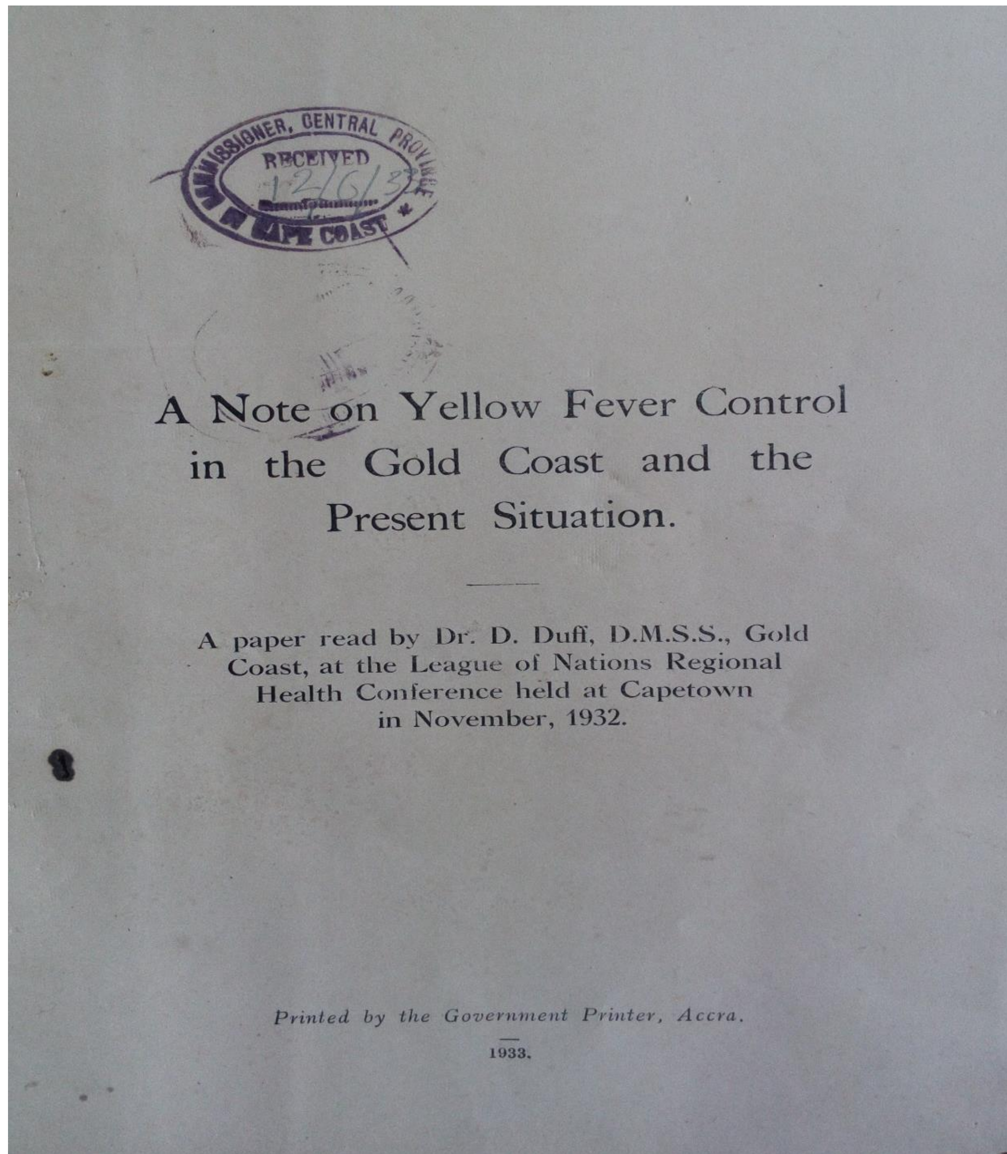

A Note on Yellow Fever Control in the Gold Coast and the Present Situation.

A paper read by Dr. D. Duff, D.M.S.S., Gold Coast, at the League of Nations Regional Health Conference held at Capetown in November, 1932.

Printed by the Government Printer, Accra.

1933.

***Fig.* 3.** Picture showing the cover page of a book published in 1932 to educate the public on yellow fever and its prevention.

