

**SHARING THE BURDEN OF SICKNESS:
A HISTORY OF HEALING
IN ACCRA, GOLD COAST,
1677 to 1957**

by

Jonathan Roberts

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To
Kevin and Maria Roberts --
unwavering and indefatigable.

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Abstract

Over the past three hundred years, the healing culture of Accra has been characterized by therapeutic pluralism rather than by the dominance of one particular regime of healing. Five major therapeutic traditions developed, including: (1) healing methods derived from West African cultures (offered by shrine priests, spirit mediums, herbalists, and layhealers with home remedies); (2) localized versions of Islamic therapies (provided by Muslim clerics and makers of medicines using the powers of the Quran); (3) Christian faith-healing (offered by pastors who used the power of Jesus and the Holy Spirit to heal); (4) medical treatments (provided by doctors, nurses and dispensers); and (5) patterns of self-healing by sufferers (with the aid of herbal medicines, patent medicines and pharmaceuticals). This dissertation will trace the simultaneous development of these traditions, demonstrating how patients shared the burden of their sickness with a variety of practitioners, knitting together different traditions to create a pluralistic healing culture. This approach will challenge historiographical conventions that have framed the story of healing in Africa within a linear narrative of medical progress, and that have privileged the activities of European-trained surgeons and physicians.

Glossary:¹

adope: dwarves

akutso, pl. *akutsei*: quarter, division of a town.

asafo: military company

aye: witch, witchcraft, witchcraft substance.

baba: skin disease, with red areas on the skin.

gbaja: (lit. pouch) venereal disease, syphilis.

gbeshi: individual fate, or personality

bela: disease, illness, sickness.

bela folo: ordinary illness.

belatsalo: doctor, physician.

bewale, the vigour and strength of a person in a physical and mental sense

Homowo: the annual harvest festival in Accra, or literally, the time to “hoot at hunger.”

jemawoy : (pl. *jemawoji*) a lesser god attached to a geographical location, usually a shrine. The major deities in Accra are Nai, Sakumo, and Korle.

kita: oath

kitakalo: swearer of an oath.

kitatomo: oath breaking.

kitatomo: something object presented as pacification, in atonement.

kla: spirit residing within the living body.

kose: bush or rural area

kusum: culture-making as practical adaptation to new influences.

¹ All *Ga* terminology used in this dissertation take the spelling from M.E. Kropp Dakubu ed., *Ga-English Dictionary with English – Ga Index* (Accra: Black Mask Ltd., 1999). The orthography of the terms is consistent with Dakubu’s work, with the exception of the character of ɔ (representing the o sound in ‘hot’) which has been changed to o to prevent gaps in the formatting of paragraphs. All *Ga* terms are in italics, with the exception of the proper noun *Ga*, which can be used to refer to the *Ga* language, the *Ga* ethnic group and the city of Accra (by *Ga*-speakers).

manj: city, or urban area under the jurisdiction of chiefs and priests.

mantse: (pl. *mantsemei*) chief

mumo bela: spiritual illness.

Nyonymo: Supreme God, Divine Creator.

oboade: knowledge passed down by ancestors, sometimes considered as given by the gods and goddesses.

otofo: ghost of someone who dies unnaturally (violently, by accident, unexpectedly, or when young).

otutu: (pl. *otutui*) mounds filled with consecrated objects that serve as shrines or points at which to worship spirits.

piriu: oath.

shiwoo: oath, promise, pledge.

sisa: ghost or ancestral shade of someone who died a natural death (in sickness or old age).

susuma: soul, shadow or subconscious

ti: consecrated healing powder made from the charred remains of herbs and symbolic reagents.

tsofa: drugs, herbs, roots.

tsofatse: (pl. *tsofatsemei*) herbalist. lit. “father of the roots/drugs”

woy: (pl. *woji*) lesser god, normally contained in medicinal ingredients.

wontse (m) : (*woyoo* (f), pl. *wontsemei/woyei*) spirit medium and herbalist.

wontsubo: herbalist who uses spiritual skill to harm, poisoner.

wulomo : (pl. *wulomei*) priest and caretaker of the shrine of a *jemanwoj*.

Yesu Kristo: Jesus Christ.

Chapter 1. Introduction.

bela tamo jarawolo -- the burden of sickness must be displayed until it is cured.
Ga proverb

Pluralitas non est ponenda sine necessitate -- plurality is not to be posited without necessity
Ockham's razor.

In the early 17th century, the city of Accra was a small fishing outpost on the coast of West Africa, connected to neighboring villages by canoe or footpath. It was a Ga village of a few hundred people, where sufferers of illnesses were served only by a handful of locally-based healers. By the 20th century, Accra had become a city of over three million people where patients could choose between five major therapeutic traditions, including: (1) healing methods derived from West African cultures (offered by shrine priests, spirit mediums, herbalists, and layhealers with home remedies); (2) localized versions of Islamic therapies (provided by Muslim clerics and makers of medicines using the powers of the Quran); (3) Christian faith-healing (offered by pastors who used the power of Jesus and the Holy Spirit to heal); (4) medical treatments (provided by doctors, nurses and dispensers); and (5) patterns of self-healing by sufferers (with the aid of herbal medicines, patent medicines and pharmaceuticals). Each of these healing approaches has changed over time, sometimes dramatically, but they can still be thought of as “traditions” because their practitioners understood themselves as the bearers of ancestral ideas, practices and material cultures related to healing. In this dissertation, these traditions will be treated as the heuristic categories that can capture the dynamic and complex history of healing in Accra.



Figure 1.1.map of Accra in West Africa.



Figure 1.2: five traditions of healing in Accra today. Clockwise from bottom left: a mallam preparing a Quranic slate wash;¹ a woman seeking healing from Bishop Dag Heward Mills of Lighthouse International Church;² a patient undergoing reconstructive surgery at Korle Bu Teaching Hospital;³ a customer buying male potency medicines from a street vendor in Accra;⁴ and (centre), a love medicine prepared by a Ga spirit medium.⁵

¹ photo by author.

² Lighthouse Chapel International. Healing Jesus Crusade, accessed October 1, 2012, <http://www.daghewardmills.org/healingjesuscrusade/>.

³ Reconstructive Surgery Africa.

http://www.resurgeafrica.org/Information/project_milestones_Plastic_and_reconstructive_surgery_in_Africa.html.

⁴photo by author.

⁵ photo by author.

Section 1. Five Therapeutic Traditions

A walk around Accra today offers ready evidence of five distinct therapeutic traditions. The first of these are derived from West African healing cultures, provided by men and women who claim the authority to heal bodily, social and spiritual illnesses. Until the 20th century, the majority of these healers were from the Ga ethnic group, but they have always been supplemented by practitioners from the Akan-speaking parts of the region, as well as from Nigeria, Togo, Benin, and other parts of West Africa. Local priests in Accra are not beholden to Ga chiefs; the healers who follow African-derived traditions garner authority outside the political sphere by associating themselves with the local deities, gods and goddesses that have been worshiped by their ancestors for centuries.⁶ The spirit mediums of the city channel the spiritual forces that have inhabited the shores of the Korle Lagoon since the founding the city, or become filled by immigrant gods that now reside in Accra. By harnessing the power of their personal deities, they gain the knowledge of occult power to cast out the supernatural causes of disease. And local herbalists (who are mostly Ga, but also come from other ethnic backgrounds) prepare draughts, salves, and powders using recipes passed down through generations. Over the past 300 years, new concepts have been added to the Ga healing lexicon, and newcomers (particularly from neighboring Akan and Ewe cultures) have brought new healing ideas and concepts to the city. New deities from around West Africa are also present in the city, brought by Ga pilgrims to shrines outside the city, or by immigrants. And new plants and paraphernalia from around the world have been incorporated into the *materia medica* of local herbalists. Today, the city is still home to a Ga tradition of healing (sustained by the beliefs of Ga practitioners, who understand themselves as the bearers of healing principles integral to the history of the Ga people), but they are now

joined by many other healers from African traditions, with which they share an interest in holistic therapies that heal the body, repair family relations, quell social disputes and facilitate spiritual harmony.

A second major group of therapists are Muslim healers who conduct healing rituals and produce healing objects based on the power of the Quran.⁷ Since at least the 19th century, the Muslim neighborhood of the *zongo* has been home to clerics who have fabricated amulets, charms and geomantic squares in aid of people suffering from bodily and spiritual ailments. The techniques of producing these apotropaics can be traced back to traditions that crossed the Sahara Desert centuries ago, but they have been reconfigured to address local concerns.⁸ In the twentieth century, Muslim immigrants from ethnic groups as diverse as Hausa, Tabon (Brazilian), Yoruba, and Zabarima communities increased the size of the Muslim community in Accra, as did domestic growth of the Ga and Akan Muslim populations.⁹ Today, one can buy charms in aid of long-standing historical health problems (such as infertility, an ongoing concern in a malarial zone with high rates of infant mortality) as well as amulets for protection against modern problems (such as car accidents, an important concern in a city

⁶ Interview, Nai Wulomo, August 5, 2002; Interview, Korle Wulomo. December 6, 2002; Interview, Sakumo Wulomo, August 31, 2003.

⁷ Healers from northern Nigeria and immigrants from Brazil brought new forms of herbalism and Quranic healing to Accra in the 19th century. See R. Stock, "Traditional Healers in Rural Hausaland," *Geojournal* 5, no. 4 (July, 1981), 363-68; Alcione M. Amos and Ebenezer Ayesu, "I Am Brazilian': History of the Tabon, Afro-Brazilians in Accra, Ghana," *Transactions of the Historical Society of Ghana. New Series*, no. 6 (2002), 46.

⁸ Raymond A. Silverman and David Owusu-Ansah, "The Presence of Islam among the Akan of Ghana: A Bibliographic Essay," *History in Africa*, 16 (1989), 325-339; Diane Maier, "Nineteenth-Century Asante Medical Practices," *Comparative Studies in Society and History* 21, no. 1 (January 1979), 79.

⁹ Deborah Pellow, "The Power of Space in the Evolution of an Accra Zongo," *Ethnohistory* 38, no. 4 (Autumn 1991), 435.

with poorly maintained roads and vehicles).¹⁰ Driven by patient requests, these new forms of Islamic medicines have been adapted to the needs of the residents of Accra.

A third group of healers are the Western-trained practitioners who work at clinics and hospitals around the city. At the start of the 20th century, only a handful of surgeons served the population from clinics within their homes and a tiny colonial hospital. This changed in 1923, when the government of the Gold Coast Colony constructed a major hospital on the outskirts of the town, to the west of the sacred Korle Lagoon. The Gold Coast Hospital, as it was officially known, was gradually expanded into a colonial medical complex that was meant to facilitate the growth of a working population in the colony and exhibit the benevolence of paternal colonialism. Initially, patients in Accra regarded the Gold Coast Hospital with some skepticism but it soon became popular for cures for illnesses like yaws and malaria, and eventually took on the local neighborhood name of Korle Bu (meaning the lowlands beside the Korle Lagoon). It also became an avenue of upward mobility for the aspirant classes of Accra, whose sons and daughters joined the new institution as the first generation of physicians, dispensers and nurses. Today there are many other clinics and private hospitals in the city, but Korle Bu is still the largest hospital in Ghana, and it a pivot point in the cycle of life in Accra: thousands of people were born at Korle Bu, almost everyone has been there at some time when they were sick, and many will have their corpses stored at the Korle Bu mortuary before they are buried. But despite the significance of Korle Bu as a medical centre, colonial medicine never became the definitive practice of healing in Accra. Other healing methods continue to flourish in the city, and patients who attend Korle Bu continue to see it as only one of many locations of healing in the city.

¹⁰Interview, Tsofatse Thunder. December 22, 2006.

A fourth avenue of therapy for sufferers of illness in Accra is Christian faith-healing, which takes place in the dozens of protestant Charismatic Christian churches in the city. The faith-healing churches of Accra conduct outdoor healing crusades where people suffering from illnesses come forward to request help from famous ministers, the most prominent of which include the spiritual healer Nicolas Duncan-Williams of Action Chapel, former physician Dag Heward Mills of the Lighthouse International, or the self-proclaimed Prophet Salifu of the Jesus is Alive Evangelistic Ministry.¹¹ The healing practices at Charismatic churches have been key to their ascent over the so-called mainline churches (Catholic, Anglican, Methodist and Presbyterian), which have largely resisted engaging in public events of faith-healing.¹² The roots of Charismatic Christianity go back to the mid-19th century, when missionaries of the Basel Mission translated the Holy Bible into Ga, enabling catechists to emphasize the healing power of the Holy Spirit. Further faith-healing influences arrived in the 1930s and 1940s, derived from Aladura revival movement in Nigeria, which emphasized the healing power of the Holy Spirit and triggered a Christian revival in the 1950s.¹³ Though small in numbers and in congregation size, the new churches offered sermons in Ga and Twi, and served local needs for bodily and spiritual health by placing prayer and faith-healing at the centre of their liturgy. In the second half of the twentieth century, the congregations of the so-called “charismatics” grew at exponential rates in

¹¹ Paul Gifford, *Ghana's New Christianity: Pentecostalism in a Globalising African Economy*. (Bloomington and Indianapolis: Indiana University Press, 2004); see also Jonathan Roberts, “Prosperity Gospel in the Superchurches of Accra,” Review for H-Net’s H-Africa of Gifford, *Ghana's New Christianity*.

¹² Cephas N. Omenyo, “New Wine in an Old Wine Bottle? Charismatic Healing in the Mainline Churches in Ghana, in *Global Pentecostal and Charismatic Healing*, ed. Candy G. Brown (Oxford: Oxford University Press, 2011), 231-249.

¹³ C.G. Baeta, *Prophetism in Ghana: A Study of Some 'Spiritual Churches'* (Achimota: African Christian Press, 2004).

comparison to mainline churches, and then began to splinter and proliferate to dominate the religious landscape of the city.

The fifth type of healing prevalent in Accra today is self-medication, a practice with a tradition dating back to the earliest herbal home-remedies. Sufferers of illness in Accra have always been able to acquire leaves, roots, and barks for the preparation of their own cures, but the growth of the patent medicine trade in the 19th century and the subsequent growth of the pharmaceutical market in the 20th century dramatically enhanced options of self-diagnosis and self-medication. By consuming imported medicines, the residents of Accra could participate in a form of medical modernity, without necessarily submitting to colonial medical authority. Today, chemist shops and medicine stalls dot the neighborhoods of the city, and a patient can choose between thousands of different generic drugs that have flooded the city from India, China, and Nigeria, or decide to purchase local brands of bottled herbal draughts. Despite the expansion of the colonial and Ghanaian national health infrastructure, government control over the distribution and sale of medicines and medical equipment has never been strictly enforced. As a result, “self-care” with medicines is a widespread practice in Accra, mostly operating beyond the scrutiny of healing professionals, in the same way that herbalism was practiced in the past.¹⁴

¹⁴ Bernhard Bierlich uses the term “self-care” to describe patients in Northern Ghana diagnosing and treating their own illnesses with bottled medicines. Bernhard Bierlich, *The Problem of Money: African Agency and Western Medicine in Northern Ghana* (Oxford, Berghahn Books, 2007), 182; Kristine Krause has argued that healing in Ghana today is defined by competition amongst a plurality of healing traditions. Kristine Krause, “‘The Double Face of Subjectivity’ A Case Study in a Psychiatric Hospital (Ghana),” in *Multiple medical realities: patients and healers in biomedical, alternative, and traditional medicine*, eds. Helle Johannessen and Imre Lazar (New York: Berghahn Books, 2006), 57; Kodjo Senah has noted that health care in Ghana is provided by a diversity of places including: “shrines, healing homes, spiritual churches, hospitals, clinics, health posts, materiality homes, and pharmacies or drugstores.” Kodjo Amedjorteh Senah, *Money Be Man: the Popularity of Medicines in a Rural Ghanaian Community* (Amsterdam: Het Spinhuis, 1997), 48, 196.

That these five major therapeutic traditions co-exist in Accra today will not be surprising to anyone who has lived in Africa. Anthropologists and sociologists have demonstrated that, in every region of the continent, multiple systems of healing operate simultaneously. In West Africa, traditions of herbalism and spiritual healing proliferate, mixing with Christian faith-healing, healing networks established by Islamic practitioners, and state medical systems.¹⁵ In Southern Africa, African, Indian and European practitioners, each with their own particular subsets of healing knowledge and practice, compete for patients within states where there are also well established and well-articulated national health authorities.¹⁶ In East Africa, drumming practices and herbalism, amongst other African traditions, share the market with Islamic and Chinese medicines, as well as state-funded medicine.¹⁷ And in North Africa, contesting varieties of Islamic healing practices and institutions operate side by side with herbalists and government-funded clinics and hospitals.¹⁸ These multiple traditions

¹⁵ Maghan Keita, *A Political Economy of Health Care in Senegal* (Leiden: Brill, 2007), 27.

¹⁶ Markku Hokkanen "Quests for Health and Contests for Meaning: African Church Leaders and Scottish Missionaries in the Early Twentieth Century Presbyterian Church in Northern Malawi," *Journal of Southern African Studies* 33, no. 4 (Dec., 2007), 733-750; Stacey A. Langwick, "Devils, Parasites, and Fierce Needles: Healing and the Politics of Translation in Southern Tanzania," *Science, Technology, & Human Values* 32, No. 1 (Jan., 2007), 88-117; Lyn Schumaker, Diana Jeater and Tracy Luedke, "Introduction. Histories of Healing: Past and Present Medical Practices in Africa and the Diaspora," *Journal of Southern African Studies* 33, no. 4 (Dec., 2007), 707-714; Julie Livingston, "Productive Misunderstandings and the Dynamism of Plural Medicine in Mid-Century Bechuanaland," *Journal of Southern African Studies* 33, No. 4, Histories of Healing (Dec., 2007), 801-810.

¹⁷ Susan Beckerleg, "Medical Pluralism and Islam in Swahili Communities in Kenya," *Medical Anthropology Quarterly*, New Series, 8, no. 3 (Sep., 1994), 299-313; Ole Bjørn Rekdal, "Cross-Cultural Healing in East African Ethnography," *Medical Anthropology Quarterly* 13, No. 4 (Dec., 1999), 458-482; Vinay R. Kamat, "The Anthropology of Childhood Malaria in Tanzania, in Robert, A H, and Inborn Marcia. *Anthropology and Public Health: Bridging Differences in Culture and Society* (Oxford University Press, 2009), 35-64; Michael Jennings, "Chinese Medicine and Medical Pluralism in Dar es Salaam: Globalisation or Glocalisation?" *International Relations* December 19 no. 4, 2005. 457-473

¹⁸ Peter Gran, "Medical Pluralism in Arab and Egyptian History: An Overview of Class Structures and Philosophies of the Main Phases," *Social Science and Medicine*, 13B, 4, (December, 1979), 339-341.; Carla Makhoul Obermeyer, "Pluralism and Pragmatism:

have deep roots in Africa, and elsewhere, and there is strong evidence to show that healing pluralism is not just a sudden condition of postcolonialism. Rather, as Steven Feierman has pointed out “African medical systems point ever more clearly to a long-standing therapeutic pluralism.”¹⁹ No longer can we think of African healing as a type of primordial ethnomedicine; rather, historians must think of the healing landscape as one that was always diverse, always changing and always contested, with clusters of therapeutic regimes competing in different ways in each region.

However, despite assertions by anthropologists that therapeutic diversity has deep roots in Africa, historicizing pluralism has profound implications. The logical principle of Ockham’s razor obliges us to find parsimony within plurality, that is, to assert a singular hypothesis rather than propose a complex set of explanations. For almost a century, the thesis of medical progress has offered parsimony to historians of medicine, because it relies on the reductionist evidentiary framework of science to assert knowledge about the body and disease. It also offers a seductive narrative sequence, with a beginning point of cultural ignorance, followed by a medical discovery, climaxing in the heroic implementation of medical practice. The end of result of this plotline can be success or failure, but the narrative trajectory remains the same. As Hayden White notes, historical narratives of this variety do not necessarily represent “sequences of real events,” but rather are representations of the past that offer “coherence, integrity, fullness and closure,” along with a moral imperative as the force that drives the story along.²⁰ Indeed, the metanarrative of medical

Knowledge and Practice of Birth in Morocco,” *Medical Anthropology Quarterly* 14, no. 2 (Jun., 2000), 180-201.

¹⁹ Steven Feierman, “Change in African Therapeutic Systems,” *Social Science and Medicine. Part B: Medical Anthropology* 13, no. 4 (1979), 277.

²⁰ Hayden V. White, *The Content of the Form: Narrative Discourse and Historical Representation*. (Baltimore: Johns Hopkins University Press, 1987), 24.

progress must necessarily nullify and exclude the realities of therapeutic diversity in order to chronicle the orderly advance of scientific medicine.

Africa has been an integral part of the medical master narrative, as a setting where Europeans (in particular physicians and epidemiologists) struggled to overcome the ignorance of Africans and defeat the diseases that impeded commerce and colonization. So certain is the trope of medical advance that it has naturalized the expectation that medicine, if not already preeminent, will eventually surpass all other healing traditions to become the definitive, universal healing practice. As a result, African therapists have been relegated to an ethnographic present, as the followers of a disappearing world of indigenous tradition. And as a knock-on effect, the healing traditions (like Christian Faith-healing, Islamic healing, and self-medication with unregulated healing products) are either silenced or disregarded as quackery.

Evidently, it is time for a new approach to the history of healing in Africa. Rather than slavishly following the dictates of Ockham's razor, or blindly accepting the whiggish narrative of medical progress, historians must look to local or indigenous notions of healing in order to explain pluralism. The territory upon which this dissertation will sketch out a new history of therapeutic pluralism in Accra, a location that has been understood as a privileged site of medical advances in West Africa. Though Accra is embedded within the medical historiography of the Gold Coast and Ghana, it is also a city where a diversity of non-medical voices call out from the past. This commitment to pluralism is best expressed in the Ga phrase, *bela tamo jarawolo*, a saying that literally means which translates as "the burden of sickness must be displayed until it is cured."²¹ What this turn of phrase implies is that problems are often complex, and that they must be shared with many people if one

hopes to solve them. In the more literal context of healing, this suggests that a sufferer must seek help from as many people as possible in order to affect a cure. Here is a fresh perspective, one that puts the patient and their caregivers at the centre of the healing process, as people seeking help from a variety of healing traditions, with an openness to new insights about their suffering. By focusing on the way that patients shared the burden of their sickness with different types of healers, we can demonstrate the agency of sufferers in Accra in a way that the metanarrative of medical progress has been unable to do.

Section 2. Confronting narratives of European medical hegemony

The history of disease and healing in Africa has been almost exclusively written by Western historians who have, in abidance with the logic of their training, privileged the story of medicine. These histories begin with the stories of white medical pioneers, many of whom were associated with missionary activity during the 19th century. Chief among these are accounts of the role of medicine in the process of conversion, featured in biographies of Robert Moffat, David Livingstone and Emin Pasha. Though these men were surgeons who relied on rudimentary methods such as tooth pulling, lancing boils, and smallpox inoculations,²² the wider reading public in Europe and the USA regarded missionaries as

²¹ This saying has an analog in Twi, the language of Akan cultures to the north of the city: “*se wo anton wo yaree a wo enya ayaresa*” – you must sell your disease if you want to find a cure.

²²As the work of Jean and John Comoroff, Paul Landau, and Seth Quartey has shown, European missionaries in Africa quickly discovered that basic surgical techniques offered an effective means of attracting African patients to mission stations, and therefore celebrated European medical technology as a means of attracting converts. Jean Comaroff and John L. Comaroff, *Of Revelation and Revolution: Christianity, Colonialism and Consciousness in South Africa*, 2 (Chicago: University of Chicago Press, 1997); Paul Stuart Landau, “Explaining Surgical Evangelism in Colonial Southern Africa: Teeth, Pain and Faith.” *Journal of African History* 37, no. 2 (1996): 261-81; Paul Stuart Landau, *The Realm of the Word: Language, Gender, and Christianity in a Southern African Kingdom* (Portsmouth, NH: Heinemann, 1995); Seth Quartey, *Missionary Practices on the Gold Coast, 1832-1895: Discourse, Gaze, and Gender in the Basel Mission in Pre-Colonial West Africa* (Youngstown, N.Y.: Cambria Press, 2007).

“heroes of the dark continent.”²³ The storyline of the missionary-doctor was further perpetuated by hagiographies of Albert Schweitzer, who was hailed by his European admirers as a savior of both bodies and souls.²⁴ In the post-Second World War, the physician-turned-historian Michael Gelfand continued this tradition with books such as *Tropical Victory* and *The Sick African*,²⁵ but, as Maryinez Lyons has argued, Gelfand’s work served to perpetuate the link between the expansion of Christianity and the provision of medical care.²⁶ Moreover, these paternalistic accounts of medical heroes in Africa obscured the activities of practitioners of other healing traditions, and reduced Africans to immobile, unwell masses, who required both spiritual and medical salvation.