Source: PRAAD- Cape Coast, ADM 23 / 1 / 632 *Yellow Fever Outbreak.*

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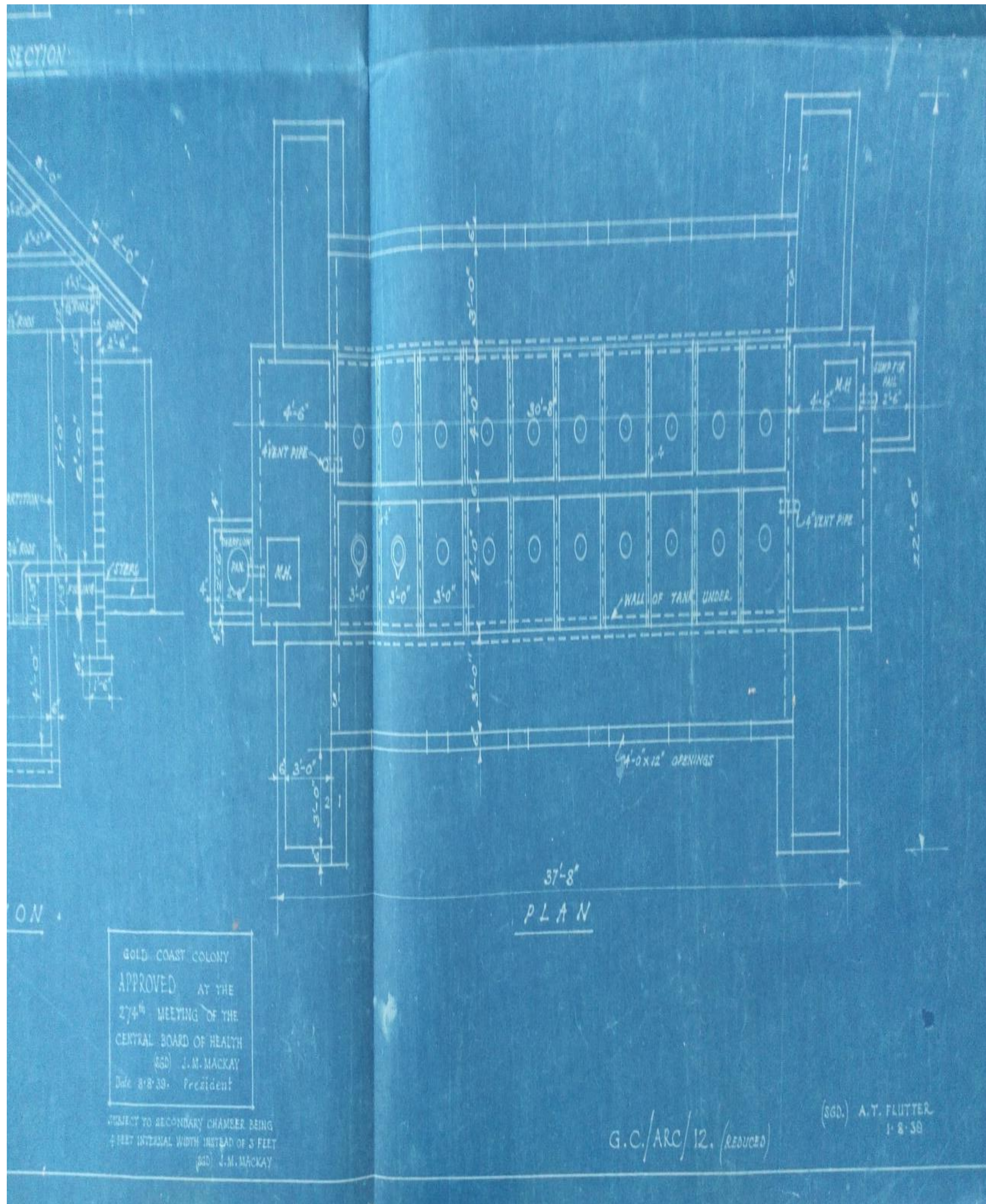