In the 1970s and the early 1980s, the religious teleology behind this foundational metanarrative was largely discarded as historians endeavored to critique the efforts of

²³As the dozens of volumes celebrating the work of David Livingstone, Robert Moffat, and Emin Pasha attest, the missionary doctor became a heroic figure in the European public imagination in the late 19th and well into the 20th centuries. A sample of works include *Scenes and services in South Africa. The story of Robert Moffat's Half-century of Missionary Labours* (London, J. Snow, 1876); W. A. Elliott, *"Nyaka" the Doctor: the Story of David Livingstone, with Chronological and Distance Notes and Memoranda of Progress and Development on his Routes* (London: London Missionary Society, 1908); and James W. Buel, *Heroes of the Dark Continent: A Complete History of All the Great Explorations and Discoveries in Africa, from the Earliest Ages to the Present Time* (New York: Hunt & Eaton, 1890).

²⁴ George N. Marshall and David Poling, *Schweitzer: A Biography* (Baltimore: Johns Hopkins University Press, 2000), 238; Schweitzer has been since criticized for his “Moral Paternalism” (Manuel M. Davenport, “The Moral Paternalism of Albert Schweitzer,” *Ethics* 84, no. 2 (Jan., 1974), 116-127) and his “benevolent racism” (“Dr. Schweitzer's Racism,” a review of *Out of My Life and Thought: An Autobiography by Albert Schweitzer*, ed. Antje Bultmann Lemke, (S.I.: Johns Hopkins University Press, 1998) by Ali A. Mazrui, *Transition* 53 (1991), 96-102) but Schweitzer’s ethical model was also adopted by physicians concerned about nuclear war (Anthony P. Polednak, *Albert Schweitzer and International Health Journal of Religion and Health* 28, no. 4 (Winter, 1989), 323-329).

²⁵ Michael Gelfand, *Tropical Victory: an Account of the Influence of Medicine on the History of Southern Rhodesia, 1890-1923* (Cape Town : Published for the Rhodes Centenary Celebration Committee Southern Rhodesia by Juta, 1953), 247 and Michael Gelfand, *The Sick African: A Clinical Study* (Cape Town Stewart Printing Company, 1948).

²⁶ Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge: Cambridge University Press, 1992), 1; Lyons also mentions Oliver

missionaries and physicians. However, these secularized histories, written mostly by former physicians (such as Oliver Ransford and J.N.P Davies), still adhered to a positivist narrative that assumed that, though mistakes had been made, western medical practices and pharmaceuticals would eventually bring “medicine to the African masses.”²⁷ As Gwyn Prins pointed out, despite being able to critique itself, the historiography of the late 20th century remained wedded to the idiom of the search for the “magic bullet” cure -- a narrative that naturalized colonial medicine as a universal healing force.²⁸ Invisible within this storyline, once again, were the African therapists and patients operating outside the colonial medical system, whose activities were deemed to be either insignificant or in decline.

Oddly, the first major challenge to Eurocentric metanarratives of healing in Africa came neither from African critics and nationalists, nor from historians interested in African healing cultures. Rather, it came indirectly, via reassessments of population growth by Thomas McKeown. In a series of articles and books, published between the late 1950s and the 1970s, McKeown made a convincing argument that the growth and health of European populations in the second millennium was due to an “improvement in economic and social

Ransford’s *"Bid the Sickness Cease": Disease in the History of Black Africa* (London: J. Murray, 1983) as a later work that reinforced this metanarrative.

²⁷ Ransford, *"Bid the Sickness Cease"*; Mario J. Azevedo, Gerald W. Hartwig, and K D. Patterson, *Disease in African History: An Introductory Survey and Case Studies* (Durham, N.C: Duke University Press, 1978); a number of other accounts of epidemics, primarily by the physicians who fought them in the 1940s and 1950s, can be found in and in a variety of essays in E E, Sabben-Clare, David J. Bradley, and Kenneth Kirkwood, eds. *Health in Tropical Africa during the Colonial Period* (Oxford: Clarendon Press, 1980); a survey of tuberculosis, schistosomiasis, trypanosomiasis and the use of chemotherapy for these illnesses and others can be found in the work of Charles Wilcocks, a former member of the East African Medical Corps and a Director of the British Bureau of Hygiene and Tropical Disease. See Charles Wilcocks, *Aspects of Medical Investigation in Africa* (London: Oxford University Press, 1962).

²⁸Gwyn Prins, "But What Was the Disease? The Present State of Health and Healing in African Studies," *Past & Present* (1989), 160-62.

conditions” rather than breakthroughs in public health or medicine.²⁹ This undercut assumptions that medicine was the sole factor in determining the health of societies.³⁰ By the 1990s, historians of medicine in Africa began to use McKeown’s perspective to challenge assumptions about the triumph of colonial medicine. By studying the demographic effects of epidemics, historians such as Philip Curtin, Myron Echenberg, Meghan Vaughn, and Gwyn Prins, were able to challenge the notion that colonial medicine had vanquished illness in Africa and observe that colonial rule actually facilitated the spread of disease.³¹ Within these revisionist histories, colonial medicine was identified as a distinct strand of healing culture -- one that largely offered cures for the very diseases that colonialism helped to spread.³² Unfortunately, in order to tell the story of colonial medical intervention, historians established an imposition-response paradigm that required quick, introductory summaries of African healing practices as a setting for the larger story of the epidemic. The intention of these authors was certainly not to generate an African ethnomedical present, but there was

²⁹ Thomas McKeown & R. G. Record, “Reasons for the decline of mortality in England and Wales during the nineteenth century,” *Population Studies*, 16 (1962), 121; See also Thomas McKeown & R.G. Brown, “Medical evidence related to English population changes in the eighteenth century,” *Population Studies* 9 (1955), 119-141; Thomas McKeown, R.G. Brown & R.G. Record, “An interpretation of the modern rise of population in Europe,” *Population Studies* 26 (1972), 345-382; Thomas McKeown, *The Role of Medicine: Dream, Mirage, or Nemesis?* (Princeton, N.J: Princeton University Press, 1979).

³⁰McKeown, *Role of Medicine*, xvi; Lyons used this component of McKeown’s argument to advocate for the study of the “total ecology” of disease, an approach that would include scientific, human and environmental factors in the study of the aetiologies of disease. Lyons, *Colonial Disease*, 7. For further detail on the critique of health care in the second half of the 20th century see John Ehrenreich, *The Cultural Crisis of Modern Medicine* (New York: Monthly Review Press, 1978), 2-16.

³¹ Philip D. Curtin, *Disease and Empire: The Health of European Troops in the Conquest of Africa*. (Cambridge: Cambridge University Press, 1998); Myron Echenberg, *Black Death, White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914-1945* (Portsmouth N.H.: Heinemann, 2002); Megan Vaughn, *Curing Their Ills: Colonial Power and African Illness* (Oxford: Polity Press, 1991); Lyons, *Colonial Disease*.

³²Steven Feierman characterizes medicine as one of many “forms of ethnomedicine,” each of which are distinct products of their own historical circumstances. Steven Feierman,

simply no space in their narratives to describe how indigenously-generated healing ideas, practices and material cultures changed over time.

For the most part, the history of local and regional therapeutics in Africa has been taken up by anthropologists, who have been able to avoid medical storylines entirely by assessing specific ethnic or regional healing practices on their own terms. The work of John Janzen has epitomized this approach. In a major study of patient behavior in the Kongo, Janzen argued that sufferers of illness and their accompanying “therapy management groups” (made up of family and friends) sustained a culture of “medical pluralism” in the region.³³ By seeking help from more than one healing tradition, Janzen argued, patients and their retinues approached healing as a “quests for therapy” without a prescribed beginning or end, and without privileging medical care.³⁴ An accompanying work, published in the same year, was *Lemba: a Drum of Affliction*, in which Janzen used Kongo oral traditions, in tandem with Portuguese and Belgian archival material, to trace the emergence and decline of the Central African Lemba drumming and healing cult -- a system whereby the sufferers of the Lemba sickness (a mixture of bodily, social, financial, and spiritual ills) in turn became the healers of future patients.³⁵ What Janzen’s studies revealed was that healing was integral to the history

“Struggles for Control: The Social Roots of Health and Healing in Modern Africa,” *African Studies Review* 28, No. 2/3 (Jun. - Sep., 1985), 73-147.

³³ John M. Janzen, *The Quest for Therapy: Medical Pluralism in Lower Zaire* (Berkeley: University of California Press, 1982).

³⁴ Janzen, *The Quest for Therapy*, 7-8; Janzen’s work followed ideas about patient behaviour and pluralistic healing presented by Charles Leslie and Arthur Kleinman: C. Leslie "Medical Pluralism in World Perspective [1]," *Social Science & Medicine. Part B: Medical Anthropology* 14, no. 4 (1980), 191-195; Arthur Kleinman, *Patients and Healers in the Context of Culture* (Berkeley: University of California Press, 1980), 50-68.

³⁵ John Janzen, *Lemba: A Drum of Affliction in Africa and the New World* (New York: Garland Publishing, Inc., 1982).

of a changing moral economy in the Kongo, and his work suggested that similar studies could be done in other regions of Africa where pluralistic healing systems were evident.³⁶

Some historians have followed Janzen's lead. In East Africa, Gloria Waite used the songs of spirit mediums to reconstruct the history of indigenous conceptions of illness in the Kilombero Valley of south-central Tanzania, and found that healing played a fundamental role in the historical development of Ngoni, Nsenga and Chewa societies.³⁷ Jean Allman and John Parker traced the rise and fall of the traveling spirit of Tongo through the 20th century, a deity who was sought out by patients around West Africa as a spiritual force that could thwart the malicious power of witches.³⁸ Other historians have focused on new types of Christian faith-healing based on what Matthew Schoffeleers has termed the "*nganga* paradigm."³⁹ Still others have written about the ubiquity and mobility of Quranic amulets

³⁶Janzen. *Lemba*; Janzen's work was followed by scholars studying group healing practices of *ngoma* throughout Southern and Central Africa. See Rijk van Dijk, Ria Reis and Marja Speirenborg, *The Quest for Fruition through Ngoma* (Oxford: James Currey, 2000).

³⁷ Gloria Waite. *A History of Traditional Medicine and Health Care in Pre-colonial East-Central Africa* (Lewiston, N.Y.: Mellen Press, 1992), 11-12, 120.

³⁸ Maier, "Asante Medical Practices," 63-81; Jean Allman and John Parker. *Tongnaab: The History of a West African God* (Bloomington: Indiana University Press, 2005).

³⁹ The historical literature on this topic is best developed in Southern Africa, starting with Sundkler's *Bantu Prophets* and more recently with the work of Matthew Schoffeleers (Bengt Sundkler, *Bantu prophets in South Africa* (New York, International African Institute of Oxford University Press, 1961); Matthew Schoffeleers, "Folk Christology in Africa: The Dialectics of the Nganga Paradigm," *Journal of Religion in Africa* 19, 2 (June, 1989), 157-183; Matthew Schoffeleers, "Ritual Healing and Political Acquiescence: The Case of the Zionist Churches in Southern Africa," *Africa* 61, 1 (1991), 1-25; Tracy Luedke, "Spirit and Matter: The Materiality of Mozambican Prophet Healing," *Journal of Southern African Studies* 33, no. 4 (December, 2007), 715-731); Paul Gifford and Birgit Meyer have published articles and books detailing the role of healing in West African Charismatic Christian churches (see Paul Gifford, "Ghana's Charismatic Churches," *Journal of Religion in Africa* 24, no. 3 (August, 1994), 241-265; Paul Gifford, *African Christianity: its Public Role* (Bloomington: Indiana University Press, 1998); Gifford, *Ghana's New Christianity*; Birgit Meyer, "Christianity in Africa: From African Independent to Pentecostal-Charismatic Churches," *Annual Review of Anthropology* 33 (2004), 447-474.

and charms around Africa.⁴⁰ The most innovative of these works, such as Nancy Rose Hunt's account of missionary medicine at a Congo River station in the Belgian Congo,⁴¹ have sought to reject the Eurocentric paradigms of the colonial medical encounter, and utilize local chronologies of change in the story of health and healing.

However, what has limited the most recent work on healing in Africa is that each study has focused on a single strand of indigenous practice, rather than recognizing the coexistence of many different healing methods, and without demonstrating how patients move to and fro between many different types of health care providers. There are two recent exceptions. Anne Digby has traced the historical "patterns of resort" taken by sufferers in South Africa,⁴² finding that patient eclecticism was the norm because "no one had overall authority to act as a gatekeeper in accessing a pluralistic provision of health care."⁴³ And in a remarkable composite work, Karen Flint's *Healing Traditions* demonstrates how Zulu, European and Indian practices operated in parallel in the Natal Colony of South Africa during the 19th and 20th centuries, and how patients were able to seek help from more than one practitioner in the search for a cure.⁴⁴ This dissertation will follow the lead of Digby and Flint by demonstrating how, in the city of Accra, sick patients often sought aid

⁴⁰ David Robinson, *Muslim Societies in Africa* (Cambridge, Cambridge University Press, 2004), 52-58; Rais Akhtar, *Health and Disease in Tropical Africa: Geographical and Medical Viewpoints* (Harwood Academic Publishers, 1987), 286-288; Lambek, *Knowledge and Practice*; John Janzen and Edward C. Green, "Continuity, Change and Challenge in African Medicine," in *Medicine across Cultures: History and Practice of Medicine in Non-Western Cultures*, Helaine Selin and Hugh Shapiro, eds. (Dordrecht: Kluwer Academic Publishers, 2003), 1-26.

⁴¹ Nancy Rose Hunt, *A Colonial Lexicon: of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham: Duke University Press, 1999).

⁴² Anne Digby, *Diversity and Division in Medicine: Health Care in South Africa from the 1800s* (Oxford: Lang, 2006), 373.

⁴³ Digby, *Diversity and Division*, 391.

⁴⁴ Karen E. Flint, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948* (Scottsville: University of KwaZulu Natal Press; Athens: Ohio University Press, 2007). Flint argued that although these traditions changed over time, European

from more than one healer, and different practitioners competed for the attention of patients.

The medical historiography of the Gold Coast has not embraced the multifaceted story of therapeutic pluralism, and, as such, stands as an impediment to understanding the past diversity of healing cultures in Accra. The foundational works of Dr. David Scott and Dr. K. David Patterson, written in the 1960s and 1970s, were, for their time, groundbreaking, and they continue to influence the study of healing in Ghana. As physician-historians, Scott and Patterson focused on the social dimensions of public health, including scientific advances in parasitology, bacteriology and virology,⁴⁵ and they assessed the aggregate reductions in morbidity and mortality in the Gold Coast Colony.⁴⁶ But though they offer the backbone of a medical historiography, essential to understanding the activities of doctors, nurses and medical technicians in Accra, these authors were firmly wedded to the trope of medical progress.⁴⁷ Patterson noted the “increasing public acceptance of an alien medical system” allowed medicine to advance in Ghana, while Scott chose to evoke the idiom of Darwinism to describe the advance of medicine, stating that “advances in public health must be seen as a continuous process of evolution.”⁴⁸ Both admitted that there was much work

medicine remained distinct because white doctors and the apartheid state prohibited any syncretism with African or Indian healing practices

⁴⁵ David Scott considered the progress made by the Gold Coast Government against epidemic illnesses in Ghana to be only the beginnings of a long struggle against disease. As he put it, public health measures were always part of a “continuous process of evolution” and that epidemiologists were “only among the foothills of great advances in disease prevention and control.” David Scott, *Epidemic Disease in Ghana, 1901-1960* (London: Oxford University Press, 1965), 193, 203-04.

⁴⁶ K. David Patterson, “Health in Urban Ghana: The Case of Accra, 1900-1940,” *Social Science and Medicine* 13B, no. 4 (1979), 266.

⁴⁷ K. David Patterson, *Health in Colonial Ghana: Disease, Medicine, and Socio-economic Change, 1900-1955* (Waltham, Mass.: Crossroads Press, 1981), 105.

⁴⁸ Patterson, *Health in Colonial Ghana*, 11; Scott, *Epidemic Disease in Ghana*, 203.

yet to be done to relieve the inhabitants of West Africa from the scourge of disease, but they believed that medicine was marching forward.

The work of Patterson and Scott was followed two decades later by a comprehensive work by Professor Stephen Addae, *Evolution of Modern Medicine in a Developing Country*, which follows the established beliefs that physicians would be the champions in the fight against disease and that medicine would gradually reveal itself as a dominant model for healing practice in Ghana.⁴⁹ Addae does include much sharp criticism of the curative bias of medicine on the Gold Coast and in Ghana, something that Patterson and Scott were only able to touch on briefly. Addae also finds time to discuss some aspects of African healing culture, but only in the context of African remedies for specific illnesses. Rather than entertaining the possibility of a multifaceted pluralistic therapeutic storyline, he defers to the work of renowned anthropologist Patrick Twumasi on the subject of African healing practices.⁵⁰ The *Evolution of Modern Medicine in a Developing Country* is currently used as a textbook in courses about medical history in the Departments of History at the Universities of Ghana (Legon) and Cape Coast, while the study of non-Western healing continues to be relegated to the domain of anthropology.

The emergence of medical history Ghana as a discrete field of inquiry has obscured a wide variety of storylines about non-medical forms of healing, including the extent of indigenous plural healing networks, the evidence of dramatic changes in the folk use of medicinal plants in West Africa, and the growth of Islamic and Christian healing cultures in the city. This dissertation shows how, rather than adhering to a singular regime of healing,

⁴⁹ Stephen Addae, *The Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960* (Durham: Durham Academic Press Ltd, 1996), 36. Addae argued that although colonial medicine initially focussed its efforts on the health of Europeans in the Gold Coast, it eventually came to benefit “all Africans.”

⁵⁰ Addae, *The Evolution of Modern Medicine*, 8-14.

the residents of Accra have sustained the coexistence of several different notions of health and types of practice for at least 300 years, despite the presence of a dominant Ga ethnic group, despite the establishment of a British colonial medical infrastructure, and despite the conversion of most of the population to either Islam or Christianity. The residents of Accra not only tolerated the existence of multiple healing traditions, they also “sold” their sicknesses to various healers, seeking out the best possible treatments for both physical and spiritual illness. In doing so, they have woven together a plural therapeutic culture that has stood the test of time, lasting for more than three hundred years.

Section 3. Historicizing pluralism

Incorporating multiple traditions into the story of healing in Africa should be simple. After all, historians have inherited an immense amount of anthropological material on medical pluralism (a concept which, in this dissertation, will be referred to as either therapeutic pluralism or pluralistic healing, to avoid the medical idiom). The work of Steven Feierman and John Janzen in the late 1970s and early 1980s showed that Africans tend to gravitate towards spiritual healing, form kinship-bound therapy management groups, and embark on what have been termed “quests for therapy” amongst many healing traditions.⁵¹ The predilection for pluralism has been confirmed in the Ghanaian social and cultural context also, as Ghanaian sociologist Patrick Twumasi has asserted that the results-oriented approach of patients has led to the presence of so many therapeutic options in Ghana.⁵² Twumasi noted that sufferers of illness “can maintain a parallel set of orientations and in fact

⁵¹ Steven Feierman, “Change in African Therapeutic Systems,” John M. Janzen, *The Quest for Therapy: Medical Pluralism in Lower Zaire* (Berkeley: University of California Press, 1982). Part B: *Medical Anthropology*, 13, no. 4 (1979) 280; Janzen, *Quest for Therapy*.

⁵² Patrick Twumasi. *Medical Systems in Ghana: A Study in Medical Sociology* (Ghana Publishing Corporation, Assembly Press, (1975) 2005), xiii, 124.

may be positively oriented both to traditional and scientific medical practices,” an attitude that allows them to be flexible and open to new ideas in their search for health and well-being.⁵³ The importance of patient-driven therapeutic pluralism is reinforced in the findings of Leith Mullings, who demonstrated in her study of mental illness in Labadi (a suburb of Accra) that patients tended to select treatments they considered “appropriate to their life situation at a given moment,” by Kristine Krause, who argued that patients in Accra appropriate therapies in a subjective manner, and by Kodjo Senah, who noted that the patient is an “active participant in the process of diagnosis and treatment management” in Ghana.⁵⁴ Anthropologists from other parts of Africa, including Charles Good, Helga Fink, Michael Lambek, Susan Reynolds Whyte, Susan Rasmussen, to name only a few, have also offered evidence of healing pluralism in other parts of Africa, including the interweaving of African healing traditions, medical health care, and (depending on the context), Islamic medicines, Christian healing practices, and medical commodities.⁵⁵

⁵³ Twumasi, *Medical Systems in Ghana*, 124.

⁵⁴ Leith Mullings compared both Ga healing methods and Christian faith healing in her study of mental illness in Labadi (Leith Mullings, *Therapy, Ideology, and Social Change: Mental Healing in Urban Ghana* (London: University of California Press, 1984), 192; Kristine Krause has argued that healing in Ghana today is defined by competition amongst “herbalists, bonesetters, traditional midwives, Muslim healers like mallams and marabouts, possession priests like *tronua* among the Ewe, *akomfo* among the Akan, Tigare and Mami Wata Shrines and a variety of Christian healers and prophets.” Krause, “Double Face of Subjectivity,” 57; Kodjo Senah has noted that health care in Ghana is provided by a diversity of places including: “shrines, healing homes, spiritual churches, hospitals, clinics, health posts, materiality homes, and pharmacies or drugstores.” Senah, *Money Be Man*, 48, 196.

⁵⁵ Charles M. Good, *Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya* (New York: Guilford Press, 1987); Susan Reynolds Whyte, *Questioning Misfortune* (Cambridge: Cambridge University Press, 1997); Helga Fink, *Religion, Disease, and Healing in Ghana: A Case Study of Traditional Dormaa Medicine* (München: Trickster Wissenschaft, 1990); Michael Lambek, *Knowledge and Practice in Mayotte: Local Discourses of Islam, Sorcery and Spirit Possession* (University of Toronto Press, 1993); Susan Rasmussen. *Healing in Community: Medicine, Contested Terrains, and Cultural Encounters Among the Tuareg* (Westport, CT: Bergin & Garvey, 2001); Krause, “Double Face of Subjectivity,” 54-71; See also David Baronov, *The African Transformation of Western Medicine and the Dynamics of Global Cultural Exchange*

Unfortunately, a scholar seeking to historicize therapeutic pluralism faces three substantial challenges. The first is the obvious lack of historical accounts of patient behavior in the African past. Sources like the *Diary of Samuel Pepys*, which Roy Porter relied on to recreate the cognitive world of Early Modern English patient, are simply not available in the documentary records of the African past.⁵⁶ Historians can assume that, as Gwyn Prins has argued, the histories of individual quests for therapy within “a pluralist medical environment” will offer insight into the core characteristics of societies in Africa, but finding the sources to recover that past is a daunting task.⁵⁷ In order to accumulate as much information about healing in the past in Accra, this dissertation uses a wide variety of historical materials such as travelers’ journals, court records, statistical surveys, oral interviews, and other disparate fragments, in order to piece together the story of healing pluralism in an African city.

A second challenge to historicizing pluralism arises when one tries to calculate the comparative efficacy of different healing traditions. One might suggest that multiple therapeutic options coexist because they are effective at treating different diseases or culture-bound syndromes, and the historian only needs to sort out which healing tradition heals which illness. Unfortunately, the clinical definition of efficacy as a scientifically proven result is limited in the sense that it addresses bodily wellness on western medical terms, which, in the almost complete absence of laboratory data and clinical trials, is almost impossible to determine historically. What is much easier to work with is perceived efficacy on behalf of

(Philadelphia: Temple University Press, 2008), 31; Martyn Sama and Vinh-Kim Nguyen, *Governing health systems in Africa* (African Books Collective, 2008), 25.

⁵⁶ Porter, Roy. "The Patient's View: Doing Medical History from Below," *Theory and Society*. 14 (1985), 184.

⁵⁷ Prins, “But what was the disease?” 178. Prins notes that historical insight can be gained by watching “how communities defend themselves against disruptive but unavoidable influences.”

the patient or their caregivers, an outcome that can be reasonably assessed with the limited historical data available. For instance, if we have accounts of supplicants attending a shrine to cleanse themselves of a curse, we must abandon any attempt at registering clinical efficacy, but we can judge how the people who attended the shrine perceived it as being efficacious. Thus, rather than making assertions about how a universal sort of efficacy revealed the superiority of medical treatments, this dissertation will highlight how patients understood the different utility of the plurality of healing traditions in Accra.