***Fig.* 4.** Picture showing a drawn plan of a twenty-sitter pan latrine built in the Central Province.

Source: PRAAD- Cape Coast, ADM 23/1/2658 *Septic Tank Latrines.*

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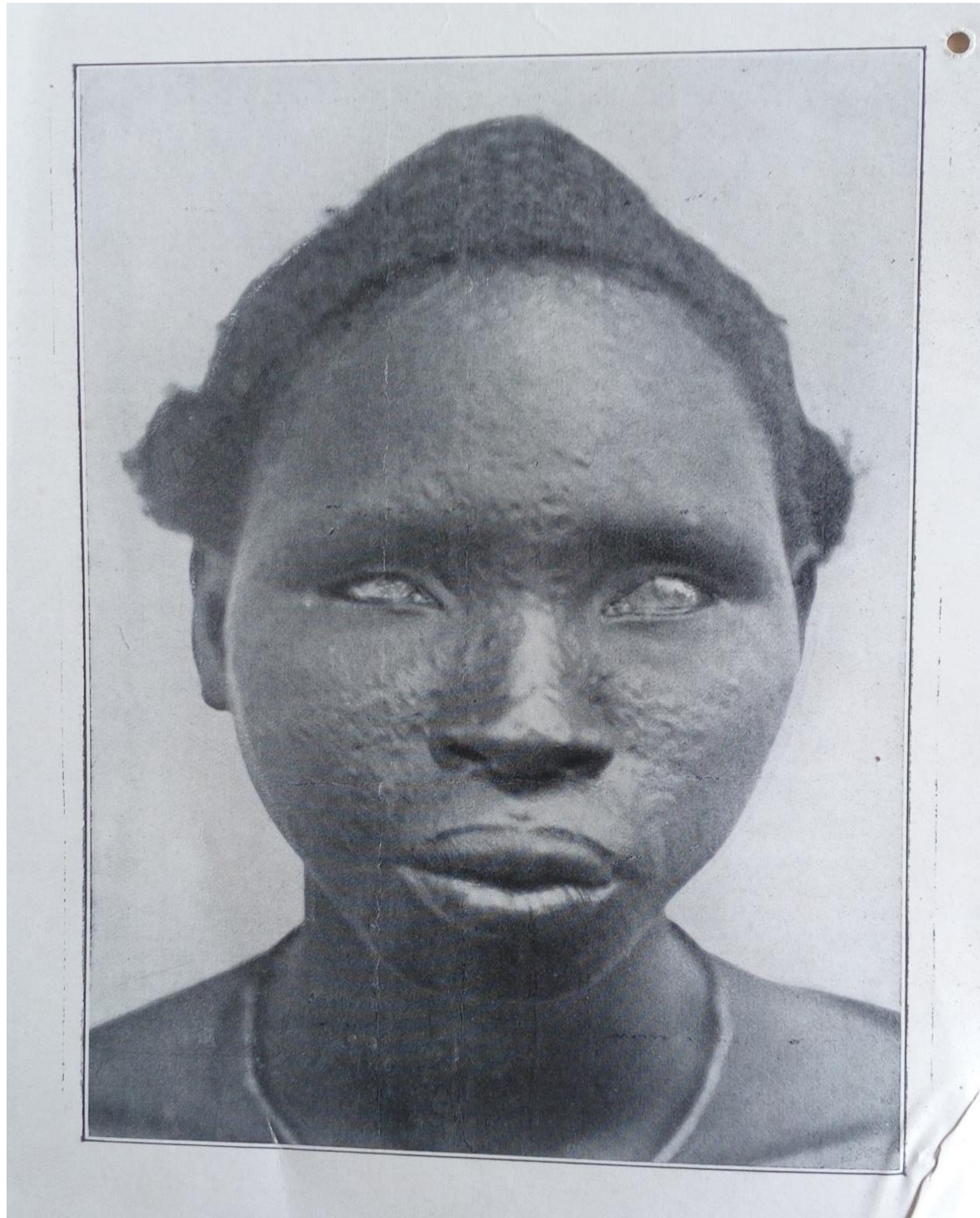

***Fig.* 5**: Picture showing a Gold Coast African who has been infected with small pox infection.

Source: P. S. Selwyn-Clarke, *Vaccination or Small Pox*. (Accra: Government Press, 1922). See also PRAAD- Cape Coast, ADM 23/ 1/176 Small Pox Infection Diseases.