A third, and more troubling, challenge faced by historians who wish to read therapeutic pluralism back into the past is that doing so might actually serve to limit the agency of Africans as historical characters. Though an anthropologist might be able to argue that Africans today *tend* to emphasize spiritual health, *tend* to form kinship bound therapy management groups, and *tend* to “explore all avenues of a cure,”⁵⁸ this does not mean we can build a historical model of patient behavior upon these three tendencies. To do so would be to simplify human decision making in the extreme, and may even lead to the replication of Enlightenment stereotypes of the capricious or superstitious African bricoleur -- the patient who was willing to try any old thing to heal themselves, regardless of logic or efficacy.⁵⁹ This is not to say that Feierman and Janzen’s ideas, and their use by subsequent scholars, cannot help us understand the history of African therapeutics. Indeed, as this dissertation will show, there does seem to have been a set of tendencies that patients in Accra followed which are akin to the “quest for therapy” model, as patients and their caregivers sought out both physical and spiritual healing from multiple practitioners. However, while many

⁵⁸ Adam Ashforth, “An Epidemic of Witchcraft? The Implications of AIDS for the Post-Apartheid State,” *African Studies* 61, no. 1 (2002), 133.

⁵⁹ William Pietz, “The problem of the fetish, I,” *Res* 9 (Spring 1985): 5-17; “The problem of the fetish, II.” *Res* 13 (Spring 1987): 23-45; “The problem of the fetish, IIIa: Bosman’s Guinea and the enlightenment theory of fetishism,” *Res* 16 (Autumn 1988): 105-123.

patients in Accra did play the healing field by seeking treatments from what we can distinguish heuristically as African, Christian, Muslim, and medical sources, many others wholeheartedly committed themselves to single healing cultures (such as African elites within medicine, Ga patients and their associations with the Ga pantheon of deities, Muslim connections with mallams as healers). What then are we to make of cases when people were guided or coerced into following a singular therapeutic tradition?

One way that we can avoid imposing contemporary models of therapeutic pluralism on the past is by taking the advice of Steven Feierman, who argued that we must investigate which social institutions “control therapeutic choice.”⁶⁰ John Janzen noted that the power to choose therapies was vested in the aforementioned therapy management group, but other social forces were in play in the colonial setting of Accra that dictated where, when, and how a patient sought therapy. As Megan Vaughn and Alexander Butchart have shown, the Foucauldian concept of biopower is a useful conceptual tool means for explaining the relationship between the power of the colonial state and the body of the sick person.⁶¹ Though the history of Accra has been largely characterized by a weak regulation of healing practices, there have been instances when the bodies of colonial subjects were understood as medical units that could be manipulated according the dictates of medical professionals. The colonial medical system drew in employees, soldiers, clients and the destitute, restricting their treatments to the space of the hospital, and prohibiting other healers from entering colonial medical spaces. The forces of biopower in Accra were never terribly robust, because they always competed with parallel African and religious therapies, and they never exercised

⁶⁰ Feierman, “Struggles for Control,” 83.

⁶¹ The concept of biopower is elaborated in two of Michel Foucault’s works (*The Birth of the Clinic* (New York: Vintage, 1994) and *History of Sexuality Vol.1*); Two Africanist historians who have used the concept to analyse the expansion of colonial and state medical systems

absolute control over the bodies of patients. Unlike the South African mining industrial complex, where the health-status of workers was medicalized under the purview of mining companies and the state, patterns of healing pluralism were definitely the norm in Accra. However, at specific times during the colonial era, the Medical Department negatively affected the freedom to choose between healing traditions.

Another way to avoid imposing models of patient behavior, and demonstrate the positive agency of patients, is to utilize the concept of distinction proposed by Pierre Bourdieu, which suggests that people follow practices and consume goods in order to display a sense of taste that will distinguish themselves ethnically, religiously, economically or culturally.⁶² When understood as a performance, being sick is a time when a person (or their therapy managers) attempt to position themselves vis-à-vis others within society, as consumers of particular types of health care that assert their social status. Being Ga, for instance, might mean patronizing Ga healers when ill, whereas being modern in the 20th century might mean that a Ga patient also visited the hospital when sick. Being a pious Christian or Muslim might also entail a performance when sick, either in seeking out faith-healing within one's congregation, or denying the need for a secular cure. The goal of the patient in these cases is to get better *while at the same time* differentiating themselves from other patients. Indeed, the performance of a sick person might be held sequentially on multiple therapeutic stages, for instance, at a shrine, at a clinic, at a church, or in front of the pharmacy shelf, and patients might be able to code-switch between healing regimes in order to conduct their quests for therapy. Nonetheless, by demonstrating how the agents within a healing culture (in this case, patients and caregivers) made choices to either follow one

are Megan Vaughn and Alexander Butchart (Vaughan, *Curing Their Ills*; Alexander Butchart, *The Anatomy of Power: European Constructions of the African Body* (London: Zed Books, 1998)).

regime of healing or hop between healers in a search for a cure, we can show how they actively constituted the nature of therapeutic pluralism in Accra.⁶³ Additionally, we can better explain why new therapeutic traditions might have appealed to the residents of Accra as means of gathering cultural or social capital.⁶⁴ By embedding oneself within the colonial medical network either as a patient or a nurse, technician or doctor, one gained access to the prestige associated with colonial power. Distinction, as a means of social differentiation, could be mobilized both by patients and by healers.

In sum, historicizing therapeutic pluralism is not a mere process of reading contemporary findings into the past. Though we can locate tendencies in patient behavior that echo anthropological findings of the past few decades, pluralistic healing in Accra evolved organically, over a long period of time. If there was an invisible hand of efficacy at work in past centuries, it would be difficult to reveal, and even doing so would reduce our history to one based on western notions of clinical medical outcomes. During the past 300 years, powerful regimes of healing did briefly emerge to the point where patients sometimes felt beholden to singular therapeutic traditions, but over the long durée, no hegemonic episteme, no dominant ontological framework, and no essential pattern of patient behavior emerged. Rather than relying on one specific model, the historian must look at political conflicts, economic upheavals, social divisions and cultural clashes in order to understand how a healing culture can change. The goal of this dissertation is to enumerate such changes, era by era, to show how therapeutic pluralism flourished in the West African city of Accra.

⁶² Pierre Bourdieu, *Distinction: A Social Critique of the Judgment of Taste* (Cambridge, Mass: Harvard University Press, 1984 [1979]).

⁶³ Bourdieu, *Distinction*, 467.

⁶⁴ The notion of social and cultural capital is elaborated in Pierre Bourdieu, *The State Nobility: Elite Schools in the Field of Power* (Stanford: Stanford University Press, 1996 [1989]).

Section 4. Four categories of analysis: aetiologies, practices, material culture, spaces

Healing can be defined briefly as actions taken to facilitate health, but in order to compare and contrast healing cultures, it is necessary to further define what we mean when we use the term “health.” This is essential because the pluralistic outlook of patients in Accra suggests that a patient’s understanding of health can differ dramatically in each circumstance of illness. The current international definition of health, adopted by the World Health Organization in 1948, states that “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁶⁵ The broad scope of this definition demonstrates that the international medical community is aware that many societies judge the health of an individual holistically rather physically. However, it still assumes that there are universal medical parameters with which to measure the health of any given person in any given society. The notions of health in Accra today differ from the WHO definition precisely because they are plural; it is a city where patients welcome divergent notions of illness and wellness, and seek therapies from healers with differing, and often incommensurable, notions of disease causality. What this dissertation will demonstrate is that in the past, just as it is today, well-being in Accra has been assessed situationally and contingently, rather than judged against a singular definition of health.

To more precisely address the meaning of health amongst the people of Accra today and in the past, the thoughts and acts that go into producing health will be broken down into four constituent parts, including aetiologies (notions of disease causality and belief in healing spirits), practices (the actions and intentions of generating health), material culture (the symbols and equipment associated with healing practice), and spaces (the geographic

⁶⁵ World Health Organization, Constitution of the World Health Organisation. Basic Documents 45th edition (Geneva, 2006), accessed May 17, 2011, <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>.

divisions of therapeutic regimes). These four parameters of culture will be used in order to understand how healers and patients distinguished between different modes of healing in the past, how healing practices changed over time, and how demand for different types of healing waxed and waned over time.

Firstly, the dissertation will demonstrate how the existence of plural ideas of illness in Accra has been facilitated by the Ga language, which was the majority language in the city until the 1950s. Conceived of within Ga aetiologies of disease, notions of illness fall into two basic categories. The first is natural illness (*bela folo*), sicknesses caused by accidental causes like colds, coughs, constipation, worms, stomach troubles, rashes, and malaria. The second is social or spiritual illness (*mumo hela*), sicknesses caused by human-made curses or malicious spirits.⁶⁶ Sufferers who have thought about their illnesses within these Ga categories understood that the causes of their maladies progressed along a continuum.⁶⁷ Initially, an illness might be considered to be natural, something treatable with basic herbal remedies or with pharmaceuticals. However, if an illness was chronic, recurring, or lingering it could be regarded as unnatural, requiring a cure involving the power of spirits.⁶⁸ In such cases, patients and their therapy management groups seek aid from local deities, imported spirits from around West Africa, mallams who can heal with the Quran, and pastors who

⁶⁶ Both Mullings and Senah discuss the bipartite understanding of health held by Gas in Accra today, but they are also aware that illnesses can transition between *bela folo* and *mumo hela* depending on the progression of the illness. Mullings, 66; Senah, *Money Be Man*, 141.

⁶⁷ This schema of aetiological thought is congruent with Gabriel Fosu findings in the Akwapim village of Berekuso, Gabriel B. Fosu, "Disease Classification in Rural Ghana: Framework and Implications for Health Behaviour," *Social Science and Medicine, Part B: Medical Anthropology* 15, no. 4 (Fall, 1981), 471-482.

⁶⁸ Though this sort of question can arise in any culture, John Janzen and Edward Green have argued African aetiologies shift paradigmatically toward spiritual explanations because there is a tendency for patients in Africa to think that "something else is going on" other than a simple malady. John M. Janzen and Edward C. Green, "Continuity, Change, and Challenge in African Medicine," in *Medicine across Cultures: History and Practice of Medicine in Non-Western*

offer access to the healing power of Jesus. Within this conceptual framework of natural and spiritual illness, it is irrational for patients to follow a single therapeutic route because the illness could leap suddenly from one state to the other. Rather, it makes more sense to make use of the many different healers in the city as “helpers” (to use Ghanaian anthropologist Patrick Twumasi’s term) -- healing guides, each with their own notions of causality, that can aid in a patient’s quest for therapy.⁶⁹

Secondly, the dissertation will show the continuity of multiple practices of healing in Accra despite the initial presence of a strong Ga state and, later, an active colonial medical regime. Unlike in Europe, where the modern era witnessed the gradual marginalization of astrologers, Paracelsians, homeopaths, “wise-women” and layhealers in favour of state monopolies for surgeons, physicians and apothecaries,⁷⁰ the choices of patients in Accra did not diminish. A key point to make here is that, whereas in some other African polities, the

Cultures, ed. Helaine Selin and Hugh Shapiro (London: Kluwer Academic Publishers, 2003), 6; see also Krause, “The Double Face of Subjectivity,” 56-7.

⁶⁹Patrick A Twumasi, “A Social History of the Ghanaian Pluralistic Medical System,” *Social Science and Medicine* 13B, no. 4 (December, 1979), 351.

⁷⁰ Using the work of Keith Thomas, Steven Feierman has traced the slow marginalization of non-medical practitioners and the growth of medical institutions in Europe as a comparison to the proliferation of plural systems of healing in Africa. Steven Feierman, “Change in African Therapeutic Systems,” 281; Keith Thomas, *Religion and the Decline of Magic* (Harmondsworth: Penguin Books, 1973) ; See also Foucault, *Birth of the Clinic*; for recent work on the plural roots of healing in Europe see David Gentilcore, “Was There a “Popular Medicine” in Early Modern Europe?” *Folklore* 115, no. 2 (Aug., 2004), 151-166, Mary Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge: Cambridge University Press, 2010), and Ronnie Moore, Stuart McClean, eds., *Folk healing and health care practices in Britain and Ireland: stethoscopes, wands, and crystals* (Berghahn Books, 2010); for a sample of parallel literature on the relative decline of witchcraft and magic vis-à-vis medicine, see Jonathan Barry, Marianne Hester and Gareth Roberts, *Witchcraft in early modern Europe: studies in culture and belief*, (Cambridge: Cambridge University Press, 1998) and more recently, Edward Bever, “Witchcraft Prosecutions and the Decline of Magic,” *Journal of Interdisciplinary History*, 40, no. 2 (2009), 263-293; finally, it should be noted that this trend was reversing rapidly in the 20th century, as patients increasingly sought out alternative therapies, especially for chronic or severe illnesses. See Eisenberg D.M. et al., “Trends in alternative medicine use in the United States, 1990-1997: results of a follow-up national survey,” *Journal of the American Medical Association* 1998 Nov 11 280, no. 18:1569-75.

use of healing and medicines emerged as elements of state power (for example, the use of *mutbi* by Zulu chiefs as a medicoreligious embodiment political power,⁷¹ the accumulation of *nyama* by Mande rulers as an occult force that facilitated political power,⁷² or the creation of the *ajalela* national war medicine by the chiefs of Dahomey),⁷³ Ga chiefs never attempted to appropriate healing power. On the contrary, the first chief of the Ga state, Ayi Kushie, is said to have purposely surrendered the sacred rites of the state to the priestly classes of the *wulomei* in the 15th century, as a means of freeing himself from the taboos related to the local deities.⁷⁴ The division of the political sphere from the spheres of religion and healing meant that practitioners of the healing arts were able to maintain the power to name, explain, and fight illness in Accra without interference from the state. Additionally, even though British medical officials did aspire to achieve medical hegemony, the financial impossibility of rebuilding the city of Accra according to the dictates of sanitation theory, the distinct lack of interest by colonial governors in ameliorating the health of colonial subjects, and the absence of cures for endemic tropical illnesses such as malaria, made it impossible to permanently establish medicine as a singular healing ideology during the colonial era.

Thirdly, the dissertation will show how the material culture of healing in Accra was diversified by the presence of a growing, changing, and unregulated market in healing

⁷¹Flint, *Healing Traditions*, 67-89.

⁷²John Johnson, *The Epic of Son-Jara. A West African Tradition* (Bloomington, 1986), 43-45; D. T. Niane, *Sundiata, an Epic of Old Mali* (London, 1965 [2001]), 70-71; Lansiné Kaba, "The Pen, the Sword, and the Crown: Islam and Revolution in Songhay Reconsidered, 1464-1493," *Journal of African History* 25, no. 3 (1984), 250.

⁷³David Ross, "European Models and West African History: Further Comments on the Recent Historiography of Dahomey," *History in Africa* 10 (1983), 296; Richard Burton, *A Mission to Gelele, King of Dabomey* 2 (London: Tylston and Edwards, 1893), 21.

⁷⁴Quarcoopome argued that the taboos imposed on priests were too strict to allow them to play a secular role as brokers of transatlantic trade in the Ga territories. Samuel S. Quarcoopome, "The Impact of Urbanization on the Sociopolitical History of the Ga Mashie of Accra: 1877-1957" (Ph.D. Thesis, Institute of African Studies, University of Ghana, 1993), 115.

products. As a port city on the Atlantic coast, and as a commercial outlet for the kingdoms of Denkyira, Akwamu, and Asante, Accra became a hub for the export of gold, ivory, slaves, and for the import of goods such as cloth, guns and alcohol.⁷⁵ To these commodities were added healing reagents, such as herbs, roots, tree barks, and animal parts, shipped north and south along the inland trade routes. Herbalists in Accra also adopted medicinal flora from Asia (such as the leaves of the neem tree) and the New World (including roots like sarsaparilla). And in the 20th century, residents of the city started buying and selling patent medicines and pharmaceuticals in the marketplaces with only cursory monitoring by British medical authorities. Additionally, sufferers of illnesses in the city sought out the healing power of gods and goddesses from the West African littoral, from the Guinea rainforest, and from the savannah beyond the rainforest, making it a hub for what John Parker has described as the “thriving cross-cultural trade in ritual commodities” in West Africa.⁷⁶

Fourthly, the dissertation will describe how urban spaces have dictated relationships of health and healing in the city of Accra. Since its founding as the Ga capital in 1677, the city has been slowly aggregated as a series of neighbourhoods, or *akentsei*, each with ethnic lineages. All of these urban quarters adopted the umbrella Ga identity after generations of settlement, but they also remained loyal to the different gods and goddesses that they brought to Accra, some of which were used to heal specific problems. For example, Fante fishermen brought their own gods related to making a living on the sea, while Akwapim

⁷⁵ Records of the Royal African Company show that Accra was known in the 17th and early 18th century as a centre for the gold and ivory trade, with slaves being a third-ranking commodity. Fisher ed., “A Description of the Castle’s Forts and Settlements Belonging to the Royal African Company Of England on the Gold Coast” in *Extracts from the Records of The African Companies*, 107; for details on the goods traded at Accra in the 17th century see Kea, *Settlements, Trade, and Politics*, 216-23 and Anquandah, “The Accra Plains,” 4-5; Bosman, *New and Accurate Description of the Coast of Guinea*, 70.

brought deities used to fight witchcraft. In the 19th century, the city became further subdivided when the Christian population (made up mostly of Ga and Akan-speakers) self-segregated itself into the Basel Mission “saalem” in 1827,⁷⁷ the Muslim *zoygo* (a multiethnic neighborhood of Hausa, Yoruba, and Ga residents) started to grow just north of Ussher Town in the 1850s,⁷⁸ and the British built a “European reservation” (exclusively for white officials) in the 1880s,⁷⁹ followed by the walled campus of Korle Bu hospital in 1923.⁸⁰ These spatial divisions segmented the city along both religious and medical lines, and offered spatial domains within which healers could distinguish themselves geographically and professionally. However, though the city could be mapped according to the contours of healing knowledge and power, patients were never segregated. Despite some attempts by the colonial government to control the movement of peoples around the city, those who were suffering with sicknesses were always free to move in and amongst different arenas of practice in their search for therapies, sustaining and knitting together African healing practices, Islamic healing, Christian faith-healing, and the medicinal products available in the

⁷⁶ John Parker, “Witchcraft, Anti-Witchcraft and Trans-Regional Ritual Innovation in Early Colonial Ghana: Sakrabundi and Aberewa, 1889-1910,” *Journal of African History* 45, no. 3 (2004), 395.

⁷⁷ Jon Miller, *Missionary Zeal and Institutional Control: Organizational Contradictions in the Basel Mission on the Gold Coast 1828-1917* (Cambridge: Routledge, 2003).

⁷⁸ K. O. Odoom, “A Document on Pioneers of the Muslim Community in Accra,” *Institute of African Studies: Research Review* 7, no. 3 (1971), 3; Spelling from Dakubu, *Ga-English Dictionary*, 76.

⁷⁹ Raymond Dumett notes that Europeans retreated to a suburban reservation (by the advice of colonial physicians) rather than create African locations as the government did in the Republic of South Africa. Dumett, “The Campaign against Malaria,” 170.

⁸⁰ C.C. Reindorf, *The History of the Gold Coast and Asante: Based on Traditions and Historical Facts Comprising a Period of More Than Three Centuries from About 1500 to 1860* (Accra: Ghana Universities Press, 1966), 218; John Parker, *Making the Town: Ga State and Society in Early Colonial Accra* (Portsmouth, NH: Heinemann, 2000), 157; Odoom, “Document on Pioneers,” 3; the spelling of *zoygo* is from Dakubu, *Ga-English Dictionary*, 76; Korle Bu Hospital. *Korle Bu Hospital. 1923-1973. Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir* (Accra: Advent Publishing, 1973), 141.

marketplace, even during the height of colonial medical power during the mid-twentieth century.

Section 5. Chapter breakdown.

Chapter 2 will begin with the demise of the former capital city of the Ga, Ayawaso, an inland market town with an estimated population of 20,000 people. Known to Europeans as “Great Accra,” Ayawaso collapsed when it was sacked by the armies of the Akwamu Empire in 1677, a traumatic event in Ga history that triggered the flight of thousands of refugees to the coastal village of Accra on the Atlantic Ocean. At this time, the vast majority of residents of the new coastal capital were Ga-speakers who conceptualised illness and health largely within the Ga lexicon. Over time, Akan notions of disease causality (and, to a lesser degree, concepts of healing found in neighbouring Ewe and Hausa languages) did find their way into Ga healing terminology, offering Ga-speakers a diversity of ideas with which to conceptualize the forces that caused ill health. However, despite the fact that Ga-speakers borrowed healing ideas from other West African cultures, there was little transatlantic dialogue about healing with Europeans during the slave trade. This chapter will demonstrate how high death rates for Europeans, and a high degree of occupational chauvinism by both African healers and European surgeons, limited the exchange of ideas and practices between Africans and Europeans in Accra. The only component of African healing that changed due to contact with Europeans during this period was herbalism, as practitioners selectively adopted medicinal flora from Asia and the Americas. Included in this chapter is a discussion of plants from around the world that herbalists incorporated into the repertoire of plant medicines in Accra.

The third chapter will cover the 1850s to 1908, a period when three major strands of healing practice were emerging in Accra. The prominence of therapists who used healing techniques drawn from Muslim traditions began to grow in Accra during the late 19th century as trade links with Islamic communities the interior, in neighboring Nigeria, and in Brazil began to grow. At the same time, pastors at the Basel Mission, with the help of local catechists, translated the Bible into Ga, which offered new ways for patients to conceive of misfortune and illness. Surgeons and physicians remained a tiny minority in the city at this time and the high death rate for Europeans continued to impinge on the establishment of European medicine. Even when Christian catechists adopted European surgical techniques, they were unable to heal the illnesses of the tropics. In 1877, the professional status of surgeons as colonial state-endorsed healers did strengthen when the British chose Accra as the new capital of the Gold Coast Colony, but at just as colonial doctors established themselves as providers of health care endorsed by the colonial state, European medical ideas and practices began to change, lending new authority to sanitary science and laboratory science. Bacteriology began to challenge humoral theory, creating contradictions in disease causalities that became evident during the bubonic plague epidemic of 1908. Though the British were able to construct suburban enclaves for colonial officials east of the old city of Accra, their attempts to demolish and rezone the urban core were resisted vociferously by the residents of Accra. This chapter will conclude by showing how, at the start of the 20th century, the reach of the colonial medical state remained quite modest. Meanwhile, Ga and other African healers, as well as practitioners using Islamic medicines, continued to serve patients in the city, while residents were increasingly interested in European patent medicines as cures for their personal ills.

The fourth chapter will cover the period of 1908-1939, a time of rapid economic growth due to a rise in cocoa exports from the port of Accra. This was an era of colonial modernity, a time British medical officials voiced aspirations to rebuild the capital city of the prosperous colony according to the dictates of sanitary science and medicine. But in practice, the Gold Coast Government largely employed low cost strategies of remaking the urban landscape to facilitate health, relying largely on the segregation of the white population in a new residential neighbourhood outside the city. The result of segregation was that the old Accra neighbourhoods of James Town and Ussher Town, once the centre of interactions between Europeans and Africans in the city, became spatially delineated as unsanitary and unhealthy. Also included in this chapter is a re-reading of Margaret Field's 1937 *Religion and Medicine of the Gã People*: firstly as a body of data that demonstrates how the core principles of Ga healing continued to thrive in the city, and secondly as colonial text that unwittingly attempted to conceal the changes wrought by colonial modernity.⁸¹ Finally, the story of the dramatic expansion of the market for patent medicines will be covered. These medicines were consumed as markers of social sophistication for the aspirant class, and they created new avenues of class distinction for the growing cadres of African clerks and professionals. However, in some interesting cases they were also re-inscribed with local meanings by patients, and used in unexpected ways. For example, Atwood Bitters, a British made laxative, took on a new meaning as a fertility medicine in Accra because of its association with locally brewed herbal bitters. The chapter will conclude by arguing that medical modernity in Accra was remade by local residents to fit into their pluralistic outlook on healing.

⁸¹ Margaret Field, *Religion and Medicine of the Gã People*, (London, Oxford University Press, 1937).

Chapter 5 documents the construction of the Gold Coast Hospital in 1923, which quickly became the largest British colonial medical institution in West Africa. Physically removed from the city core to a neighbourhood across the lagoon called Korle Bu, the Gold Coast Hospital represented an attempt by the Medical Department to offer a distinct alternative to African ideas about healing. Though most patients only attended the Gold Coast Hospital for cures for specific illnesses like yaws and syphilis, the institution was most remarkable in the way it facilitated the development of a class of African doctors, nurses and dispensers, who took on the role of bearers of the culture of colonial medicine in Accra. The chapter will cover the gender and racial divisions that developed within the new colonial medical system, the reactions of patients to the new types of therapies provided at Korle Bu, and the establishment of a colonial culture of maternity in Accra. However, once again, though the Gold Coast Hospital offered a foothold for colonial medicine on the edge of the city, it operated only in the context of a pluralistic healing society, where the four other strands of healing practice continued to thrive, as is evident from accounts of the doctors and nurses who worked there, and in the actions of the patients who attended the hospital. In fact, despite the colonial rhetoric surrounding the establishment of the Gold Coast Hospital, and the significance of the growth in a new African class of medical workers, patients continued to see visits to Korle Bu as only one choice amongst many healing alternatives in Accra.