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***Fig.* 6:** Picture showing a European child (middle) with the small pox disease in the Gold Coast.

Source: P. S. Selwyn-Clarke, *Vaccination or Small Pox*. (Accra: Government Press, 1922); PRAAD- Cape Coast, ADM 23/ 1/176 Small Pox Infection Diseases.

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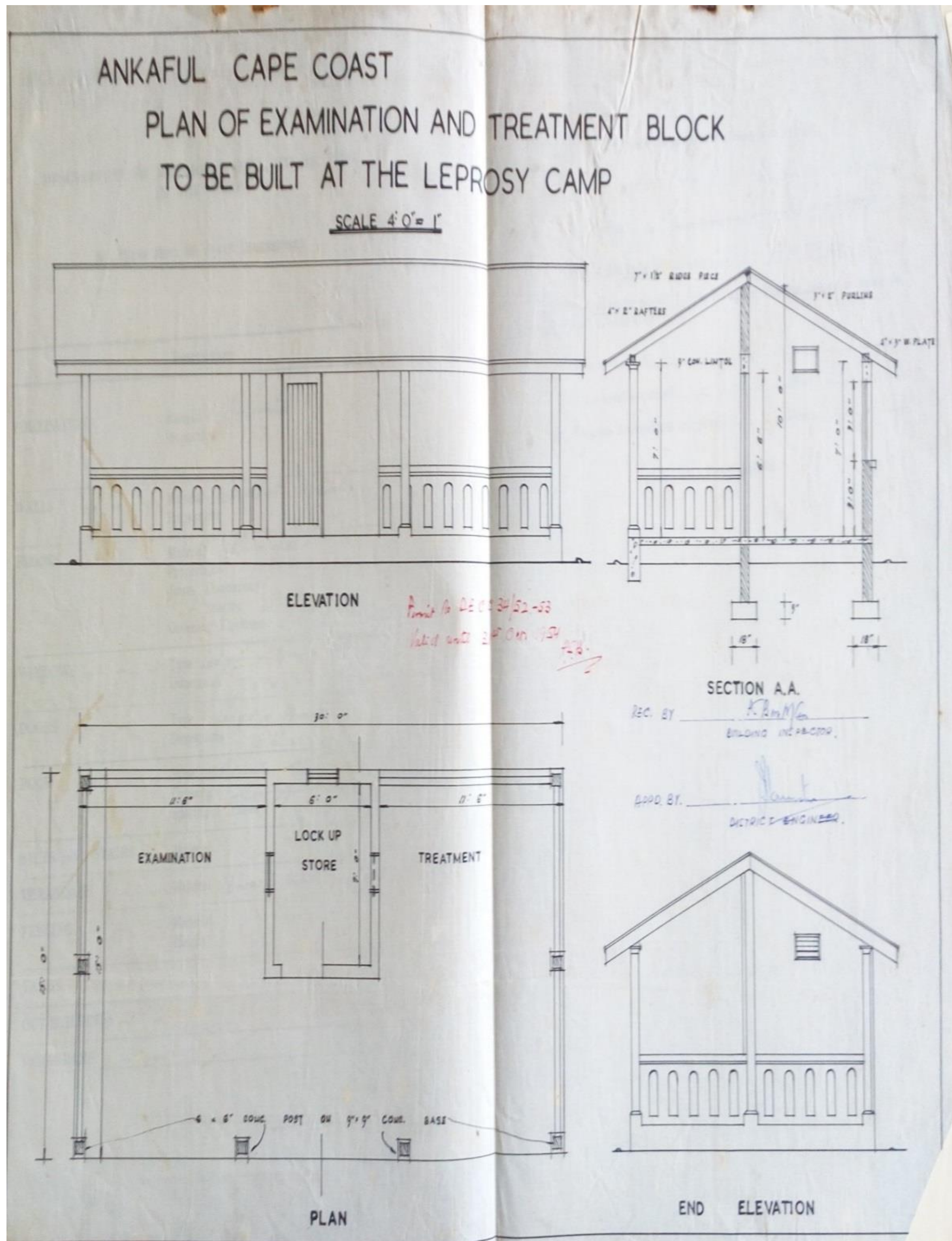