The sixth chapter is about a singular event in the history of Accra, the short-lived success and subsequent failure of an Allied anti-malaria campaign during the Second World War. This moment of medical technocracy in Accra was unprecedented and will be used as a case study to address the question of why sanitation and medicine did not eventually dominate the city of Accra to the exclusion of all other healing practices. In 1942, when

Accra became a transit point for Allied aircraft destined for North Africa, British and American malariologists implemented a plan to eradicate the mosquito population by conducting a city-wide campaign to both re-engineer the waterways of Accra and spray the city with DDT. Additionally, they propagated a colonial medical discourse that reduced the inhabitants of Accra into abstracted subjects: individually, as African bodies that carried malaria in their “bloodstream,”⁸² and collectively as a racial reservoir of disease that could be managed according to systems of vector control.⁸³ The immediate effect of the campaign was a rapid decline in malaria amongst allied soldiers, at rates never before seen in the history of healing in Accra. Yet despite the short term success of the campaign, the Government of the Gold Coast was forced to abandon the project when the Americans (and their funding) left in 1944. This chapter will show how the inhabitants of the city continued to suffer from high rates of malaria despite military interventions, and how the technocratic hopes of rebuilding the city according to the rules of medical science were quickly abandoned by a fiscally constrained colonial government. Meanwhile, the practices of African-derived healing, Islamic healing, Christian faith-healing and self-medication survived the war and continued to thrive in the post-war period, unaffected by a brief moment of medical technocratic overrule.

The seventh chapter will review the diversity of healing cultures present in Accra on the eve of independence, based on a 1958 sociological report entitled *Accra Survey*.⁸⁴ The *Survey* showed that, though the influence of colonial medicine was manifested in the form of several hospitals and clinics, dozens of practicing physicians, and the provision of curative

⁸² NARA. R. 705, Vickery, “History of the Medical Section Africa-Middle East,” 213.

⁸³ PRAAD, ADM 5/3/46, *Report on Service Malaria Control* (Accra and Takoradi: Gold Coast, May 1945).

drugs like chloroquine and penicillin, the colonial medical system was still only one choice within with a plurality of other healing options. Active in the city at the time of the *Survey* was a strong network of Ga healers, who plied their trade according to Ga concepts of illness and health. The *Survey* also pointed out several other African-derived influences like Afa divination, acupuncture, and Zabarima cults of affliction, which were brought to the city by immigrants but were adopted as avenues to health by the general population. As the city grew, so did its marketplaces, and this chapter will discuss how the number and variety of patent medicines and pharmaceuticals increased dramatically, and how advertisers began to market these products directly to African consumers. While patients in the city continued to seek bodily and spiritual cures from multiple different sources, they became increasingly interested in bypassing healers in favour of self-care with imported medicines.

The dissertation ends in 1957, the year that the Gold Coast became the independent nation of Ghana, and the conclusion will assess the significance of this period as well as cast a look forward to the postcolonial period. The independence of Ghana, in some ways, is an artificial end point because it did not radically alter therapeutic pluralism in Accra but it does serve as an appropriate ending point for this study for three reasons. First, archival records of medical services and public health are much diminished in the immediate postcolonial period, and their reliability is questionable (a situation greatly lamented by the three major historians of medicine in Ghana). Without adequate documentation, simply continuing the story of biomedicine in the city would require more robust methods of data collection, including a much enlarged oral history project. The second reason why it is necessary to end the dissertation at independence is because the 1950s was a decade of dramatic demographic

⁸⁴ Ione Acquah, *Accra Survey: A Social Survey of the capital of Ghana, formerly called the Gold Coast, undertaken for the West African Institute of Social and Economic Research, 1953-1956* (London: University of London Press Ltd. 1958).

change in Accra, a time when immigration almost doubled the population within a decade (from 200,000 in 1954 to 350,000 in 1964).⁸⁵ The effect of this growth was a reduction of the Ga majority to only 38% of the urban population.⁸⁶ Correspondingly, Ga healers slipped to a minority position, comprising only 43% of all healers following indigenous African healing traditions.⁸⁷ Though they remained arguably the most important subgrouping of healers in the city because they offered a holistic healing based on Ga aetiologies, and though they continued to dominate the provision of health care in the core Ga neighbourhoods of Central Accra, their overall share of patient visits in the city diminished.

A third reason is that independence inaugurated several new storylines in the history of healing in Accra, such as President Kwame Nkrumah's efforts to Africanize the medical system,⁸⁸ the rapid expansion of the market for imported pharmaceuticals from Europe, India and China,⁸⁹ the emergence of chloroquine-resistant strains of malaria, the new wave of so-called "Charismatic" Christian churches and their conflicts with Ga *wulomei*,⁹⁰ the

⁸⁵ Acquah, *Accra Survey*, 31; Accra Metropolitan Assembly. *MCE's message*, accessed March 1, 2011, http://www.ama.ghanadistricts.gov.gh/?arrow=dce&_=3. The Chief Executive of the Accra Metropolitan Assembly, estimated that approximately three million people live in Accra while about one million visit the city for business each day.

⁸⁶ Jolanta Lissowska, "The demographic, social and professional structure of the population of Accra between 1960 and 1970," *Africana Bulletin* 32 (1984), 113-129, cited in Samuel Agyei-Mensah and Ama de-Graft Aikins "Epidemiological transition and the double burden of disease in Accra, Ghana," *Journal of Urban Health* 87, no. 5 (2010), 879-897.

⁸⁷ Acquah, *Accra Survey*, 123. By 1958, Ga healers made up only 45% of all "traditional" healers in Accra. In 1948, the Ga made up 52% of the population of Accra. Considering the growth in immigration and the birth rate of the non-Ga population, by 1957, the Gas would have certainly been in the minority.

⁸⁸ Patrick A. Twumasi and Dennis Michael Warren, "The Professionalisation of Indigenous Medicine: A Comparative Study of Ghana and Zambia," in *The Professionalisation of African Medicine*, ed. Murray Last and G.L. Chavunduka (Manchester: Manchester University Press, 1986), 122.

⁸⁹ Senah, *Money Be Man*, 4.

⁹⁰ Rijk van Dijk, "Contesting Silence: The Ban on Drumming and the Musical Politics of Pentecostalism in Ghana," *Ghana Studies* 4 (2001), 31-64.

collapse of the public medical infrastructure in the 1970s and 1980s,⁹¹ and the subsequent growth in the market for locally produced bottled herbal remedies.⁹² Though they do follow patterns of pluralism established in the past, these postcolonial narratives of healing require separate treatment because the dataset of primary sources and interview evidence is so large.

As a final section of the conclusion, an epilogue will discuss the trends in healing in the Ghanaian capital during the late 20th and early 21st centuries. In particular, it will point out that although the share of patient visits within the Ghana Health Services may have increased during the 20th century, it has not been to the exclusion of other healing traditions. It will be noted that Ga and other African indigenous traditions continue to thrive, and that the therapeutic channels of Christian faith-healing and self-care with packaged medicines have grown even more quickly than the state-supported medical system. In conclusion, the epilogue will demonstrate that different strands of healing practices in the city have not followed fixed trajectories of ascendance and or decline, but rather, have waxed and waned in influence according to political, social and economic trends in the city.

Section 6: Sources -- the Ga language, documents, and oral interviews.

The terminology used by Ga-speakers to refer to healing will be introduced in the second chapter in order to familiarize readers with the basic conceptions of healing in Accra. This lexicon of healing was compiled from three sources: word lists drawn up by Basel missionary Johannes Zimmerman, dictionaries of Ga compiled by linguist Mary Esther Kropp-Dakubu, and through a discussion of healing ideas with healers living in Accra

⁹¹ Govindaraj, Ramesh, et al. "Hospital Autonomy in Ghana: The Experience of Korle Bu and Komfo Anokye Teaching Hospitals." *School of Public Health, University of Ghana* (August 1996), 15-16, 21-22, accessed October 26, 2010, <http://www.hsph.harvard.edu/ihsg/publications/pdf/No-41.PDF>.

⁹² Twumasi and Warren. "Professionalisation of Indigenous Medicine," 117-135.

today.⁹³ An analysis of the healing terminologies within the Ga language cannot offer a precise chronology of change in the history of healing. However, isolating the proto-Ga-Dangme, Akan and Ewe terms within contemporary Ga can tell us how Ga-speakers thought about health, how they conceptualized acts of healing, and how they incorporated concepts of disease and healing from neighboring ethnic groups into their own notions of illness and wellness.

Moreover, knowing the Ga language helped me to understand what it meant to be “healthy” in Accra. The Ga term for health, *bewale*, is expansive in its meaning. It can be used to describe health in the bodily sense (*mi je bewale* - I am well), but it refers to many other things, including access to economic opportunity, the power to grow physically and mentally, and a person’s individual fecundity and fertility. In other words, within the Ga language, there is no mechanistic understanding of a healthy body, nor is bodily stasis a measurable goal. Rather, *bewale* is a constantly shifting state, one without a precise English language equivalent. Using the Ga lexicon of healing and associated loan words, this thesis will show how notions of health in Accra were often comprised of bodily concerns connected to financial, marital, kinship, social, and political health. By the 20th century, other languages began to play a major role in defining notions of health, as immigrants from other parts of West Africa arrived in the city, and as English became the language of medicine in Accra, but Ga-speakers did remain in the majority until the middle of the 20th century.

The dissertation is also supported by documentary evidence from the era of the Atlantic slave trade, including letters, journals and travelogues by Dutch, Danish and English travelers. These texts must be utilized with caution because they were part of a slave trade

⁹³ Johannes Zimmerman, *Grammatical Sketch of the Akra or Ga Language including a Vocabulary of the Akra or Ga Language with an Adangme Appendix* (Stuttgart, 1858), Dakubu, *Ga-English*

discourse that generated alterity between Europeans and Africans, but the writings of men like Jean Barbot, Pieter De Marees, Jan Bosman, and Ferdinand Rømer are still immensely important because they demonstrate the centrality of healing in the daily lives of people living in West Africa during the 17th and 18th centuries.⁹⁴ Also useful are the journals and botanical texts of Paul Isert, a Danish surgeon who lived in Accra during the 1790s, which offer insight into the diversity of herbal medicines used by the Ga of Accra and the Twi-speakers along the Akwapim Ridge.⁹⁵

The next set of important documentary records are three major texts written specifically about the Ga ethnic group. Each of them contains vital information about the Ga and, as ethnographic artefacts, they also make a statement about how knowledge about Ga society and culture has been produced over the past 100 years. The autoethnographic *History of the Gold Coast and Asante*, written in 1894 by Accra-born, Basel Mission catechist Carl Christian Reindorf, is a foundational work because it is a compilation of local oral traditions. However, it must also be treated as a product of its era because it narrates the history of the Ga according to a teleological transition from a pagan “fetishcracy” to a

Dictionary; Mary E. Kropp Dakubu, *Korle Meets the Sea: A Sociolinguistic History of Accra* (Oxford: Oxford University Press, 1997).

⁹⁴ In particular Jean Barbot, *A Description of the Coasts of North and South Guinea: And of Ethiopia Inferior, Vulgarly Angola ...* (London: Henry Lintot and John Osborn, 1980 [1732]); Pieter De Marees, *Description and Historical Account of the Gold Kingdom of Guinea (1602)*. Translated from the Dutch and edited by Albert van Dantzig and Adam Jones (Oxford: Oxford University Press, 1987); Ludvig Ferdinand Rømer, *A Reliable Account of the Coast of Guinea (1760)*. Translated by Selena Axelrod Winsnes (Oxford: Oxford University Press, 2001); Many of these travel journals have internal contradictions, evidence that they are not exclusively eyewitness accounts and that some claims should be regarded as fabrications. See Gérard Chouin, “Seen, Said, or Deduced? Travel Accounts, Historical Criticism, and Discourse Theory: Towards an “Archeology” of Dialogue in Seventeenth-Century Guinea,” *History in Africa* 28 (2001), 53-70.

⁹⁵ Selena Axelrod Winsnes, *Letters on West Africa and the Slave Trade: Paul Erdmann Isert’s Journey to Guinea and the Caribbean Islands in Columbia (1788)* (Oxford: Oxford University Press, 1992).

Christian modernity.⁹⁶ A later ethnography of Ga religion and healing by Margaret Field, researched in the 1920s and written in the 1930s, also includes immense detail about Ga religious and healing practices. However, as a contribution by a co-opted colonial official to the nascent field of anthropology, it deployed an ethnographic gaze that searched for a “true Ga” -- an ethnic essence devoid of the influences of years of commercial activity and colonial rule.⁹⁷ The ethnomusicology of Marion Kilson from the early 1970s is also useful as a type of rescue ethnography that offers oral tradition through song.⁹⁸ Kilson’s interpretations of the songs sung by Ga elders and priests show how Ga ethnic identifications are often connected to religion and to healing, and how they also expose the gender divisions found within Ga religion and society. Kilson’s work also represents a search for the essentials of Ga-ness (Kilson makes claims about the collectivity of the ethnic group by stating what the “Ga say” without offering specific references) but it remains an important element in understanding how Ga-speakers have constructed their political, social, gender, religious and medical identifications.⁹⁹ These ethnographic texts must obviously be taken in their particular contexts and should not be used to tribalize the Ga, but they remain essential in understanding the construction of the Ga identity.

Colonial government documents are also fundamental sources for the history of healing in Accra. In particular, the records held at the Public Records and Archives Administration, or PRAAD, contain the files of Gold Coast Medical Departments and the Accra District Commissioner, which include letters, memos, dispatches, and ordinances containing vital information about the daily lives of healers and patients. There are also many volumes of court records held at PRAAD that contain information about healing. Though they are

⁹⁶ C.C. Reindorf, *History of the Gold Coast*, 105, 109.

⁹⁷ Field, *Religion and Medicine of the Gã People*, 85.

⁹⁸ Marion Kilson, *African Urban Kinsmen: The Ga of Central Accra* (London: Hurst, 1974).

filtered through the translations of court recorders, and largely represent appeal cases brought forward by people with the financial and social capacity to appear in front of a British magistrate, the details of these cases offer a window into the ideas, practices, and material culture of healing in Accra. Considerable gaps in the colonial record remain. For example, there are few documentary sources on the city between 1810 and the 1850s (a time of relative economic stagnation) leaving a half-century gap of information on healing after the abolition of the slave trade. Additionally, the British did not establish a court in Accra until 1850, and even after this period (since cases were restricted to criminal offenses) the information they contain about healing is sparse.¹⁰⁰ As such, the first half of the 19th century is a period that must be knitted together with the few source materials available.

The colonial documentary materials from the 20th century are much richer, and this dissertation takes advantage of two particular archival fonds that describe the expansion of colonial medicine from the 1920s to the 1950s. The first is the account of the antimalaria campaign of the Second World War, found in the extant records of the Inter-Allied Malaria Control Group at PRAAD.¹⁰¹ This collection of military documents and entomological reports is an unabashed account of the objectification of the colonial subject during a period of medical technocracy in the city that lasted less than a few years. The reactions by the local population to the dredging and spraying campaigns are only obliquely referred to, but careful reading of the documents offers evidence of local resistance to the anti-malaria campaign. The second is the *Korle Bu Hospital Golden Jubilee Souvenir*, which contains dozens of oral memories of the early years at the Gold Coast Hospital, including accounts from former

⁹⁹ Kilson, *African Urban Kinsman*, 81.

¹⁰⁰ Roger Gocking, *Facing Two Ways: Ghana's Coastal Communities under Colonial Rule* (Lanham, Maryland: University Press of America, 1999), 250-1.

¹⁰¹ PRAAD, ADM 5/3/46, *Report on Service Malaria Control*

employees.¹⁰² Published in 1973, a time when funding for the Ghanaian medical system was in rapid decline, it contains memories of the early years of the most important medical institution in the country. Though couched with tropes of nostalgia, the booklet is a repository of reminiscences, both bitter and sweet, that demonstrate how colonial medicine was used to justify colonial rule, and how the medical professions offered upward mobility to the aspirant classes of the Gold Coast.

Three books written by physicians also play a fundamental role in the dissertation because they offer a narrative skeleton for colonial medical activity in the city. The aforementioned publications of British epidemiologists, K. David Patterson and David Scott (both of whom worked and conducted research in the Gold Coast Colony during the last decade of colonial rule) provide a statistical foundation for understanding the epidemiology of the city during the first half of the 20th century.¹⁰³ The third is Professor Stephen Addae's published dissertation/textbook which is regarded as the seminal work on the history of medicine in the Gold Coast.¹⁰⁴ Another influential document, one that will be sourced extensively in chapter 7, is the aforementioned *Accra Survey* by Ione Acquah, an immensely rich sociological study conducted in the mid-1950s and published in 1958.¹⁰⁵ Acquah considered the provision of health care central to her assessment of city, and has bequeathed to historians a wealth of quantitative and qualitative data that about healing on the eve of Ghanaian independence. Written biographies about the transition of colonial medical authority into the hands of British-trained African medical elites also figure prominently in the latter part of the work, including individual memoirs by doctors, as well as a collective

¹⁰² *Golden Jubilee Souvenir*.

¹⁰³ Patterson, *Health in Colonial Ghana*; Scott, *Epidemic Disease in Ghana*.

¹⁰⁴ Addae. *The Evolution of Modern Medicine*; also very useful was Stephen Addae, *The Gold Coast and Achimota in the Second World War* (Accra: Sedco, 2004).

¹⁰⁵ Acquah, *Accra Survey*.

biography of Gold Coast physicians by Adell Patton, Jr.¹⁰⁶ These accounts demonstrate how the practices of medicine and the narrative of medical progress were appropriated by African-born physicians who trained in Europe, and then returned to work in Accra.

Over the course of seven years, I conducted over 100 interviews with shrine priests, spirit mediums, herbalists, diviners, pharmacists, doctors, nurses and people who had been their patients. Parts of these interviews were conducted in English, the official language of Ghana, but Ga healers and patients still conceptualise and express ideas about sickness and health within the Ga language. As such, these interviews required translation and cultural interpretation, for which I must thank Nii Oshiu Richard Codjoe (the Secretary of the Sakumo Shrine), Ebenezer Abiase and Abigail Biney (both Ga-speaking residents of Accra), who aided me during my research. Not only did they provide translations, they offered interpretations that produced rewarding discussions about healing terminology and disease causality.

Due to the potential for exploitation of research subjects, the academic community maintains rigid ethical barriers to protect patients who may be in vulnerable states of health. In order to conform to standard research protocols, all of the participants I interviewed were screened beforehand to ensure that they were in control of how much or how little they wanted to participate, and I did not interview anyone who fell into the category of a “vulnerable population.”¹⁰⁷ Unfortunately, this eliminated interviews with people who were

¹⁰⁶ Reverend Dennis Kemp, *Nine Years at the Gold Coast* (London: Macmillan and Co., 1898); M. A. Barnor, *A Socio-medical Adventure in Ghana: Autobiography of Dr. M.A. Barnor* (Accra: Vieso Universal, 2001); Patton, *Physicians, Colonial Racism, and Diaspora in West Africa* (Gainesville, FL: University of Florida Press, 1996).

¹⁰⁷ In the Canadian Federal Government Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, a vulnerable population is referred to as “those whose diminished competence and/or decision making capacity make them vulnerable.” For point by point description of the principles with which the Board assesses research proposals, see

sick, who were seeking therapy, or who were recovering from illness. However, it was possible to interview many people in Accra who had been patients in the past, and had since recovered. Many were willing to discuss the way that they took on the role of being sick, the ways that they conceptualized illness, and the way that they selected healers and chose therapies. Also, although I was unable to interview their patients directly, the healers I met with offered rich details about their relationships with patients, the way that patients selected therapies, the competition amongst healers for patients, and the reasons for the sustenance of a pluralistic healing culture in the city.

The selection of interviewees was not scientific, but it was comprehensive. I started in 2002 at the major shrines, conducting interviews with priests, then asked around and made contacts with as many healers as I could find in James Town and Ussher Town. I interviewed anyone who self-identified as a healer and who was interested in discussing their trade, and then followed through by meeting with any former patients who were willing to discuss the therapies that they had undertaken. I also interviewed many nurses and physicians who had worked at Korle Bu. The interviews were usually about an hour long, and they mostly took place in the houses or family compounds of the interviewees. The strategy for each initial meeting was to cover the basic questions about the background of the interviewee and to ask them to discuss their understandings of illness and wellness, and their knowledge of local healing practices. Many of the interviews turned into general conversations about the vagaries of spiritual illnesses and the difficulties of keeping healthy. Some healers were forthcoming about their ideas about healing and the historicity of practice, while others were more guarded about revealing healing practices that they considered proprietary. Some former patients were also reluctant to discuss the varieties of

Government of Canada. *Panel on Research Ethics*, accessed January 3, 2008.

therapies that they had sought, while others were quite willing to list the types of healers that they had visited. About one quarter of interviewees were interested in discussing healing enough so that I could arrange subsequent meetings, and I developed cordial relations with many people in and around the old quarters of James Town and Ussher Town, with whom I could visit without an appointment. I ensured that all of the people I interviewed that the information I was gathering would not be replicated or exchanged in a way that would violate what they considered to be their intellectual property. I continued collecting interview evidence until 2010, over the course of five visits to Accra.

Most interviewees were willing to discuss healing without remuneration. In particular, the doctors, nurses and most of the former patients that I spoke to did not consider it appropriate for me to offer money for their time (and they did offer me hours and hours of their time in some cases, which was very much appreciated). However, most of the African healers that I interviewed requested remuneration according to the amount they would have received for tending to a sick client. Between 2003-2010, this rate averaged at \$15 (USD) per hour for priests, spirit mediums and herbalists, sometimes with the addition of a gift of schnapps or whisky and additional payments for any materials used to demonstrate the production of medicines. Additionally, to gain permission to visit the shrines of the major gods, I was required to give a sheep or a goat to each shrine, along with gifts of schnapps, cloth and cash. The total for each shrine was \$150. After offering payments, my relationship with healers became less formal, and since I lived in the neighborhood, I could drop in on people who I had interviewed before and dialogue with them in a relaxed fashion.

Interpreting oral evidence has its difficulties. The old neighborhoods of Accra are not museums of the past, nor can knowledge gained through interaction with healers and patients be easily read back through time.¹⁰⁸ The city has changed dramatically over the past 300 years, especially in the last half of the 20th century, when the population grew from an estimated 300,000 to over one million.¹⁰⁹ Moreover, the barriers of language translation, cultural interpretation, and occupational secrecy are not easy to overcome for a *blofonyo* (white person) from *ablotsiri* (Europe/the West). But if one is sensitive to these difficulties, the information that can be drawn out of oral evidence is substantial. As Jan Vansina has argued, oral accounts of the past may not conform to Western historicity and chronology but they can still offer tremendous insight into the meaningful experiences of past generations.¹¹⁰ By getting to know people who have overcome illness I learned about myriad techniques of bodily, social and spiritual healing. For example, by shopping at the Timber Market where women sell herbal medicines, I observed what sorts of medicinal plants that sufferers of illness, layhealers and herbalists purchased for both common maladies and for consecrated healing devices. By attending witchcraft trials at the house of the sea goddess, Nai, I was able to recognize that accusations were often a way for a patient to explain the causes of illness. By attending rituals at the home of a local spirit medium, I was able to observe the customary rites of pouring libation, ablution with herbal potions, ritual animal sacrifice, and the songs and incantations that accompanied these practices. And by walking

¹⁰⁸ The term “ethnographic present” has a long lineage in anthropology but was most clearly defined by Johannes Fabian as “the practice of giving accounts of other cultures and societies in the present tense” (Johannes Fabian, *Time and the Other: How Anthropology Makes Its Object* (New York: Columbia University Press, 2002), 80). Fabian considered the practice problematic because the form of ethnographic description freezes time in such a way that historical influences are rendered inaccessible; Roger Sanjek points out how the formal aspects of writing in the ethnographic present can obscure historical change. See Roger Sanjek, “The Ethnographic Present,” *Man* 26, no. 4 (1991), 612-14.

¹⁰⁹ Kilson, *African Urban Kinsmen*, 8; Ghana, *Ghana Statistical Service*, 2010.

around the city with the priests of the shrines, I was able to “read” the stories embedded within mnemonic spirit mounds through the words of the priest’s linguist, as he recalled the historical events associated with each place. In other words, the practical wisdom gained from meeting with these patients and healers has been indispensable.

As stated earlier, there are very few illness narratives to be found within these disparate sources. Individualized, personal perspectives on health from the past can only be found in glimpses, and by way of triangulation. But the plurality of sources used in this dissertation offers a way around the established medical histories of city, colony and country. It is in the bits and pieces -- the lists of herbs, snippets of court records, fragmented oral recollections, and old bottles of medicine -- that the story of therapeutic pluralism emerges.

¹¹⁰ Jan Vansina, *Oral Tradition as History* (Madison: University of Wisconsin Press, 1985), 199.

Chapter 2. Dynamism and Plurality: Health and Healing in Accra from 1677 to the mid-1800s.

In 1780, Jean Barbot, the agent-general of the French Royal African Company, noted that

It ... often happens that one doctor is discharged with a good regard, and another called in his place, knowing well how to manage the superstitious simplicity of his patient. His first act is to condemn all the former physician has done, whereupon new offerings are made, cost what they will, to get what may be had, for fear of being also turned away very shortly, as his predecessor was, and another again brought in, in his stead. For this change of doctors, or physicians, will happen twenty times or more successively...¹

Patronizing in tone, this passage sets up the West African healer as a charlatan and denigrates the patient as a credulous fool. Such is the nature of the discourse about healing found within accounts written by Europeans who visited the West Coast of Africa in the 17th and 18th centuries. Jean Barbot and other European merchants who visited West Africa in the 17th and 18th centuries portrayed Africans as beholden to “fetish” -- a set of superstitions thought to be evidence of the primitive mentality of Africans. The term fetish came from the Portuguese *feitiço*, a late middle-ages term for magical practice that associated the religion and medicine of West Africa with heretical practices of diabolism and malificium. Of course, European travelers were merely imposing the context of the European reformation on their cultures, as William Pietz has so clearly argued in his three articles on the “problem of the fetish.”² But though historians now realize that they must lift the veil of fetish to understand the lived experiences of people in West Africa in the early modern period, they

¹ Barbot, *Description of the Coasts of North and South Guinea*, 280.

² Pietz, “The problem of the fetish, I,” “The problem of the fetish, II,” “The problem of the fetish, IIIa.

have yet to read through European sources in order to unpack the dynamic content of West African societies during this time period.

This chapter will reassess the history of healing on the Gold Coast by reexamining the European travelogues of the 17th and 18th centuries, starting the same quote from Barbot, which offers two key insights about the nature of healing in West Africa. The first insight is that, quite simply, there were many African healers resident on the Gold Coast. Patients could access multiple types of therapies, in the form of different deities, different practices, different herbal regimens and different consecrated medicines. This plurality of healing methods was not the result of a band of fraudulent quacks lining up to deceive credulous patients, but the outcome of circulation around West Africa of many different ideas about health and healing. The second insight is that patients had the power to choose between practitioners and healing systems. With pluralism came choice, and with choice came the power to hire healers who promised to cure and to fire those who failed to do so. When Barbot's statement is correlated with data derived from historical linguistics, archeology, and botanical records, it is further evident that there was no prototypical West African ethnomedicine or "fetish" culture on the Gold Coast the early modern period. Rather, the healing culture of the region was both dynamic (due to the rapid changes that occurred during the era of transatlantic slave trade) and pluralistic (because the many types of healing from each part of West Africa aggregated together in places like Accra).

The chapter is divided into five sections. The first section draws on the documentary evidence, the archeological record, and oral tradition to provide a narrative of the history of Accra from 1677 to the early 1800s, a time when the city became increasingly connected to distant regions of West Africa and to the broader Atlantic World. The second section unpacks different components within the Ga healing lexicon, demonstrating how the

terminology of healing is comprised of a plurality of Ga-Dangme, Akan, Ewe and Hausa influences. The third outlines the major practices of healing in Accra, including deity worship, spirit possession, dancing, drumming, animal sacrifice, libation, and ritual surgery, and argues that these practices accumulated in the city from a variety of sources and that practitioners altered their customs to the patterns of political, economic and social change. The fourth section shows how Accra, as a nodal point in the transatlantic commercial circuit, became a clearinghouse for herbal simples harvested from around West Africa, as well as a place where people appropriated medicinal flora from Asia and the Americas. It will also show how a market for commodified healing ingredients coexisted with a demand for consecrated healing devices. The fifth section demonstrates how even European sailors and soldiers, realizing that their own ship's surgeons could not keep them alive in the tropics, embedded themselves within the diverse healing networks of the city. As a result, European medicine survived only as a marginal component of the larger pluralistic healing network of Accra.

Section 1. The Transformation of Accra into a Polyglot Trading Centre

The Accra Plains, the dry grasslands that slope southward from the Akwapim Ridge to the Atlantic Ocean, have been inhabited by humans since approximately 4000 BC.³ According to oral traditions, Ga-speakers migrated to the area from the east (possibly from what is now Nigeria) and settled in a series of coastal communities stretching from Tema to Langma, in an area already occupied by the speakers of Guang family of languages.⁴ Oral evidence for this migration does not include dates, but archeological evidence suggests that Ga-speakers established a capital city at Ayawaso around 1400 A.D., on the edge of Akan-

³ James Anquandah, *Rediscovering Ghana's Past* (London: Longman, 1982), 115.

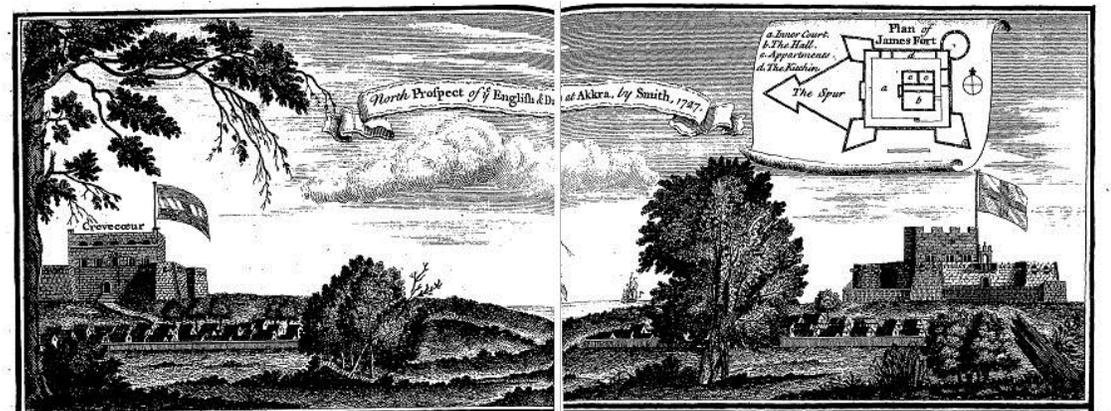


Figure 2.1. “North Prospect of the English and Dutch at Akkra, by Smith, 1727.”

Though the villages of “Little Accra” on the Guinea Coast were probably not as neatly defined as they appear in this stylized print, there were distinct identities held by people living in the shadows of each fort. At the base of Fort Crevecoeur is the village of *Kinka*. The inhabitants of this part of Accra claim first-comer status as the original Ga-speaking inhabitants of the city, and their oral traditions recall a strong trading connection with the Dutch.⁵ Across the small valley to the right is the village known as Ngleshi (a local pronunciation of “English”) which was established when the James Fort was constructed. Both of these towns were comprised of different sub-quarters (*akutsei*), each with a distinct history connected to the ethnicity of its founders. *Source*: map from Thomas Astley, *New General Collection of Voyages and Travels*, 2 (London, 1745), 616-7.

⁴ C.C. Reindorf, *History of the Gold Coast*, 101.

⁵ Interview, Nai Wulomo, August 5, 2002. The Nai coat of arms depicts a meeting between the Dutch merchant Jan Pranger and Nii Boi Tono III, the priest of the Nai shrine.

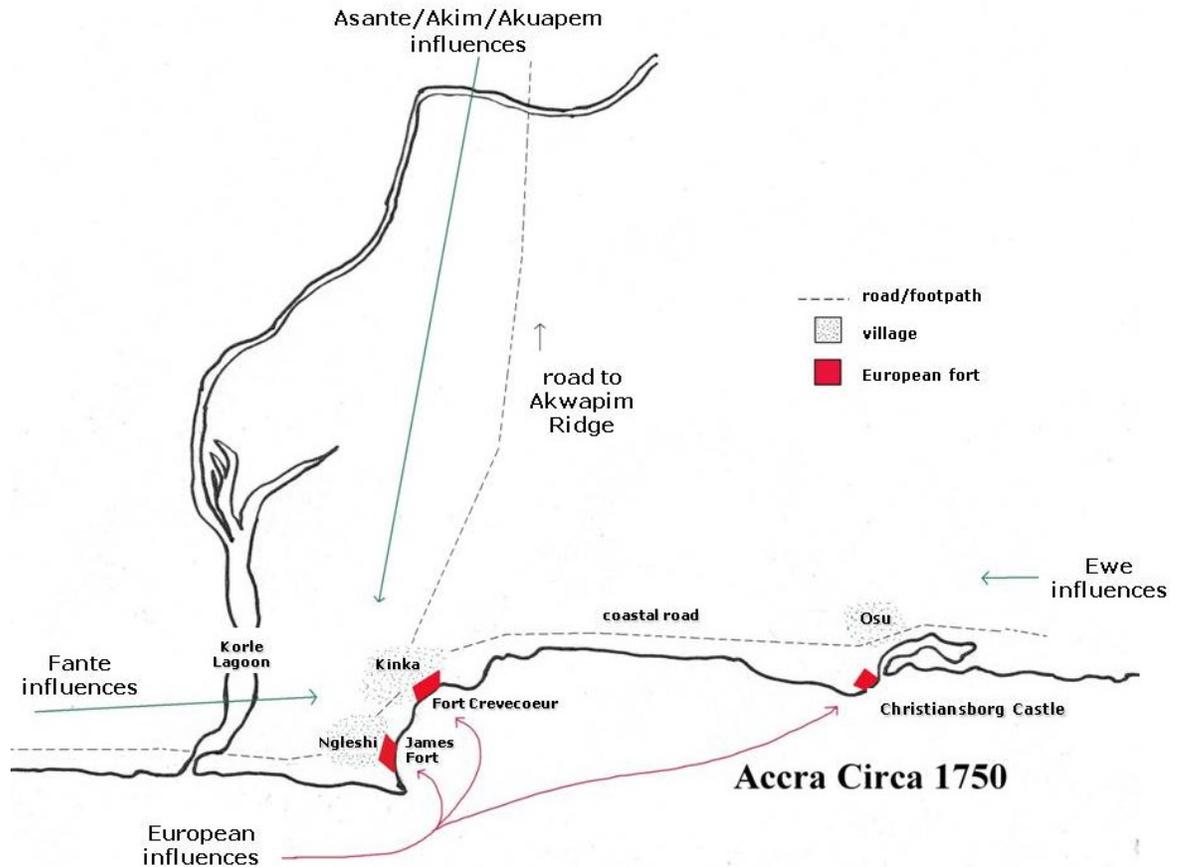


Figure 2.2. Map of Accra, circa 1750. Only three tiny outposts of European medical influence existed in the city during the slave trade, and Ngleshi, Kinka and Osu were spatially distinct. The path to the Akwapim Ridge was an established trading route, one that would have been used to convey herbal simples back and forth from the rainforest and further savannah regions of West Africa. At this time, villages on the Akwapim Ridge (such as the market at Aburi) were points of exchange where merchants traded European goods like cloth, guns and liquor for slaves, gold and ivory. Akan traders were likely resident in Accra, as were Akan-speaking immigrants who had moved to the city after the fall of Ayawaso. Ewe and Fante influences would have arrived with immigrants, merchants and fishermen from the along the coast. *Source:* map by author.

speaking territory at the base of the Akwapim Ridge.⁶ From their inland capital (known to Europeans as “Great Accra”)⁷, Ga merchants were able to control the gold trade moving south from the Akan rainforest and the salt trade from the lagoons of the coast. The diversity of this commerce supported a large marketplace, which made Ayawaso a cultural crossroads for Guang, Ga, and Akan languages.⁸ The population of Ayawaso grew further in response to an increasing trade with Europeans along the Atlantic coast, first with the Portuguese, who established a trading post near the Korle Lagoon sometime during the 1570s,⁹ and later when the Dutch built Fort Crevecoeur in 1642, the Danish built Christiansborg Castle in 1661, and the English built James Fort in 1672.¹⁰ The new fortresses transformed Accra into an outpost for the traffic in human bodies, making it a key part of what archeologist James Anquandah has called a “slave trade economic revolution”

⁶ Jean Barbot, *Barbot on Guinea: The Writings of Jean Barbot on West Africa. 1678-1712*. Edited by P.E.H. Hair, Adam Jones and Robin Law (London: The Hakluyt Society, 1992), 430, fn 441; Odotei, “Pre-colonial activities of the Ga,” 67.

⁷ Jean Barbot referred to the inland capital of the “kingdom of Acra” as “Great Acra,” which he said was “inland at the foot of the mountains which can be seen from the sea.” Barbot, *Barbot on Guinea*, 430. In a treaty between King Okaikoi and the Danish Africa Company, the inland capital of the Gas was called “Great Acra.” Ole Justesen and James Manley, *Danish Sources for the History of Ghana, 1657-1754* 30, no. 1 (Copenhagen: Kgl. Danske Videnskabernes Selskab, 2005), 12.

⁸ C.C. Reindorf, *History of the Gold Coast*, 97. See also Wilks, “Rise of the Akwamu Empire,” 104; Ray Kea, *Settlements, Trade, and Politics in the Seventeenth-Century Gold Coast* (Baltimore: Johns Hopkins University Press, 1982), 36; Dakubu, *Korle Meets the Sea*, 105; Anquandah, “Accra Plains,” 3.

⁹ Anquandah, *Rediscovering Ghana’s Past*, 117. Slightly different dates (according to when construction commenced or was completed) are given in: Albert Van Dantzig, *Forts and Castles of Ghana* (Accra: Sedco Pub Ltd, 1999), 8; C.C. Reindorf, *History of the Gold Coast*, 24. Reindorf notes that the fort was built with the help of some Fante merchants.

¹⁰ Parker, *Making the Town*, 10. The Portuguese built a trading post in Accra in the early or mid-16th century (De Marees, *Gold Kingdom of Guinea*, 85). The English built a post in 1650, which later became James Fort. The Dutch built a slave post in the city in 1642, then enlarged it and named it Fort Crevecoeur, in 1652. In 1868 it was sold to the British and renamed Ussher Fort. The Danes took control of an old Portuguese fort at Osu in 1657, rebuilt it and named it Christiansborg Castle. It was bought by Britain in 1850. For further information on the slave forts of Ghana see Van Dantzig, *Forts and Castles of Ghana*.

on the Gold Coast of Africa.¹¹ The new commerce in slaves also encouraged the settlement of merchant and working classes in Accra, bringing Ewe and Fante migrants to the city.¹²

The inland capital at Ayawaso prospered until the end of the 17th century when, weakened by internal political disputes, the Ga were unable to defend themselves against an uprising by the vassal state of the Akwamu.¹³ In 1677, the armies of the Akwamuhene, Afera Kuma, marched south from the rainforest and, after a series of battles, conquered Ayawaso and took control of the trade routes from the coast to the interior.¹⁴ Refugees from the ruined city fled south to satellite villages along the coast, the majority seeking shelter at a pair of hamlets built in the lee of Fort Crevecoeur and James Fort.¹⁵ Their respite was brief. In 1680, the Akwamu armies attacked again, sacking and burning the Ga coastal villages. The Dutch and British protected some of the inhabitants by housing them in their forts,¹⁶ but many were forced to flee to neighboring chiefdoms along the coast.¹⁷

¹¹ Anquandah, "The Accra Plains," 3.

¹² The British imported Yoruba-speakers from the vicinity of Lagos to help construct James Fort. The descendants of these migrants claim the Alata quarter of James Town as their ancestral neighborhood, and are remembered in Ga songs as migrants who became Ga-speakers. C.C. Reindorf, *History of the Gold Coast*, 40; Marion Kilson, *Kpele Lala: Ga Religious Songs and Symbols* (Cambridge, MA, 1971), 269.

¹³ C.C. Reindorf, *History of the Gold Coast*, 33-34.

¹⁴ C.C. Reindorf, *History of the Gold Coast*, 20, 25. The precise date of the fall of the inland capital of the Ga is unclear because disputes between the Akwamu and the Ga carried on for at least three decades in the mid-17th century. Carl Christian Reindorf dates the defeat by the Akwamu armies and the subsequent suicide of King Okaikoi at June 20, 1660 (C.C. Reindorf, *History of the Gold Coast*, 34) and Irene Odotei dates the fall of Ayawaso at 1680 (Odotei, "Pre-colonial Economic Activities of Ga," *Research Review* (NS), Michigan State University 11, no. 1 & 2 (1995), 69. The date of 1677, however, is agreed upon by scholars such as Ivor Wilks, Marion Kilson and Emmanuel Akyeampong as the date the fall of the inland capital (Ivor Wilks, "The Rise of the Akwamu Empire, 1650-1710," *Transactions of the Historical Society of Ghana* 3 (1957), 104; Kilson, *African Urban Kinsmen*, 5; Emmanuel Akyeampong, "Bukom and the Social History of Boxing in Accra: Warfare and Citizenship in Precolonial Ga Society," *The International Journal of African Historical Studies* 35, no. 1 (2002), 40-41).

¹⁵ C.C. Reindorf, *History of the Gold Coast*, 38-39.

¹⁶ Thomas Astley, *New General Collection of Voyages and Travels*. 2. (London, 1745), 618.

Some merchants took refuge to the east at Popo and Whydah, while the King of Accra travelled west to seek protection with the King of Fetu, near Cape Coast.¹⁸ These years of exile and turmoil are memorialised in Ga songs and oral traditions as a period of mixing of peoples, languages and cultures.¹⁹ When the coastal villages near the European slave forts at Accra were rebuilt several years later, they replaced Ayawaso as the political capital of the Ga, and merchants in Accra became increasingly involved in trading slaves and gold for European imports such as cloth, guns, and liquor.²⁰

The immigrants from Ayawaso settled in three distinct neighborhoods in Little Accra, each established according to commercial associations with European slave traders: James Town (known as English Accra or in Ga, Ngleshi) at the base of James Fort;²¹ Ussher Town

¹⁷ For a discussion of the movement of the Ga diaspora around the Gold Coast and Benin, and the settlement of different clans and armies in Accra, see C.C Reindorf, *History of the Gold Coast*, 36-43; Dakubu, *Korle Meets the Sea*, 147.

¹⁸ The English aided refugees after the sacking of the inland Ga capital, but then switched their allegiance to the Akwamu when they realized that the trade routes were no longer under the control of Ga merchants. K.Y. Daaku, *Trade and Politics on the Gold Coast 1600-1720* (Oxford: Oxford University Press, 1970), 154; Bosman, *New and Accurate Description of the Coast of Guinea*, 61.

¹⁹ For examples of *kpele* songs that refer to the destruction of “Great Accra” as a time of mixing of people, languages, cultures and religions see Kilson, *Kpele Lala*, 259-60; for an 18th century European account of the invasion of Accra by the Akwamu see Rømer, *Reliable Account of the Coast of Guinea*, 116-21; Bosman describes the people of Accra as the “Coast Negroes” who are either born in the city or “come from other places hither to live,” Bosman, *New and Accurate Description of the Coast of Guinea*, 70.

²⁰ Bosman, *New and Accurate Description of the Coast of Guinea*, 70; Fisher, ed., “A Description of the Castle’s Forts and Settlements Belonging to the Royal African Company Of England on the Gold Coast” in *Extracts from the Records of The African Companies*, 107; Kea, *Settlements, Trade, and Politics*, 216-23; Anquandah, “The Accra Plains,” 4-5; for some primary documents mentioning the grain and livestock trade, see Fisher ed., “Winnebah 21 Dec. 1773. Thomas Westgate to “Dear Dick” (Richard Brew at Annamaboe),” in Ruth A. Fisher, *Extracts from the Records of the African Companies* (New York: The Association for the Study of Negro Life and History, 1930), 92.

²¹ Barbot referred to James Town as “Soko” (which Hair, Jones and Law footnote as “Chokor” -- the name for the area to the west of the Korle Lagoon today) and stated that its housing was dispersed around a wide area. The people of the Alata quarter of Ngleshi claim descent from a group of either Fon or Yoruba slaves or labourers who were brought to Accra to build James Fort in 1673. Van Dantzig, *Forts and Castles*, xi.

(known as Dutch Accra or in Ga, Kinka) at the base of Fort Crevecoeur (later Ussher Fort); and Christiansborg (known as Danish Accra or in Ga, Osu) at the base of Christiansborg Castle (see Fig. 1.2).²² Each of these neighborhoods was, in turn, made up of a patchwork of *akutsei*: historically defined quarters with a chiefly stool and a clan lineage that either led back to the founding of Accra, the arrival of Ga refugees after the fall of the inland capital, or the settlement of immigrant groups from other parts of West Africa. James Town was subdivided into the Sempe, Akumadze, and Alata *akutsei*, Ussher Town into the Gbese, Abola, Asere, and Otublohum *akutsei*, and Christiansborg into the Kinkawe, Ashinte, Alata and Anahor *akutsei*.²³ However, though the lineages of the people living in these *akutsei* differed, they all spoke Ga, they all nominated chiefs as representatives within a broader Ga polity, and they all participated in an annual harvest festival known as Homowo,²⁴

The history of ethnic mixing in the coastal Ga capital of Accra indicates that while Ga was the majority spoken language, the inhabitants of the city were exposed to several other languages. In particular, Akan languages were prominent (as they had been at the former

²² Astley notes, based on the words of Willem Bosman, that the King of Accra was so wealthy that his followers did not fish or make salt, but rather prospered through the gold and slave trade with Europeans, leaving other occupations to other (ill-defined) social or linguistic groups. Astley, *New General Collection of Voyages*, 619.

²³ The chiefs and priests residing in these quarters today retain oral traditions that recall the founders of each neighbourhood. For example, the Alata quarter of James Town was founded by Yoruba migrants or slaves (C.C. Reindorf, *History of the Gold Coast*, 40), while Otublohum was founded as a royal quarter for the representatives of the Akwamu in Accra (Wilks, "Akwamu and Otublohum," 391-404). For further detail on the quarters of each town, see C.C. Reindorf, *History of the Gold Coast*, 24-28, 38-48, and Quarcoopome, "Impact of Urbanization," 119-122.

²⁴ Though the *akutsei* of Accra formed a collective polity, the ancestry of the founders of each neighborhood was never forgotten. During the annual harvest festival of Homowo, Ga religious experts, healers, and chiefs conducted rites in honour of the local gods and goddesses and in memory of the ancestors who founded the town. For Field's accounts of the contributions of each quarter to Ga religious practices, see Field, *Religion and Medicine of the Gã People*, 64-65, 87-88.

inland capital at Ayawaso)²⁵ because of intermarriage, immigration, and commercial links northward with the Akwapim, Akim, and Asante, and, and westward with the fishing cultures of the Fante.²⁶ Accra in the 17th and 18th centuries was home to business people from various linguistic backgrounds, such as Quashie Gambia, a slave merchant who traded with the British, and Akoda, a Fante trader who traded along the coast in cattle, gold, slaves, pottery, beads and clay pipes.²⁷ Accra-based traders also had connections with merchants in the interior, and some travelled regularly to Aburi, about 40 kilometres north of Accra, where they exchanged cloth, guns and brandy for gold, slaves, ivory at a thrice weekly market.²⁸ Ewe-speakers were also prominent in the city because Dangme-speaking territory was coterminus with the Ewe lands across the Volta River.²⁹ Over the course of two hundred years of interaction with the surrounding language and ethnic groupings in West Africa, Accra became a polyglot “speech field,”³⁰ a multiethnic commercial centre that was

²⁵ Dakubu, *Korle Meets the Sea*, 105

²⁶ Henry Meredith noted that, prior to the abolition of the slave trade in 1807, Accra was a “conflux of Ashantees, Akims, Aquapims, Fantees, Aquamboes, Crepees” and other people from inland ethnic groups. Henry Meredith, *An Account of the Gold Coast of Africa, with a brief history of the African Company* (London: Cass, 1967), 217-18.

²⁷ Kea, *Settlements, Trade, and Politics*, 221; Fisher ed., “David Mill to Richard Miles. Cape Coast Castle. July 19, 1774,” in *Extracts from the Records of The African Companies*, 95. Paul Isert claimed that after the fall of Ayawaso, Accra came under control of “kabossies,” merchants who held more power than priests and chiefs in the city, see Wisnes, *Letters on West Africa and the Slave Trade*, 133 ; It should also be noted that cattle were a major trade good because Accra is at the far end of the Benin Gap grasslands where cattle may be reared. For an earlier example of the trade in cattle see Jones ed., “Wilhelm Johann Müller’s description of the Fetu Country, 1662-9,” in Adam Jones, *German Sources for West African History, 1599-1669* (Wiesbaden: Steiner, 1983), 209.

²⁸ Astley, *New General Collection of Voyages*, 619-20. Astley notes that there were even ‘Malayan’ slaves sold at Aburi, a term that may refer to Muslims in general; see also Kofi Affrifa, *The Akyem Factor in Ghana’s History 1700-1875* (Accra: Ghana Universities Press, 2000), 58.