Fig. **7.** Picture showing the drawn plan of the Ankaful leprosarium.
Sources: PRAAD-Cape Coast, ADM 23/1/1403 *Leprosy Clinic in the Central Province.*

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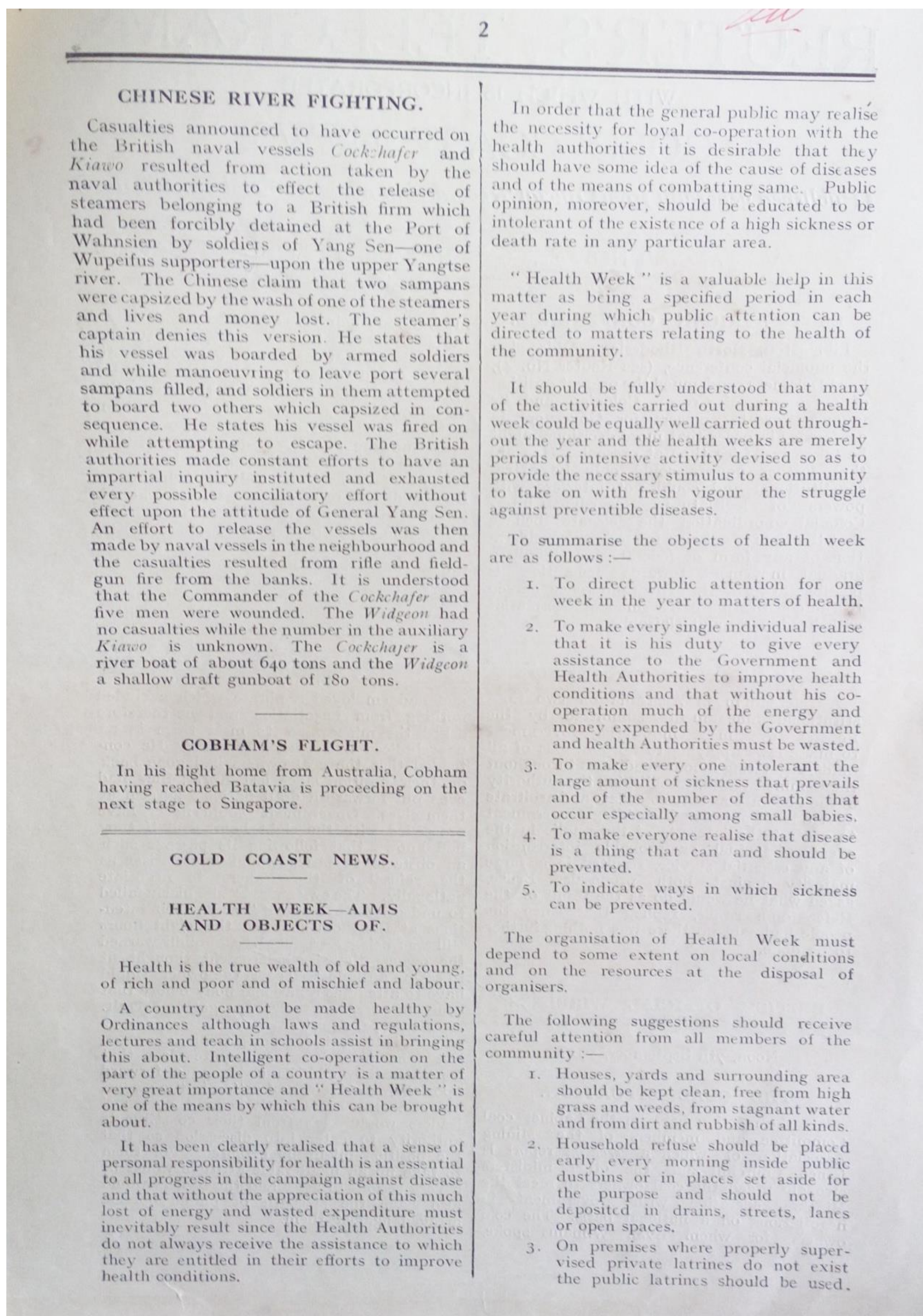

2

CHINESE RIVER FIGHTING.