²⁹ The connections between Ewe-speakers and Ga-speakers was strong, especially after a dramatic influx of refugees and slaves into the city after the Anlo-Ewe Wars of the 1860s and 1870s. See C.C. Reindorf, *History of the Gold Coast*, 9; Dakubu. *Korle Meets the Sea*, 114-15.

³⁰ Dakubu, *Korle Meets the Sea*, 162. Dakubu uses Hymes’ definition of speech field as “a total range of communities within which a person’s knowledge of varieties and speaking rules

open to newcomers, a spirit aptly expressed in the hybrid Ga/Akan saying “*Ablekuma abakuma wo* - may people come and join us.”³¹

Section 2. The Linguistic Influences on Healing in Accra.

In the 17th and 18th centuries, the coastal capital of Accra was home to residents who expressed ideas about disease causality and the spirit world in multiple ways. The Ga were dominant in the city, and Little Accra became the urban centre from which concepts of being authentically Ga (either through activity in chiefly politics, participation in the Ga army, communion with the deities that spoke Ga via religious elites, or by celebrating the annual harvest festival of Homowo) were generated. But though the Ga ethnic group was dominant in the city, Ga-speakers appropriated linguistic terminology from other languages over time.³² As Mary Esther Kropp Dakubu has demonstrated, the aggregate nature of the Ga language reflects the stratigraphy of influences that surrounding ethnic groups had on Ga politics and culture.³³ Though it is not possible to date the incorporation of foreign words,

potentially enables him to move communicatively,” from John J. Gumperz and Dell Hymes, eds., *Directions in Sociolinguistics; the Ethnography of Communication* (New York: Holt, Rinehart and Winston, 1972), 18-19.

³¹ The word *ablekuma* is a name for a neighborhood, but etymologically is a conjunction of the Ga word for corn and an Akan diminutive form.

³² Dakubu argues that Akan dialects were present in the inland capital of the Ga during the formation of the Ga language, and that Ga was also strongly influenced by Guang dialects (which may have been spoken in the same area before the arrival of Ga migrants. Later influences came from Ewe, Hausa, Portuguese and English. Dakubu also suggests that Akan dialects were more influential than Ewe simply because Akan-speaking merchants were more involved in the gold and slave trade. Dakubu, *Korle Meets the Sea*, 11-12, 100-117, 120-128.

³³ M.E. Kropp Dakubu, “Akan,” in *Concise Encyclopedia of Languages of the World*, E. K. Brown and Sarah Ogilvie, eds. (Amsterdam: Elsevier, 2009), 17-19.

the terminologies related to the causes of illness found within the Ga language of today demonstrate a layering of ideas about healing within the Ga vocabulary.³⁴

To gain access to the cognitive world of people who inhabited Africa in the distant past, historians can use word lists (created by linguists out of contemporary languages) that express core concepts about the cognitive worlds of particular linguistic groups.³⁵ Jan Vansina has argued that the semantic legacies of African languages can offer a window into the deep past that documents are unable to provide,³⁶ and David Schoenbrun has characterized core word lists as “durable bundles” of information that can be used as source materials for deep regional histories on the continent.³⁷ The case of the Ga language is no different. Linguists like Mary Esther Kropp Dakubu have isolated a number of sounds and shapes within Proto-Ga-Dangme (PGD) that that make up the foundational elements its

³⁴ As a language that has adapted and changed according to successive waves of cultural contact, Ga has only recently been codified and therefore it is difficult to date changes in the language. The Ga script, created by missionaries to translate the Bible in the mid-19th century, is rarely used in written forms of communication today, and the modern language flourishes primarily in its oral form. Recent works of Ga literature, mostly in the form of Ga language schoolbooks, do not have a standardized spelling and they change as new words are regularly introduced into the language, a reflection of the dynamic nature of the language. The first Ga word list was written by Christian Jacobsen Protten in 1764, and published in Copenhagen, but it was too brief to be considered a dictionary. See Jacobsen Protten. *En nyttig grammaticalsk indledelse til tvende hidindtil ubekjendte Sprog, Fanteisk og acraisk* ... (Copenhagen, 1764). The second attempt at building a lexicon was undertaken by Zimmerman in 1858, and resulted in a dictionary, and shortly afterwards, a Ga bible. See Zimmerman. *Grammatical Sketch of the Akra or Ga Language* (Stuttgart, 1858). A new Ga bible, with a standardised script, was released in June of 2006 by the Bible Society of Ghana.

³⁵ Christopher Ehret, *The Civilizations of Africa* (Charlottesville, Va: University of Virginia Press, 2002); Jan Vansina, *Paths in the Rainforests: Toward a History of Political Tradition in Equatorial Africa* (Madison: University of Wisconsin Press, 1990); David Lee Schoenbrun, *A Green Place, A Good Place: Agrarian Change, Gender, and Social Identity in the Great Lakes Region to the 15th Century* (Portsmouth, N.H.: Heinemann, 1998); Kairn A. Klieman, “The Pygmies Were Our Compass”: *Bantu and Batwa in the History of West Central Africa, Early Times to c. 1900 C.E.* (Portsmouth, NH: Heinemann, 2003).

³⁶ Vansina, *Paths in the Rainforests*, 11.

³⁷ David Schoenbrun, “Conjuring the Modern in Africa: Durability and Rupture in Histories of Public Healing between the Great Lakes of East Africa,” in *American Historical Review* (December, 2006), 1405.

constituent languages, and have labeled them with a system of starred forms (see Table 2.1). What their studies have revealed is that the terminology related to curing and healing in Ga share common starred forms. For example, within the word for health, *bewale* (defined as the vigour and strength of a person in both a physical and mental sense) Dakubu located the PGD starred form of *wā, a basic component of words relating to health, strength and hardness.³⁸ The flow of a person's *bewale* can be diminished by blockages that cause *bela*, illness, which manifests itself in a variety of ways.³⁹ The primary task of a healer is to remove these blockages by healing the body directly or by purifying the spirit of the patient, so that the patient experiences bodily wellness and is also able to fulfill their usual social roles.⁴⁰

Ga notions of disease causality connect a person's *bewale* to the well-being of the body, the *gbomotso*. Joyce Engmann has argued that the word *gbomotso* is a fundamental Ga term because it is a concatenation of *mo* (PGD: *me-), the term for person, and *tso* (PGD: *tse-), the word for tree, which suggests that the body houses the sentient spirit, or operates like a mask that covers the spiritual essences of the person.⁴¹ The implication here is that the outward body is a surface upon which signs about the causes of illness can be read and interpreted. At the onset of bodily illness, Ga-speakers readily identify bodily malfunctions as indicators of sickness, and then consider the immediate causes. If an illness is something quite commonly experienced and treated, then it falls into the category of a natural illness, or

³⁸ Dakubu, *Ga-English Dictionary*, 66; Engmann, "Immortality," 156.

³⁹ Field, *Religion and Medicine of the Gã People*, 111; Interview, Nii Oshiu Codjoe, February 23, 2005. In Ga, prospering and flourishing is *shwere*, a blockage is *tsi*, and to purify is *tsuu*.

⁴⁰ Senah, *Money Be Man*, 140.

⁴¹ Engmann, "Immortality," 156. Engmann argues that the Ga say that the body is like a costume *kakamotobi* used in masquerades.

Ga term	Proto-Ga-Dangme (PGD) starred form	English gloss
<i>bewale</i>	*wā	health, vigour
<i>mo</i>	*mc-	person
<i>mumo</i>	*mu'	breath or spirit
<i>su</i>	*su	poison, bewitch, practice black magic
<i>ti</i>	*tí	black medicinal powder
<i>tso</i>	*tse-	tree
<i>tsofatsu</i>	*tse-	dispensary
<i>tsofa</i>	*tse-	herbs and other objects imbued with healing power
<i>tsofabemo</i>	*tse-	pharmacy, drug store
<i>tsofatse (pl. tsofatsemei)</i>	*tse-	maker of herbal or consecrated healing objects
<i>wa</i>	*wā	strong, healthy
<i>wonj (pl. woji)</i>	*wode	god, deity
<i>wonjtse (pl. wonjtsemei)</i>	*wode	male medium of a deity
<i>wonjtulo</i>	*wode	herbalist who uses skill to cause harm
<i>woyoo (pl. woyei)</i>	*wode	priestess, female medium of a deity.

Table 2.1. A sample of healing words with Proto-Ga-Dangme (PGD) roots.

Source: M.E. Kropp Dakubu, *Ga-English Dictionary with English - Ga Index* (Accra: Black Mask, 1999).

<i>adedenkruma</i> (castor oil plant)
<i>hiiatso</i> (herb)
<i>sulu/suru</i> (herb)
<i>wosuma</i> (seaweed)
<i>nyanyara</i> (herb)
<i>amlebo</i> (small frog)
<i>blika yitso</i> (black cobra head). ⁴²

Table 2.2. A typical list of reagents used to make *ti*. *Source:* interview evidence (names of herbalists withheld by request).

⁴² Burkill, *Useful Plants of West Tropical Africa*, 133-36.

bela folo. For example, a case of indigestion might point to basic causes of illness, such as spoiled food or worms.⁴³ A patient with indigestion might take immediate steps to cure that bodily malady, and if such a disease is quickly remedied then there will be no need to theorize about the deeper causes of illness.⁴⁴ However, should an illness become chronic, it requires further consideration to figure out what is affecting the *bewale* of the sufferer. At this point, a Ga patient or healer will likely suspect that the disease is a *mumo bela*, a spiritual illness. Such suspicions often lead to a search for a spirit (*wɔŋ*, plural *wɔji*) or deity (*jemawɔŋ*, plural, *jemawɔji*) that is causing the illness.⁴⁵ Both the *wɔji* and *jemawɔji* contain the PGD root

⁴³ In Ga, a healer might say to a patient *omusu efitee/ewomuji* (your stomach is spoiled/dirty). Further causality about the cause of the spoilage or dirtiness is not usually required, and if it is investigate, will lead to a discussion of potential spiritual causes. Kodjo Senah points out that it is tempting to “suggest an ‘abdominal theory of health and disease’ because so many health complaints in Ga are blamed on malfunctions of the digestive system. See Senah, *Money Be Man*, 134; Dennis Warren encountered a similar foundational understanding of the putrefaction of bodily fluids during his investigation of disease aetiologies amongst the Bono in Ghana. See Dennis M. Warren, “Bono traditional Healers,” in Z. A. Ademuwagun, *African Therapeutic Systems* (Los Angeles: Crossroads Press, 1979), 26, 117.

⁴⁴ Edward Green and Robert Pool and others have debated whether West Africans tend towards “naturalistic” or “theoretical” explanations for illness and misfortune in the context of West Africa. See Edward C. Green, *Indigenous Theories of Contagious Disease* (Walnut Creek, Calif: AltaMira Press, 1999); Robert Pool, *Dialogue and the Interpretation of Illness. Conversations in a Cameroon Village* (Oxford: Berg Publishers, 1994); Leith Mullins and Kodjo Senah both choose to distinguish ordinary illnesses versus spiritual illnesses as a means of understanding how people in Accra choose between Ga healers or biomedical practitioners, but both concede that seeking a cure is processual. See Senah *Money Be Man*, 140-53, 174; Mullins, *Therapy, Ideology, and Social Change*, 46, 150-66; for the purposes of historicizing Ga aetiology, these distinctions are unnecessary. In the Ga language, one can choose not to reach into the realm of theory to explain an illness, but this becomes increasingly difficult if the malady lingers, or if subsequent evidence points to malicious forces as the cause of the disease. In other words, illness is a process that can either be short-circuited by a quick cure or drawn out in a search for different cures.

⁴⁵ The *jemawɔji* are characterised by Field as forces that are well established in Accra because of their historical relationship with the town and its people, and she allows for the possibility that a *jemawɔŋ* might be demoted to mere *wɔŋ* due to historical circumstances (Field, *Religion and Medicine of the Gã People*, 4-5, 72). The most powerful *jemawɔji* in Accra today are the triumvirate of Nai, the goddess of the sea, Korle, the goddess of the lagoon, and Sakumo, the god of war. They are regarded today as the deities of the Ga state, and their priests, the

*wode, which makes them central spiritual agents within Ga religion. As supernatural forces, they can affect health by blocking the flow of *bewale*, causing illness in the *gbomotso*.⁴⁶

The tool that can check the actions of these spirits is *tsofa*, a term that refers to both herbal medicines and consecrated healing devices. The root of *tsofa* is the starred form of *tse-, a foundational phoneme and morpheme for a number of other words related to healing (see Table 2.1). Herbal *tsofa* can be consumed by patients without any deep contemplation of the source of their healing power, and simple herbal draughts and poultices are the first resort of people suffering from bodily sickness. More complex or lingering illnesses may require that the healing forces that must be drawn out of the herb in combination with a variety of other reagents. A common example of this sort of aggregate medicine is *ti*, a combination of charred herbs pounded into a black ash that is mixed into poultices, suspended in potions, or rubbed into cuts in the skin (see fig 1.5). Most of the herbal ingredients used in *ti* are easily found in the forests and scrub lands of the Accra Plains, including *hiiatso*⁴⁷ and *nyanyara*,⁴⁸ two reagents that have been utilized by herbalists for

wulomei, claim that they have governed the city in conjunction with the Ga *maytsemei* since the founding of the Ga state on the Accra Plains. There are lesser deities with shrines whose power has waxed and waned over hundreds of years, including the fertility goddess Naa Ede Oyeadu, the mermaid seductress Mami Wata, the fishing god Bentum, and others, but they have been peripheral to the governance of the state, playing a role as healing forces in the city. Interview, Sakumo Wulomo, November 17, 2002; Interview, Nai Wulomo, November 28, 2002. Interview, Korle Wulomo, February 16, 2005.

⁴⁶ Field, *Religion and Medicine of the Gã People*, 4. The relationship between the lesser deities (*jemawojì*) and God (*Nyonyo*) is hierarchical, with the Divine Creator at the top. Field's informants claimed that lesser gods were simply put on earth by God (*Nyonyo*) so that people could have access to the spiritual power that God created (Field, *Religion and Medicine of the Gã People*, 61-3). Today, some priests liken them to the minions of Satan that were cast out of heaven by God and say that they can be used to do both evil and good. For example, Nii Cedi, the Pram Pram Wulomo, said that Sakumo was like Satan, one of the fallen gods that had followed Lucifer down to earth. See Interview, Nii Cedi, February 4, 2004.

⁴⁷ F.N. Hepper, *West African Herbaria* (Chicago: University of Chicago Press, 2000), 30.

⁴⁸ Dokosi, *Herbs of Ghana*, 118-19. The Latin term for *nyanyara* is *momordica charantia*. It contains the chemical alkaloid *momordicine* which is a known purgative. Isert and Thonning described the use of *nyanyara* as a tea for worms and for spiritual ablutions. Hepper, *West*

centuries. Other evidence of the use of *ti* in the past comes from archaeological digs on the Accra plains, which contain the types of pots used to hold herbal potions.⁴⁹

Another type of *tsofa* is the fabricated, consecrated, healing object. Made from a composition of plant material, animal parts and other items from the natural environment, examples of amulets, charms, and figurines transformed into objects of healing abound in European descriptions of the Gold Coast. Pieter De Marees, a Dutch traveler who visited Accra several times during the late 16th century, offered descriptions of consecrated devices used by locals to prevent insomnia, accidents, stomach ailments, and other particular maladies,⁵⁰ while Danish botanist Paul Isert noted in the late 18th century that amulets made of leather, gourds, herbs, beads and shells were worn by all members of society.⁵¹ These fabricated objects were often rubbed down with herbal paps or blackened with charred *ti* dust made from burnt herbs, roots and tree barks, in order to incorporate the spirits of the forest into the object of healing. When bound together they intensified the power of multiple *woji* into a single *tsofa*, creating a mobile, personalized packet of healing power. But whether in herbal or a consecrated form, the purpose of *tsofa* was to heal illness or misfortune, an idea expressed in Ga by the verb *tsa*, meaning to join or link together broken connections to material and spiritual forces. Whatever form they took, *tsofa* were designed to

African Herbaria, 51-52. For a contemporary example of its uses around the world see Ross, *Medicinal Plants of the World*, 213-29; Margaret Field notes that every *jemawon* has a herb which is used in bathing and blessing. In Accra today, wreaths of *nyanyara* is are worn during ceremonies by the priests of Nai, Sakumo and Korle. Field, *Religion and Medicine of the Gã People*, 121.

⁴⁹ James Anquandah, "Accra Plains, Dangmeland: A Case Study in the Eclectic Approach to Archaeological and Historical Studies," *Archaeology in Ghana* 3 (1992), 1-8.

⁵⁰ De Marees, *Gold Kingdom of Guinea*, 69; Jean Barbot also provides a lengthy description of consecrated medicines. See Barbot, *Barbot on Guinea*, 580.

⁵¹ Wisnes, *Letters on West Africa and the Slave Trade*, 118-19, 132.

repair the body, clear harmful blockages, purify the spirit, thwart *bela* and restore the flow of *bewale*.⁵²

These proto-Ga-Dangme terms offer a core Ga conceptual apparatus of healing. Historical linguists have long since abandoned precise glottochronological dating of core word lists, so it is not possible to date change over time in the Ga language, or to assume that healing terminology within Ga has not changed through time. However, as Vansina and Schoenbrun have argued, in the absence of other historical data, linguistic dating allows a historian to assert the priority of certain linguistic concepts over others. Though they may dispute the mechanisms of dating and the words that constitute the core of a language, historical linguists continue to argue that the prototerminology of cognates within word lists are more resistant to change over time than other linguistic elements of a language,⁵³ which allows us to speculate that the PGD terms about healing have been essential to the Ga world view of health and disease for at least several centuries, and perhaps for longer. Social change, as historical linguists take pains to point out,⁵⁴ is a significant factor in generating linguistic change, but the constitution of the Ga state and its speech field, though enduring turmoil and dislocation, has remained relatively intact over the past several hundred years, which bulwarks claims that the core words of PGD have been stable for centuries.

But though we can understand PGD terminology related to healing as forming a base for thinking about health and healing in Accra in the past, social change and political upheaval

⁵² Interview, Woyoo Ankroh Ansa, June 21, 2007; Interview, Bentum, March 5, 2004. These two healers used the term “*tsa*” as an incantation to link people together spiritually, thereby healing their problems and encouraging the flow of *bewale*.

⁵³ For a survey of the latest debates over core word lists and lexicostatistics, see Lyle Campbell, *Historical Linguistics: An Introduction* (Edinburgh: Edinburgh University Press, 2013).

⁵⁴ Charles Jones, *Historical Linguistics: Problems and Perspectives* (Hoboken: Taylor and Francis, 2014), 220.

have also added richness to the descriptive capacity of the Ga language (see Table 2.3).⁵⁵ In particular, a layering of loan words from Akan has diversified the means of explaining illness, specifically the spiritual causes of imbalances of body and soul. Two Akan-derived terms relating to states of health in the body are *susuma* and *kla*. *Susuma* is defined broadly as an individual spirit, shade, or shadow.⁵⁶ An assistant to *susuma* is *kla*,⁵⁷ sometimes defined as the part of the human being that endures in the afterlife.⁵⁸ The terms *susuma* and *kla* can offer descriptions of illness without reference to Proto-Ga-Dangme terminology. For example, when a person has feverish convulsions, a healer might explain that their *kla* and *susuma* are fighting each other.⁵⁹ The *susuma/kla* framework is especially useful for explaining illnesses caused by witchcraft, known in Ga by the term *ayɛ*.⁶⁰ According to ethnographic accounts of

⁵⁵ The Akan dialects of Asante, Fante, Brong, and Akuapem are closely related and are the most widely spoken group of languages in Ghana today. They are spoken in the rainforests to the north and west of Accra.

⁵⁶ “Sunsum, the soul or spirit of man; a spirit, ghost,” in Johannes G. Christaller, *A Dictionary of the Asante and Fante Language Called Tshi (Chwee, Twi), with A Grammatical Introduction and Appendices on the Geography of the Gold Coast and other Subjects* (Basel: Evangelical Missionary Society, 1881), 464; Salm and Falola have a more contemporary definition (The sunsum “helps determine individual character, intelligence, and personality. The sunsum can reveal itself in dreams or leave the body during sleep ... The sunsum is the spiritual part that can bring physical ailments, as well as leave the individual vulnerable to witchcraft and other evil spirits. A strong sunsum, however, can also help protect someone against attack by witchcraft”) in Steven J. Salm and Toyin Falola, *Culture and Customs of Ghana* (Westport, Connecticut: Greenwood Press, 2002), 35-36.

⁵⁷ *Kla* is derived from the Akan *o-kara*. Gyekye describes the “Okra” as a “divine spark” given by God, tying the individual to a larger spiritual collective. Kwame Gyekye, “Person and Community in African Thought,” in *Person and Community* (Washington: The Council for Research and Values in Philosophy, 1992), 114.

⁵⁸ This definition is found in Christaller’s Twi dictionary as well as more recent ethnographies. See Christaller, *A Dictionary of the Asante*, 255, and Salm & Falola, *Culture and Customs of Ghana*, 35.

⁵⁹ Field, *Religion and Medicine of the Gã People*, 92. Field gives the example of a child who is struggling in their sleep as a battle between *susuma* and *kla*. This was a common example given during interviews with healers, as was the example of malarial convulsions. Interview, Nii Cedi, January 26, 2005.

⁶⁰ The word for witch in Twi is either *bayi* or *ayen*. Whether Ga-speakers appropriated the term from Akan languages in the same way that they borrowed *okera* and *susum* is not known, but the illness caused by witchcraft is understood with relation to these terms. See Paul A.

witchcraft, witches can use their *susuma* to leave their bodies and fly off at night to join their coven, for the purpose of devouring the *kla* of their victims. As Margaret Field noted, the

kla, though invisible, has arms and legs and bodily organs corresponding to the visible body, and the witches cut it up, share it round, and eat it. When it is completely eaten the victim dies. If the witches relent they can reassemble the parts and give them back, but any portion missing will cause weakness or paralysis of the corresponding part of the victim's body.⁶¹

The attacks of witches can be countered through healing rituals focused on cleansing the malicious *susuma* or defending the ravaged *kla*. This sort of anti-witch therapy can be conceived of exclusively within Akan terminology, but a Ga-speaker might conjoin Ga and Akan terminology to generate new forms of witch-fighting discourse. A powerful Ga-speaking *jemawon*, for instance, might be mobilized as a healing force to cleanse a witch's *susuma* or defend a *kla* from attack, thereby thwarting the power of witchcraft.⁶²

Additional terms from Akan have served as loan words to expand explanations about illness beyond the *susuma/kla* complex. A common cause of both healing and sickness in Accra is a group of spirits described as diminutive, hairy dwarves. In Akan languages these invisible dwarves are called *mmotia*,⁶³ but Ga-speakers call them *adope* (a borrowed Akan term for “ape”).⁶⁴ The *adope* are understood by Ga-speakers to be migrant spirits whose power is harnessed by those with connections to the supernatural forces in the Twi-speaking territory

Kotey, *Twi-English, English-Twi* (New York: Hippocrene Books, 2005), 45, 328; Robert Sutherland Rattray, *Religion & Art in Ashanti* (Oxford: The Clarendon Press, 1927), 28-31.

⁶¹ Field, *Religion and Medicine of the Gã People*, 93.

⁶² Interview, Nii Cedi, January 26, 2005.

⁶³ Gabriel Bannerman-Richter, *Mmoetia: the Mysterious Little People* (Sacramento: Gabari Publishing, 1987); O. B. Dokosi, “Some herbs used in the traditional systems of healing disease in Ghana—I,” *Ghana Journal of Science* 9 (1969), 120.

⁶⁴ Interview, Amarth Amarteifio, July 18, 2003; McCaskie, “Innovational Eclecticism,” 37. Thomas McCaskie argues that healers in the Akan rainforest garnered their herbal knowledge via “spiritual tuition” from faeries (known as *nmoetia* in Twi).

to the north of the city.⁶⁵ Also derived from Akan are terms referring to shades and ghosts (*sisá* and *otofo*), for which there are no alternative terms in Ga. A lingering spirit that haunts a particular location can be understood using these words and it can take on a benevolent or malicious personality depending on how the person died: a *sisá* is the spirit of someone who died peacefully or of old age, while the vengeful *otofo* is the ghost of someone who died a violent or unnatural death.⁶⁶ These forces, which expand the notion of ancestral spirits, supplement the *woji* as powers that can be harnessed to heal and harm.⁶⁷

Terms from the Ewe and Hausa languages have also been adopted as loan words by Ga-speakers, though to a lesser degree than Akan terminology. Ewe loan words within the healing lexicon of Ga form a pairing related to venereal and skin diseases, including *gbaja* (syphilis) and *babanso* (gonorrhoea).⁶⁸ Despite the presence of *sampuu* (the Ga word for venereal disease) these Ewe terms have remained in the language as a means of distinguishing between the typologies of disease, suggesting intimate contact, both verbally and physically, between Ga- and Ewe-speakers in the past. Another borrowed word commonly used to understand illness and misfortune is *kaita*, a Hausa term for oath derived

⁶⁵ Interview, Amarth Amartefio. July 18, 2003. Amarth Amartefio, a Ga born in Asere, encountered the *adope* during a stay in Nsawam, and has used them to provide healing advice for his clients ever since. His dwarves have Akan names and are given kola nut during rituals of worship.

⁶⁶ Field, *Religion and Medicine of the Gã People*, 93-94.

⁶⁷ It is important to note here that not all Akan concepts of body, soul and illness have been appropriated by Ga-speakers. Key terms such as *bonam* (body), *bobam* (breath), and *mogya* (blood) and *nkrabea* (destiny) have never been incorporated into Ga. For more information about the importance of these terms within Akan notions of body and soul, see Kwame Gyekye, *An Essay on African Philosophical Thought: The Akan Conceptual Scheme* (Cambridge: Cambridge University Press, 1987).

⁶⁸ The roots of these terms, found in Ga, are taken from Dakubus *Ga-English Dictionary*, and correlated with Kotey's *Twi-English Dictionary* and Westermann Ewe-English dictionary. See Dakubu, *Ga-English Dictionary*; Kotey, *Twi-English*; Diedrich Westermann, *Evefiála or Ewe-English Dictionary* (Berlin: Kraus, 1973).

Ga term	Linguistic root	English gloss
<i>adope</i>	Akan. <i>adope</i> .	invisible dwarves. Believed to be able to choose particular people and teach them to heal or to harm. Can also harass and cause illness in a person.
<i>kla</i>	Akan. <i>o-kara</i> .	soul of the person, believed to join God after death
<i>ʒsisa</i>	Akan. <i>ε-sěsã</i>	ghost of someone who died a natural death or of old age
<i>susuma</i>	Akan. <i>Sunsum</i>	sprit, soul, shade, shadow, out of body experience
<i>otofo</i>	Akan. <i>o-tofo</i> .	a ghost of someone who died unnaturally, violently, in an accident, unexpectedly, or young
<i>baba</i>	Ewe	skin rash (literally: “termite”)
<i>gbaja</i>	Ewe	a venereal disease like syphilis (literally: “pouch”)
<i>kita</i>	Hausa (from Arabic <i>kitab</i>)	oath
<i>kitakalo</i>	Hausa (from Arabic <i>kitab</i>)	swearer of an oath
<i>kitakamo</i>	Hausa (from Arabic <i>kitab</i>)	swearing oaths
<i>kitatomo</i>	Hausa (from Arabic <i>kitab</i>)	oath breaking
<i>kitatomono</i>	Hausa (from Arabic <i>kitab</i>)	something presented as pacification, in atonement

Table 2.3. Some Akan, Ewe and Hausa loan words found within contemporary Ga.

The Akan terminology found here would have been spoken in both Great Accra and Little Accra, because of the significant minorities of Akwapim residents who lived there. The Ewe and Hausa terms are more difficult to date, and would have likely been adopted as loan words in the 19th century. Though dates are impossible to pinpoint, the presence of these terms speaks to the inclusive nature of the Ga language, and the way that healers and patients have appropriated healing terms from around West Africa. Source: All roots are from M.E. Kropp Dakubu, *Ga-English Dictionary with English - Ga Index*. (Accra: Black Mask Ltd., 1999).

from the Arabic *kitab*.⁶⁹ In contemporary spoken Ga, the loan word *kita* is used in conjunction with *lomo*, the Ga term for curse, because breaking an oath causes bad luck, which can result in ill health. As a single term, the *kita* would not be significant because it is a synonym for Ga terms like *piriu* (oath) or *shinoo* (oath, promise, pledge), but *kita* is also the root word of a larger set of borrowed terms for the process of making oaths, which include *kitakalo* (swearer of an oath), *kitatomo* (oath breaking), and *kitatomono* (an object presented in atonement for a broken oath). Unfortunately, there is no way to specifically date loan words without having a distinct chronology of documentary records to draw upon. This means that we can only speculate about when they entered the language (and as we shall see in chapter 3, it is likely that, because of West African patterns of migration, commerce and conflict, these terms became prevalent in the city in the late 1800s). Nonetheless, despite the fact that these words cannot be precisely dated, they are tribute to the fact that the people living in Accra were open to new ideas about healing.

As Mary Esther Kropp Dakubu has demonstrated, the Ga language “arose in a multilingual context and has existed in one ever since.”⁷⁰ The Ga healing lexicon is no exception. . Indeed, so diverse are the ideas contained within the Ga healing lexicon today that anthropologist Kojo Senah has argued that “there is no such thing as a fixed and systematic Ga canon of ideas on body and illness.”⁷¹ Ga healing was constantly changing according to the new ideas that flowed through Accra, and as such, it cannot be understood as a static ethnomedical precept that existed prior to the arrival of dynamic European healing methods. Rather, it should be historicized, as a tolerance of pluralistic healing ideas amongst

⁶⁹ Dakubu, *Ga-English Dictionary*, 80.

⁷⁰ Dakubu, *Korle Meets the Sea*, 5.

⁷¹ Senah, *Money Be Man*, 129.

the people of Accra, mostly expressed in the Ga language but also with terminology from other languages as the population of the city became more ethnically diverse.

Section 3. The Repertoire of Healing Practices in Accra

When Portuguese explorers traveled along the Guinea Coast in the 16th century, they encountered practices that they described as “fetish.”⁷² For European observers of West African customs, fetish was a marker of charlatanism or quackery, a way of distinguishing misguided African superstitions from rational orthodox European medicine.⁷³ It was used in an overtly derogatory manner, implying that West Africans misunderstood the connection between the material world and the divine realm. The discursive uses of fetish were extended by merchants and slave traders as part of an enlightenment impulse to generate a taxonomy of mankind that placed “Moors” or “Negroes” on the bottom rung of a ladder of so-called races.⁷⁴ For example, slave trader Willem Bosman described fetish as a practice based on whim and caprice, the worship of “any inanimate [object]... whether a stone, a piece of wood, or anything else of that nature.”⁷⁵ Because European stories about such practices are laden with discourses of alterity that set the African in contradistinction to the European, they must be handled with care if they are to be used as sources, but they also are

⁷² Fetish is an English transliteration of *fetisso*, a late-medieval Portuguese word for sorcery. Pietz, “The Problem of the Fetish, 1,” 5-17.

⁷³ As Roy Porter has shown, the notion of quackery was one imposed on practitioners not certified or recognized by the medical professions (which included barber/surgeons, physicians and apothecaries). Calling someone a quack was a means of excluding them from mainstream medical professions and it was also a form of “insult and abuse.” See Roy Porter, *Quacks: Fakers and Charlatans in English Medicine* (Charleston, SC: Tempus, 2000), 15-16. In the context of West Africa, the term fetish was used to distinguish between European practices and African practices, but it also carried racial connotations about the degeneracy of so-called “Negros” or “Moors”.

⁷⁴ The term Negro, for example, was used by Pieter de Marees and Bosman while Barbot used the term Moor. See De Marees, *Gold Kingdom of Guinea*; Bosman, *New and Accurate Description of the Coast of Guinea*; Barbot, *Description of the Coasts of North and South Guinea*.

the richest source of information about the healing networks of Africans on the Gold Coast.⁷⁶ This section will historicize the elements of so-called fetish practices found within European travelogues, including the worship of deities, spirit possession, drumming rhythms of healing, animal sacrifice, pouring libation, and ritual scarification. The goal is to show how the glimpse of healing practices offered to us by Europeans provides evidence of a pluralistic network of healers conducting practices that have changed over time.

To begin, it is necessary to enumerate the major gods and goddesses of Accra that have played a role as the arbitrators of the social health of the city. According to oral traditions compiled in the 19th century and interview evidence from today, Accra was once a “fetishcracy” (to use Reindorf’s term)⁷⁷ in which supreme power was wielded by priests who tended the major shrines of local deities, known as *jemawoji*.⁷⁸ After the conquest of Accra by the Akwamu, the political structure of the city became more complex as the power of chiefly title began to grow and as secular power began to accumulate in the hands of merchant families.⁷⁹ Nonetheless, the *wulomei* of Accra continued to play a major role in urban affairs

⁷⁵ Bosman, *New and Accurate Description of the Coast of Guinea*, 347.

⁷⁶ Pietz, “The Problem of the Fetish, 1,” 9.

⁷⁷ C.C. Reindorf, *History of the Gold Coast*, 105.

⁷⁸ Interview, Korle Wulomo, February 16, 2005. It is difficult to tell when a shift towards secular leaders took place, or whether there ever was an exclusively priestly ruling class. One must tune in the reverberations of Biblical feedback to get any sense of what the Ga ruling classes looked like several hundred years ago. Reindorf argued that, since the Gas claim to be Israelites, they have always had a combination of religious as well as secular forms of leadership. See C.C. Reindorf, *History of the Gold Coast*, 106. It is also interesting to note that the *wulomei* today distance themselves from the *wontsemei/woyei* by claiming that only the priests of the major shrines commune with the Supreme God via the *jemawoji* of natural landmarks, such as rivers, oceans and mountains, whereas the *wontsemei/woyei* are independent followers of the spirits of lesser gods.

⁷⁹ Parker, *Making the Town*, 12; Reindorf’s claims that Accra was once ruled by a priestly class are supported by the shrine priests of the city today, who consider themselves descendants of a prior class of theocrats. For a discussion of the process of secularization of chieftaincies in Accra, see Quarcoopome, “Impact of Urbanization,” 115-17; the belief that the first chiefs of Accra were priests is supported in current traditions at the major shrines.

and today the priests still trace their lineage back to a ruling class who derived their power from a triumvirate of paramount deities: Nai, a female goddess of the sea and overseas commerce, Korle, a goddess of the lagoon and protector of the lands around the Accra, and Sakumo, a male god who played the dual role of husband to the goddesses and a symbol of masculine authority during wartime.⁸⁰ The followers of these paramount *jemawoji* claim that their deities were the first to fill the *wonɔtsemei/woyei* of Accra, and they therefore considered themselves to be the spiritual overlords of the city.⁸¹ Their shrine houses have played dual roles as clan houses, and the priest is always a male lineage head, chosen according to the patrilineal line. The priest is chosen by the elders of the clan, often in consultation with spirit mediums who are able to contact the gods and goddesses directly for advice.⁸²

Though Reindorf emphasizes the power of Nai, Korle and Sakumo in his history of Accra, it should be noted that their influence in the city was enhanced by two major historical events. The first is the transatlantic slave trade, which allowed the major shrines to prosper by harbouring runaway slaves, who pledged their labour to the shrine priest in return for protection by the god or goddess. Nai, as goddess of the sea, also prospered by claiming rum and other gifts from captains who anchored offshore, making the shrine a clearinghouse for any new goods that appeared on the market in the city. Korle, the protector of the lands around the Korle watershed, drew her revenue from the ferry across the lagoon, which

Interview, Sakumo Wulomo, November 17, 2002; Interview, Nai Wulomo, November 28, 2002.

⁸⁰ C.C. Reindorf, *History of the Gold Coast*, 39. Reindorf records that the Nai priest was the political leader in coastal Accra when the Dutch build Fort Crevecoeur in 1642, but also indicates that Korle played a role as a defender of the lands from encroaching Akwamu and Ashanti armies, and that Sakumo organized the Ga militias to fight in the battle against the Ashanti at Katamanto.

⁸¹ Interview, Sakumo Wulomo, November 17, 2002; Interview, Nai Wulomo, November 28, 2002; Interview, Korle Wulomo, February 16, 2005.

⁸² Field, *Religion and Medicine of the Gã People*, 6-8; Interview, Korle Wulomo, September 2, 2003.

increased as the slave trade increased. The three deities were also able to consolidate their power prior to the 1826 Battle of Katamanso against the armies of the Ashanti,⁸³ when Sakumo rallied the spiritual forces of Nai and Korle by conducting rituals to “boil the war,” or heat the aggressive energies of the Ga state before battle.⁸⁴

But though Nai, Sakumo and Korle are understood as the founding triumvirate of *jemawoji* in Accra today, it may not have always been so. As John Peel has argued, West African religions were never static, because their forms of worship have been grounded in the assumption that the material world is in constant flux as it reacts to a multiplicity of occult powers.⁸⁵ One can argue that Ga religious traditions have also contained the same inherent dynamism. In fact, there is reason to believe that the three major deities of Nai, Korle and Sakumo have not always held their preeminent positions in Accra. Although oral traditions indicate that the deities are indigenous to the city (in the sense that they are attached to local bodies of water), oral traditions also indicate that they are immigrants (brought to Accra by the original Ga settlers to the land). Moreover, all three deities speak only Ga, not a language from the autochthonous Guang family that was spoken in the area before the arrival of Ga immigrants in Accra. This dual identity, as both indigene and immigrant, suggests that Nai, Korle and Sakumo have had to struggle to assert themselves vis-à-vis other deities as the leaders of the Ga spirit world over the past few centuries.⁸⁶

Additionally, there is evidence of dynamism within the pantheon of lesser spirits in Accra. None of the three major deities of Nai, Korle or Sakumo are mentioned in the travel

⁸³ Kilson, *Kpele Lala*, 127.

⁸⁴ C.C. Reindorf, *History of the Gold Coast*, 115-17.

⁸⁵ J. D.Y. Peel, *Religious Encounter and the Making of the Yoruba* (Bloomington: Indiana University Press, 2000), 93.

⁸⁶ Interview, Nii Cedi, Nii Akramah, Lantey Rozer, Nii Lantey. Nov. 17, 2002; Interviews with Korle Wulomo, September 2, 2003, February 16, 2005; Interview, Nai Wulomo. Nov. 28, 2002.

literature of the Europeans who visited the coast in the 17th and 18th centuries, which suggests that they may not have dominated the spiritual landscape of Accra until the 19th century. In fact, Paul Isert noted in the late 18th century that the people of Accra worshipped a “multitude of sub-godheads,” and he did not mention Nai, Korle or Sakumo. Today, as in the past, new gods have been “discovered” via changes to the landscape (usually in the form of a fresh water spring or an anthill), demonstrating the possibility for new gods and goddesses to enter the Ga pantheon.⁸⁷ And old gods can decline or disappear. Ayi Kushi, the first Ga *mantse* at Great Accra, worshipped Olila, a deity who is no longer present in Accra today. Margaret Field also offered evidence of the decline of Klan, a once powerful deity in Accra that was, over time, reduced to the status of a house medicine.⁸⁸ Another deity that may have been significant in the past is Oyeni, a water god housed in the former British slave fortress of James Fort that must have ascended to power in the 17th century transatlantic slave trade.⁸⁹ Foreign spirits have also played prominent roles in the city, including Fante-speaking deities like Ansa⁹⁰ and Bentum,⁹¹ and water spirits like Mami Wata/Ashiakle.⁹² These gods and goddesses prospered as the economic context of the city changed: Ansa and Bentum aided the development of fishing in Accra, while Mami Wata offered a means with which to understand the social and spiritual risks in exchanging human bodies for commodities during the slave trade.⁹³ Like the complex nature of the Ga healing

⁸⁷ Interview, Korle Wulomo, February 16, 2005; Interview, Robert Ayitey Quaye, December 30, 2005; De Marees, *Gold Kingdom of Guinea*, 85.

⁸⁸ Field, *Religion and Medicine of the Gã People*, 21-22, 77-78.

⁸⁹ C.C. Reindorf, *History of the Gold Coast*, 100-01; C.W. Welman. “James Fort, Accra, and the Oyeni Fetish,” *Gold Coast Review* 3 (1927), 73-88.

⁹⁰ Interview, Woyoo Ankroh Ansa, June 14, 2003.

⁹¹ Interview, Rahel Roye, June 17, 2003.

⁹² Kilson, *Kpele Lala*, 168; Henry John Drewal, “Performing the Other: Mami Wata Worship in Africa,” *The Drama Review* 32, no. 2 (Summer, 1988), 160-85.

⁹³ Elizabeth Isichei, *Voices of the Poor in Africa* (Rochester: University of Rochester Press, 2002), 188-209. Elizabeth Isichei argues that Mami Wata represents an ambiguity towards

lexicon, the ascendancy and the decline of these many spirits may be difficult to precisely historicize, but it does demonstrate centuries of plural and changing religious culture.

The major gods and goddess of Accra are described above largely as religious entities, but they are also powerful healing forces who express themselves through human mediums. The religious experts responsible for channeling spirits are the *wontsemei* and the *woyei* (m.s. *wontse*, f.s. *woyoo*), men and women selected by gods and goddesses as their contact points with the world of the living. Most narratives of possession start when a man or woman experiences an illness, usually a lingering, debilitating physical or mental affliction, and then climax with a sudden attack by the spirit, an episode for which the term *panyar* (a hybrid Portuguese term for seizing someone violently) has been used in the past.⁹⁴ Once a person realizes that he or she is possessed, he or she must be trained by an elder spirit medium in order to recover from their sickness and in order to learn how to become a living translator of the will of the gods and goddesses.⁹⁵ When effectively trained, these spirit mediums gain insight into the causes of disease, learn about the healing properties of herbal remedies, and are introduced to the material culture of consecrated medicines.

the trade and consumption of imported commodities that are not rooted in local systems of commerce, and thereby allow for wealth to be attained independently of the kinship group, or, during the slave trade, through the exchange of human bodies.

⁹⁴ H.C. Monad, *A Description of the Guinea Coast and its Inhabitants*, Selena Axelrod Wisnes, ed. (Accra: Sub-Saharan Publishers, 2009), 57.

⁹⁵ David Graeber argues that spirit possession is part of a “logic of affliction” that was pervasive on the Guinea Coast, according to European accounts from the 17th and 18th centuries, in which “one comes into contact with powers largely by offending them; once that power has caused one to suffer, then one has the opportunity to master it and, to an extent, to acquire it for oneself.” David Graeber, “Fetishism as social creativity: or, Fetishes are gods in the process of construction,” *Anthropological Theory*, 5 (2005), 418; an example of a contemporary trainer of the *wontsemei* and *woyei* is Woyoo Ogbame, who takes in people suffering from attacks from gods and goddesses are her compound in Chokor, and trains them to harness the healing powers that they offer. See Interview, Woyoo Ogbame Rebecca Otoo, July 10, 2003. For an example of some trainers of spirit mediums, see Field, *Religion and Medicine of the Gã People*, 101-03.

Historical accounts of religion in West Africa abound with descriptions of spirit possession, and many demonstrate the connection between spiritual power and healing power.⁹⁶ European accounts from the slave trade era describe the *wontsemei* and *woyei* dressed in ceremonial cloth,⁹⁷ with bodies decorated with white paint and ritual scars, dancing in ecstatic states.⁹⁸ A description of possession written by Danish merchant Ludewig Ferdinand Rømer in 1760 emphasized how the spirits dictated the behavior of the possessed:

With staring eyes they foam at the mouth, gasping for breath. They usually enter this [state] suddenly and unconsciously ... [they can] at times be walking with a water pot or something else on her head, talking to someone walking beside her, and in an instant she is possessed. I have seen some who have made all these contortions, and yet kept the water pot on their heads.⁹⁹

This account of a sudden clairvoyance demonstrates how supernatural forces animated and dominated the bodies of their mediums, rather than the other way around. Though perhaps shocking to a European onlooker in the 18th century, possessed mediums were a common sight at major religious events in the city, and the residents of Accra understood themselves as living with, interacting with, and moving through time with a changing cadre of local gods and goddesses.

Today, the spirit mediums of Accra channel dozens of different gods and goddesses. Different deities can be identified by the languages that they speak. Many communicated in

⁹⁶ De Marees, *Gold Kingdom of Guinea*, 71; Monad, *Description of the Guinea Coast*, 57; Rømer, *Reliable Account of the Coast of Guinea*, 92;

⁹⁷ De Marees, *Gold Kingdom of Guinea*, 85. De Marees mentioned that the people on the coast were anxious to buy white and red textiles from the European ships that passed, which were likely used by ritual experts and healers.

⁹⁸ Georg Norregard, *1658-1850. Danish Settlements in West Africa* (Boston: Boston University Press, 1968), after 96.

⁹⁹ Rømer lived at Christiansborg for 10 years, and acquired a working ability in *Ga* and *Twi*, and extensive knowledge of local customs. Rømer, *Reliable Account of the Coast of Guinea*, xiv-xv, 92.

glossolalia, often in language fragments derived from Guang, which some argue are the true languages of the spirits inhabiting the Accra Plains. But the spirits of Accra speak many other languages, including Ga, Dangme, Fante, Twi and Ewe,¹⁰⁰ and their biographies tie them to immigrant groups who have settled in Accra.¹⁰¹ Different deities can also be identified by the rhythms that they dance to. Historical accounts indicate that the *wontsemei* and the *woyei* congregated during public ceremonies and during the harvest festival of *homowo*, dancing and singing to rhythms as a means of requesting that the god and goddesses of Accra provide a good harvest and peace within the Ga state.¹⁰² The drumming meters used changed over time. The pentatonic *Kpele* rhythms used in Accra today are claimed by the *ganyo krong* (true Ga) as being traditional Ga beats (possibly as far back as when Ayawaso was the capital of Accra) and it is likely that these beats dominated the religious music scene in Accra in the 17th and 18th centuries.¹⁰³ The major Ga gods and goddesses, for instance, dance to *Kpele* rhythms. However, the heptatonic *Akon* rhythms from Akan and Fante influences are also an integral part of Ga drumming today, and many foreign gods dance to these rhythms (though there is no record of when they were incorporated into the dances of spirit mediums).¹⁰⁴

Another ritual extensively reported by European observers was the sacrifice of animals as a measure of preventative health. European travelers on the Gold Coast reported that

¹⁰⁰ Dakubu, *Korle Meets the Sea*, 105.

¹⁰¹ Bentum and Rahel Roye, for example, voice the spirits of Fante deities connected to the inter-coastal fishing industry, while Ansa speaks the Akim dialect and is associated in inland political power. Interview, Rahel Roye, June 17, 2003; Interview Bentum, June 17, 2003; Interview, Ankroh Ansa, June 14, 2003.

¹⁰² Römer, *Reliable Account of the Coast of Guinea*, 90, 92; Field, *Religion and Medicine of the Gã People*, 104-08.

¹⁰³ John Collins argues that *Kpele* rhythms precede, *Akon* and other beats. John Collins, *Highblyfe Time* (Accra: Anansasem Publications, 1994); Kilson, *Kpele Lala*, 13.

¹⁰⁴ J. H. Nketia, "Changing Traditions of Folk Music in Ghana," *Journal of the International Folk Music Council* 11 (1959), 33.

religious ceremonies often required the ritual slaughter of chickens and goats,¹⁰⁵ and that the blood of an animal was believed to give sustenance to ancestral shades and lesser spiritual entities. Such practices were understood as being both religious and medicinal -- Rømer mentions that the wealthy inhabitants of Accra paid to sacrifice animals for them on a monthly basis, as a measure to placate any spirits that might intervene in their affairs:

A rich Negro usually asks the fetish every month what condition he is in, even though he is hale and hearty. He receives the answer that his health is good; but in order that it should continue so, he is ordered to sacrifice a chicken or an egg. Instead, he slaughters a sheep or a cabrit (a goat), and the fetish is given not the meat but only a little of the entrails, and he brings the unclean part to the [cross]roads. He consumes the rest himself, in company with his friends. If, however, he falls ill, he does not hesitate to complain to the fetish that he has sacrificed so many animals during the year, and yet, despite the fetish's promise, he is being attacked by illness.¹⁰⁶

To European observers, this type of sacrifice was a throwback to a pre-Christian era, but within Ga cosmology it was congruent with beliefs that human action had to be taken in order to maintain harmony between the physical and metaphysical worlds. For people who could afford it, providing animals for sacrifice was part of a conscious strategy of maintaining individual and social wellness, and this passage suggests that some inhabitants of Accra felt it appropriate to supplicate both known deities as well as ghosts wandering at the crossroads.¹⁰⁷ Since Accra was a meeting point of many cultures and spiritual worldviews, it was prudent to use preventative medicines such as this to ward off itinerant spirits.

¹⁰⁵ Rømer, *Reliable Account of the Coast of Guinea*, 91.

¹⁰⁶ Rømer, *Reliable Account of the Coast of Guinea*, 91.

¹⁰⁷ The crossroads hold significance in the Ga conception of the spirit world as a place of transition between the souls of the living and the souls of the dead. There is eschatological concern amongst Ga healers that the ghosts of the dead might not pass into an afterlife, and may linger at path and road intersections. The power of these ghosts (*otofoi*) can be harnessed with consecrated medicines (such as bowls filled with meat and herbs) placed at crossroads. Kilson, *Kpele Lala*, 145; Interview, Bentum, June 25, 2006; Interview, Ankroh Ansa, June 21, 2007.