Casualties announced to have occurred on the British naval vessels *Cockchafer* and *Kiawo* resulted from action taken by the naval authorities to effect the release of steamers belonging to a British firm which had been forcibly detained at the Port of Wahnsien by soldiers of Yang Sen—one of Wupeifus supporters—upon the upper Yangtse river. The Chinese claim that two sampans were capsized by the wash of one of the steamers and lives and money lost. The steamer's captain denies this version. He states that his vessel was boarded by armed soldiers and while manoeuvring to leave port several sampans filled, and soldiers in them attempted to board two others which capsized in consequence. He states his vessel was fired on while attempting to escape. The British authorities made constant efforts to have an impartial inquiry instituted and exhausted every possible conciliatory effort without effect upon the attitude of General Yang Sen. An effort to release the vessels was then made by naval vessels in the neighbourhood and the casualties resulted from rifle and field-gun fire from the banks. It is understood that the Commander of the *Cockchafer* and five men were wounded. The *Widgeon* had no casualties while the number in the auxiliary *Kiawo* is unknown. The *Cockchafer* is a river boat of about 640 tons and the *Widgeon* a shallow draft gunboat of 180 tons.

COBHAM'S FLIGHT.

In his flight home from Australia, Cobham having reached Batavia is proceeding on the next stage to Singapore.

GOLD COAST NEWS.

HEALTH WEEK—AIMS AND OBJECTS OF.

Health is the true wealth of old and young, of rich and poor and of mischief and labour.

A country cannot be made healthy by Ordinances although laws and regulations, lectures and teach in schools assist in bringing this about. Intelligent co-operation on the part of the people of a country is a matter of very great importance and " Health Week " is one of the means by which this can be brought about.

It has been clearly realised that a sense of personal responsibility for health is an essential to all progress in the campaign against disease and that without the appreciation of this much lost of energy and wasted expenditure must inevitably result since the Health Authorities do not always receive the assistance to which they are entitled in their efforts to improve health conditions.

In order that the general public may realise the necessity for loyal co-operation with the health authorities it is desirable that they should have some idea of the cause of diseases and of the means of combatting same. Public opinion, moreover, should be educated to be intolerant of the existence of a high sickness or death rate in any particular area.

" Health Week " is a valuable help in this matter as being a specified period in each year during which public attention can be directed to matters relating to the health of the community.

It should be fully understood that many of the activities carried out during a health week could be equally well carried out throughout the year and the health weeks are merely periods of intensive activity devised so as to provide the necessary stimulus to a community to take on with fresh vigour the struggle against preventible diseases.

To summarise the objects of health week are as follows :—

1. To direct public attention for one week in the year to matters of health.
2. To make every single individual realise that it is his duty to give every assistance to the Government and Health Authorities to improve health conditions and that without his co-operation much of the energy and money expended by the Government and health Authorities must be wasted.
3. To make every one intolerant the large amount of sickness that prevails and of the number of deaths that occur especially among small babies.
4. To make everyone realise that disease is a thing that can and should be prevented.
5. To indicate ways in which sickness can be prevented.

The organisation of Health Week must depend to some extent on local conditions and on the resources at the disposal of organisers.

The following suggestions should receive careful attention from all members of the community :—

1. Houses, yards and surrounding area should be kept clean, free from high grass and weeds, from stagnant water and from dirt and rubbish of all kinds.
2. Household refuse should be placed early every morning inside public dustbins or in places set aside for the purpose and should not be deposited in drains, streets, lanes or open spaces.
3. On premises where properly supervised private latrines do not exist the public latrines should be used.

***Fig.* 8:** *Gold Coast News* Report on the aims and objectives of the Health Week Celebration, 1926.

Source: *Gold Coast News* Accra, Wednesday, 8th September, 1926, No. 7.

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Fig. **9:** Picture showing a sketch of the layout of Foso Town.

Source: ADM 23 / 1/ 2423 *Central Board of Health Minute.*

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