Like possession and animal sacrifice, pouring libation has been a fundamental component of religious and healing ceremonies on the Guinea Coast.¹⁰⁸ In many cultures of the Gold Coast, communication with the world of the supernatural required the pouring of drink on the ground, an offering that was believed to attract the interest of ancestors and spirits.¹⁰⁹ As Dmitri van den Bersselaar has noted, prior to the growth of the transatlantic slave trade, water was the preferred drink for libation (not corn wine or palm wine, as one might expect). However, as the trade in brandy, rum and gin increased, water was gradually replaced by hard liquors.¹¹⁰ The intoxicating spirit within *da ni na waa* (from Proto-Ga-Dangme *dã-, meaning strong drink) acted as a sort of “fast water,” lubricating communication between human beings and their deities, and became a necessity when requesting the assistance of the gods.¹¹¹ Imported liquor also had specific use as a restorative medicinal tincture (when mixed with herbs and roots)¹¹² and as an article of trade (for which gold or human bodies were exchanged). Today, the walls of the shops of herbalists in Accra are lined with bottles of liquor containing herbs and roots, evidence of the material culture of libation.

¹⁰⁸ Rømer, *Reliable Account of the Coast of Guinea*, 90.

¹⁰⁹ Emmanuel Akyeampong, *Drink, Power, and Cultural Change: A Social History of Alcohol in Ghana, c. 1800 to Recent Times* (Portsmouth, NH: Heinemann, 1996), 14.

¹¹⁰ Dmitri van den Bersselaar, *The King of Drinks: Schnapps Gin from Modernity to Tradition* (Leiden: Brill, 2007), 44; Barbot noted that some priests abstained from drinking wine, Barbot, *Barbot on Guinea*, 587; it should be noted that the technology of distillation did not reach the West Coast of Africa until the 20th century. See Simon Heap, “‘A Bottle of Gin Is Dangled before the Nose of the Natives’: The Economic Uses of Imported Liquor in Southern Nigeria, 1860-1920,” *African Economic History*, no. 33 (2005), 1.

¹¹¹ van den Bersselaar, *King of Drinks*, 44; Bosman notes that brandy was the drink of distinction for the wealthy on the Guinea Coast. Bosman, *New and Accurate Description of the Coast of Guinea*, 200. Dmitri van den Bersselaar argues that gin did not rise to prominence in West Africa until the 19th century, and that rum and brandy dominated the distilled spirits trade. van den Bersselaar, *King of Drinks*, 36-37.

¹¹² Jones provides an example of sarsaparilla soaked in brandy. Adam Jones, ed., *West Africa in the Mid-Seventeenth Century: An Anonymous Dutch Manuscript* (Atlanta, Ga.: African Studies Association Press, 1995), 97, 150, 322.

The people of Accra also practiced what Europeans perceived as minor forms of surgery, including a number of cutting and incision practices. Radical surgical interventions, such as amputations or internal surgery, were not practiced in West Africa at this time, and would have been impossible to accomplish in a tropical climate without knowledge of antiseptic surgery and without antibiotics. The types of cuttings and incisions that did take place were largely the disconnected practices of layhealers. For example, elder members of the Ga community circumcised young boys in Accra as a way of distinguishing male members of the Ga ethnic group from the Akan and Ewe ethnic groups that surrounded them.¹¹³ Another minor surgical practice conducted by layhealers was the removal of Guinea worm, a common parasite that most people living in Accra, whether European or African, probably endured at some time in their life.¹¹⁴ The Guinea worm lives in the body for two years, and then emerges in the legs or feet, causing immense pain and discomfort, and neither European surgeons nor African healers had a cure for the disease.¹¹⁵ Because the

¹¹³ Bosman, *Description of Guinea*, 210, 353,444. Bosman considered the practice of circumcision in Accra to be evidence of a degenerated form of Judaeism, but he also noted that boys on the Slave Coast and in Benin were circumcised without any commentary about the lineage of the practice.

¹¹⁴ There is only one account of a herbalist using herbs to cure Guinea worm (Amos & Ayesu, "'I Am Brazilian', 45-46). Other accounts of drawing out the worms do not mention the involvement of a professional healer; some European travelers noted that inoculation against smallpox was also widely practiced in Accra. Paul Isert noted during his stay at Christiansborg that variolation was "as common as circumcision" (Wisnes, *Letters on West Africa and the Slave Trade*, 145), but this may have been a practice taken up after merchants started inoculating their slaves in the 18th century. Herbert S. Klein and Stanley L. Engerman, "A Note on Mortality in the French Slave Trade in the Eighteenth Century," in *The Uncommon Market: Essays in the Economic History of the Atlantic Slave Trade*, ed. Henry A. Gemery and Jan S. Hogendorn (New York: Academic Press, 1979), 271; for an example of yaws inoculation see James Maxwell, *Observations on yaws on acute traumatic tetanus on tetanus infantum*, (Edinburgh: Maclachlan, Stewart and Company, 1839), 22-23, 37, cited in Richard Sheridan, *Doctors and Slaves: A medical and demographic history of slavery in the British West Indies, 1680-1834* (Cambridge: Cambridge University Press, 1985), 87-88.

¹¹⁵ Guinea Worm was an endemic disease in the area until the 20th century. The supply of clean water eliminated the disease in the city, but it is still endemic in some areas in Northern Ghana. For more information on Guinea Worm in Ghana today see Donald R. Hopkins et.

drinking water in Accra was host to the microscopic fresh-water arthropods that carried the larvae of the *dracunculiasis* worm, the only method that people had to fight the disease was to soak the infected limb in salt water until the head of the worm emerged, and then wind the worm out on a stick as carefully as possible to prevent any part from remaining under the skin.¹¹⁶ Again, the procedure for removing Guinea worm is not noted as a practice of professional healers, and therefore was more likely was undertaken by family members or simply by someone adept at removing worms.

The type of minor surgical practice that professional healers did take responsibility for was ritual scarification: the practice of making incisions on the skin and rubbing them down with consecrated powder in order to affect spiritual protection in a patient. Woodcut prints in the documentary record display people with dark marks on their skin, scars from ritual incisions impregnated with dry herbal *ti*, a preventative used to inoculate patients against attacks by malicious spirits.¹¹⁷ It is also possible that some scars, particularly those made on the cheeks, were a means of marking a person as a Ga. Today in Accra, some people argue that a single horizontal stroke or a cross on the cheek is a mark of Ga tribal identity, but this may not have been historically continuous. Paul Isert mentioned that the practice of making Ga “tribal marks” had been “done away with” by the 1800s, and that he encountered only

al., “Dracunculiasis Eradication: The Final Inch,” *American Journal of Tropical Medicine and Hygiene* 73 no. 4 (2005), 669-75. For a historical account of morbidity caused by Guinea Worm see Jones ed., “Samuel Brun’s Voyages of 1611-20,” in *German Sources for West African History*, 91, 121-22.

¹¹⁶ Jones ed., “Wilhelm Johann Müller’s description of the Fetu Country, 1662-9,” in *German Sources for West African History*, 124; T.J. Hutchison, *Impressions of Western Africa with Remarks on the Diseases of the Climate* (London: Longman, Brown, Green, Longmans, & Roberts, 1858), 63; De Marees, *Gold Kingdom of Guinea*, 200.

¹¹⁷ Barbot, *Barbot on Guinea*, 237, and De Marees, *Gold Kingdom of Guinea*, 175. Plate 16. The images in Barbot and De Marees show women with scars on their bodies, likely placed there for ritual purposes; Monad describes a procedure of drawing blood from the body via cupping, and then rubbing the wound with powdered herbs. Monad, *Description of the Guinea Coast*, 204.

one old man who was over 90 years of age with a small cross on each cheek.¹¹⁸ Moreover, there are so few references to so-called “tribal” markings during this period that it is difficult to argue that tribal scarification has been a longstanding tradition. Thus, while it is evident that ritual scarification for healing and religious purposes was practiced in the past, the types of markings used and the meanings of the practice appears to have changed over time.¹¹⁹

As this section demonstrates, the collection of practices that made up healing in Accra were certainly diverse and there is much evidence to show that they changed significantly over time. The notoriety and power of gods and goddesses of Accra changed substantially, as did their power to heal individuals and to heal Ga society. Spirit mediums were filled with new and old deities that spoke a wide variety of languages, and that danced to local *kepele* beats as well as imported rhythms brought to the city by immigrant groups. Patients practiced animal sacrifice in obeisance to a wide variety of deities as a means of preventative health, and patterns of ritual libation changed as the transatlantic commerce in alcohol changed. Additionally, practices that Europeans regarded as surgery also changed over time, as their ethnic and medicinal meanings changed. The roots of therapeutic pluralism were evident here at the earliest stage, and they would only become more complicated as the centuries moved on.

Section 4. Simple and Aggregates: the Material Culture of Healing in Accra.

The material culture of healing during the 17th and 18th centuries also offers strong evidence of a dynamic and pluralistic healing culture in Accra. For centuries, herbalists, known as *tsofatsemei* (lit. fathers of the roots), and lay-healers (mostly women who passed home remedies down through the generations) have made use of the medicinal plants found

¹¹⁸ Wisnes, *Letters on West Africa and the Slave Trade*, 140.

¹¹⁹ Interview, Tsofatse Lamptey, June 9, 2003; Interview, Bentum, July 8, 2003.

in the natural environment of the Accra Plains.¹²⁰ Within the Ga language one can find an extensive terminology of herbalism, including dozens of words that point to specific plants used for treating diseases.¹²¹ Some herbs are very local, like *biiatso* (*Fagara zanthoxyloides*), *nyanyara* (*Momordica charantia*) and *sulu* (*Ocimum gratissimum*), which are harvested in the bushes around the city of Accra. Other herbs come from beyond the Accra Plains and some even have provenances as distant as South Asia and the Americas. But the material culture of healing cannot be reduced exclusively to medicinal herbs. Healers in Accra also required the use of consecrated healing devices, objects assembled in accord with a local aesthetic of shrine and statuette construction.¹²² These devices were known as fetishes to Europeans but they were much more than just random assortments of objects. Consecrated medicines were compilations of animal parts, feathers, plant material, minerals and other symbolic components found in and around Accra, and they could also include imported goods, like brass bowls, cloth, buttons and coins. This section will describe the way that the residents of Accra, both as professional healers and as layhealers, perpetuated and innovated a material culture of healing during the 17th and 18th centuries.

¹²⁰ A general work that includes information on the uses of herbs for healing can be found in Geoffery Parrinder, *West African Religion: A Study of the Beliefs and Practices of Akan, Ewe, Yoruba, Ibo, and Kindred Peoples*, (New York: Barnes and Noble, 1970), 105-07. Specific studies include Harley's study of herbalism and magic in Liberia and Maynard's more recent work on healing in the grasslands of Cameroon, G.W. Harley, *Native African Medicine*, (London: Cass, 1970); Maynard, *Making Kedjom Medicine*.

¹²¹ C.C. Reindorf, *History of the Gold Coast*, 15; Field, *Religion and Medicine of the Gã People*, 83, 99, 114, 123, 128, 131; O.B. Dokosi, *Herbs of Ghana*, 118-19. European travelogues rarely mentioned explicit control of herbal knowledge, and Reindorf demonstrates that herbal knowledge could be passed down through networks of layhealers. Margaret Field showed that herbal knowledge was widely diffused amongst the *wulomei*, the *wontsemei/woyei*, the *tsofatsemei*, and herbal specialist layhealers, and contemporary evidence shows that knowledge of the curative powers of herbal medicines is widespread in Accra today. For example, *nyanyara* is widely known in Accra as a febrifuge and a purgative.

¹²² Barbot, *Barbot on Guinea*, 578-81.

After the fall of Ayawaso, Little Accra on the coast was well-positioned to become a market for medicinal flora because it occupied the seaport at the end of the “Akyem” trade route, a commercial pathway leading from the Guinea Coast to the Guinea Rainforest and the Western Sudan.¹²³ The extent of regional commercial exchange through Accra is evident in the archaeological record as well as in commentary found in European traveler’s accounts.¹²⁴ The mix of herbal curatives harvested and traded in Accra could be used in a variety of ingestible forms (such as concoctions, potions, decoctions, suspensions) and put to use in a variety of ways (as laxatives, emetics, diuretics, and analgesics).¹²⁵ Others were ground into powders and combined with palm oil to make ointments, or mashed together to make herbal paps, or even harvested as chewing sticks and tooth scrubs.¹²⁶ Many of the more complicated herbal remedies prepared in Accra would have been composed by the *tsogatsemei*, the professional herbalists, but access to knowledge about medicinal flora was not learned exclusively through apprenticeship with a professional healer. A lay-person, through careful study and by gathering a lifetime of knowledge about plants and their healing spirits, could also make medicines. Most mothers and grandmothers in Accra today have some

¹²³ Anquandah, “The Accra Plains,” 5; K.B. Dickson, *A Historical Geography of Ghana* (Cambridge: Cambridge University Press, 1969), 42-44, 50-53. Dickson notes the presence of Mande words in Akan dialects, and the mixture of round and square houses along the coast as evidence of trade relations between the Western Sudan, the Guinea Rainforest, and the Guinea Coast.

¹²⁴ Anquandah, “Accra Plains, Dangmeland,” 1-8.

¹²⁵ De Marees, *Gold Kingdom of Guinea*, 164; William Hutton, *A Voyage to Africa: Including a Narrative of an Embassy to One of the Interior Kingdoms, in the Year 1820; with Remarks on the Course and Termination of the Niger, and Other Principal Rivers in That Country* (London: Printed for Longman, Hurst, Rees, Orme, and Brown, 1821), 386.

¹²⁶ De Marees, *Gold Kingdom of Guinea*, 31; Wisnes, *Letters on West Africa and the Slave Trade*, 139, 174-75. Thonning and Isert did not name the species of the trees used as dental hygiene, but the Ga names for a chewing sponge is *taa kotsa* and chewing sticks are known as *taatso*. Thonning and Isert catalogued herbs, but there was likely a trade mineral products, like natron (used as an antacid). For a 20th century perspective on the natron trade see Donald E. Vermeer, *Geophagy among the Ewe of Ghana*, *Ethnology* 10, no. 1 (January, 1971), 56-72.

knowledge of healing herbs, and it is probable that knowledge of so-called ‘kitchen physick’¹²⁷ was passed down from mother to daughter, but there is no strict gender delineation of herbal knowledge in Accra. And because knowledge about medicinal herbs was diffuse, it served as a potential means of healing oneself, or someone close to you, without having to resort to a “quest for therapy” within a particular medical or religious regime.

The most comprehensive list of herbal reagents used by healers in Accra comes from a compendium of plants collected by Paul Isert in the late 18th century, a Danish abolitionist who lived in Accra for several years (see Table 2.4).¹²⁸ Isert worked on the Gold Coast as a surgeon, tending to the medical needs of Danish officials at Christiansborg Castle and administering medicines to slaves but he was particularly interested in the flora of the coastal plains and the Akwapim Ridge. After working as a surgeon inspecting slaves for several years, he developed an abhorrence for the trade and petitioned the Danish government to promote the development of plantations in the Akwapim Ridge, which he hoped would grow the same cash crops as those grown in the Danish West Indies. With a utopian vision of scientific progress, Isert aspired to restructure the flow of commodities within the Danish

¹²⁷ Louise H. Curth, *From Physick to Pharmacology: Five Hundred Years of British Drug Retailing* (Aldershot, Hampshire, England: Ashgate, 2006), 3. Curth defined kitchen physick as “remedies being prepared in the home from ‘natural ingredients’.”

¹²⁸ Jones ed., “Michael Hemmersam’s Description of the Gold Coast,” in *German Sources for West African History*, 112; Hepper, *West African Herbaria*. Michael Hemmersem describes a trade in berries and fruits used as medicines on the Gold Coast and the herbaria produced by botanists Paul Isert and Peter Thonning in the 1770s and 1780s contains over forty medicinal plants that were traded around the Gold Coast.

Latin Name	Region	Vernacular name	English (where translatable)	Uses for healing	Pg #
<i>Baphia nitida</i>	Aquapim	no vernacular	camwood	child development, joints, fungus infections, sores	85
<i>Blighia sapida</i>	Guinea	“Atia-tjo”	akee apple	poison, poultice	115
<i>Boerhavia diffusa</i>	Guinea	“Tjalala”	hogweed or pigweed	dysentery	80
<i>Cardiospermum halicacabum</i>	Guinea	“Sablabó”	balloon vine/ heart seed	injuries	115
<i>Cissus quadrangularis</i>	Guinea	no vernacular		Guinea worm, lung illnesses	131
<i>Clausena anisata</i>	Guinea	“Abami-tio”		stomach disorders, facial swellings	113
<i>Erythrina senegalensis</i>	Guinea	“Naba-tiölu”		dysentery, colic, easing difficult deliveries	89
<i>Fagara zanthoxyloides</i>	Guinea	“Hah-tio”	candlewood	gout-pains, toothache	113 - 14
<i>Flacourtia flavescens</i>	Guinea	“Amagomi”		gonorrhoea, wasting cough	61
<i>Gardenia ternifolia</i>	Ga	“Paettaepiae-bi”		different illnesses	107
<i>Indigofera pulchra</i>	Guinea	no vernacular		old leg-injuries	92
<i>Ipomoea mauritiana</i>	Guinea	“Löloa-pang”		dropsy, gonorrhoea	47
<i>Lantana camara</i>	Guinea	“Nanni-kumi”	wild sage	snakebites	129
<i>Lonchocarpus cyanescens</i>	Guinea	“Akassi”	West African Indigo	old leg-injuries	94
<i>Momordica charantia</i>	Guinea	“Jan-j’na”	African cucumber	worms	51 - 52
<i>Ocimum gratissimum</i>	Guinea	“Sylu”		malignant bilious fever	65
<i>Phyllanthus amarus</i>	Guinea	“Aumaadoati”		fever, stomach pains Dropsy	58
<i>Physalis angulata</i>	Guinea	“Amotobi”		abortifacient, mumps, skin diseases	120
<i>Triumfetta rhomboidea</i>	Guinea	“Toubé”		Guinea worm	125-26

Table 2.4. A sample from Isert’s list of medicinal herbs. This partial list of herbs from Isert’s catalogue features a number of common reagents used around 1800 in Accra. The uses of the herbs listed cover a wide variety of maladies (including sexual dysfunction, birth control, venereal disease, stomach ailments, wounds, worm infestations, tooth problems, fevers, etc.) indicating the power of local herbs to cure basic elements of bodily illness. Sources: F. N. Hepper, *West African Herbaria of Isert and Thonning* (Chicago: University of Chicago Press, 2000).

economy by stimulating the growth of plantations close to what he considered to be their natural labour supply.¹²⁹ To gather information about the flora of the region, he arranged an expedition to the Akwapim Ridge, and during the few weeks that he traveled through Ga and Akwapim villages, he accumulated a wealth of information on plants.¹³⁰ Isert's samples are still held in Copenhagen, and in 1976, F.N. Hepper compiled them, reclassified them, and supplemented them with later collections by Danish surgeons and travelers from the 19th century.

Isert's list contains over 30 species used by healers in Accra, many of which were common weeds found in the fields around Accra, like the aforementioned, all-purpose *Momordica charantia*. Others came from the moist climate of the Akwapim Ridge, like the purgative seeds of *Aframomum melegueta*. He also included some very rare plants specific only to the microclimates of the Gold Coast, such as a parasitic flowering red plant in Akwapim that grew exclusively in the roots of one species of tree and was used locally for the

¹²⁹ Mary Louise Pratt, *Imperial Eyes: Travel Writing and Transculturation*, 2nd ed (New York: Routledge, 2008), 37. Mary Louise Pratt argued that the travel writing of Europeans in Africa during the end of the 18th century assumed a "Utopian, innocent vision of European global authority" that naturalised manipulations of the environment based on the knowledge of natural philosophy rather than on conquest and enslavement. Isert's vision for Danish territories in West Africa, however, did not exclude the possibility of using slave labour. Rather, he advocated the abolition of the slave trade and the utilization of an African labour supply on Danish-run, African based plantations.

¹³⁰ Isert's catalogue was supplemented by work done by Peter Thonning after Isert's death. Peter Thonning was commissioned by the Danish Government to care for the plantations established by Paul Isert. He resided at Christiansborg from 1799-1803. When he returned to Copenhagen he established a herbarium, which was subsequently destroyed during a British bombardment of the city in 1807. Some duplicates of Thonning's work have survived, as have some of his plant samples, which are held at the University of Copenhagen. R. K. Brummitt & C. E. Powell, eds., *Authors of Plant Names: a List of Authors of Scientific Names of Plants, with Recommended Standard Forms of their Names, including Abbreviations* (London: Royal Botanic Gardens, Kew, 1992).

treatment of venereal disease.¹³¹ Recent chemical analyses of some of the plants catalogued by Isert have shown that many of them, not surprisingly, do contain potent medicinal compounds. Two examples are the herb *biiatso*, which has analgesic properties, and the ubiquitous *nyanyara*, which contains alkaloids that make it a useful purgative and anthelmintic.¹³²

Isert was also aware of local febrifuges and he reported (albeit with some skepticism) that local herbalists had a cure for malaria:

[one] myth is that of the wonder cure, the expulsion of the fever tumor, which the Black is supposed to know. The older Coastmen recount the phenomenon to the newly-arrived doctor. Indeed, even any soldier who has been in the country for three years longer than the doctor believes himself to have a better insight into medicine than the latter.¹³³

Isert did not explicitly mention the names of any particular antimalarial herbal remedies available on the Gold Coast, but his informants might have been referring to any number of plants used to fight fevers in Ghana today, including *cryptolepis sanguinolenta*,¹³⁴ a yellow root

¹³¹ Wisnes, *Letters on West Africa and the Slave Trade*, 165. Wisnes suggests this might be *Phytolacca icosandra*, an herb with antifungal medicinal properties. See K. Hostettmann and A. Marston, "Countercurrent Chromatography in the Preparative Separation of Plant-Derived Natural Products," *Journal of Liquid Chromatography & Related Technologies* 24, no. 11/12 (June 15, 2001), 1714.

¹³² A comprehensive list of the scientific articles published on the compounds found within the species listed by Isert can be found in Appendix A.

¹³³ Wisnes, *Letters on West Africa and the Slave Trade*, 156.

¹³⁴ Bep Oliver-Bever, *Medicinal plants in tropical West Africa* (Cambridge: Cambridge University Press, 1986), 131, and Maurice M. Iwu, *Handbook of African Medicinal Plants* (CRC Press, 1993), 163-64; *Cryptolepis sanguinolenta* is sometimes called 'Ghana Quinine' and it is available in the local markets in bottled form as a malaria remedy. It has not yet been mass produced for use outside of Ghana. For information on how over 20 species of bitter leaves, roots and barks are mixed used interchangeably as fever medicines in Ghana today see Asase, et. al., "Ethnobotanical study of some Ghanaian anti-malarial plants," Table 2; Isert might also have been aware of the composite use of herbs in antimalarial draughts. In a 2003 clinical trial at Korle Bu Hospital, a decoction prepared with some of the herbs found on Isert's list (including *Jatropha curcas* and *Physalis angulata*) eliminated malaria parasites from the blood of patients when administered orally. Nii-Ayi Ankrach et al., "Evaluation of Efficacy and Safety of a Herbal Medicine Used for the Treatment of Malaria," *Phytotherapy Research* 17 (2003), 697-701.

that contains antimalarial alkaloids, *rauwolfia caffra*, a type of milkweed,¹³⁵ or the barks of *kbaya senegalensis*, *sarcocephalus esculentus* or *crossopteryx febrifuga*.¹³⁶

From a 21st century pharmaceutical perspective, Isert's compendium offers evidence of a dense local herbarium of curative reagents, but what is even more interesting about the list is the presence of foreign plants. Isert likely assumed that all of his specimens were native to the region, but foreign medicinal flora were also present in his catalogue, including the West Indian Bahama Tea (*lantana camara*), used for snakebites, a South Asian anthelmintic (*cissus quadrangularis*), used to fight Guinea worm, and a South American tropical plant (*physalis angulata*) used variously as an abortifacient and skin salve. This is the oldest extant record of the incorporation of herbs from around the world into the repertoire of healers of the Gold Coast, and it speaks to an openness by healers on the Gold Coast to incorporate novel herbal simples into their remedies.¹³⁷ There is no record of these herbs being traded as commodities in local markets, so they may have been cultivated or encouraged to grow in the wild, but either way herbalists appropriated them as medicinal reagents.

The medicinal flora native to the Gold Coast were most certainly traded around local and regional markets. As Judith Carney has shown, plants from West Africa found their way

¹³⁵ John Hutchinson and John McEwen Dalziel, *Flora of West Tropical Africa* (London: Crown Agents for the Colonies, 1927), 377-78; Oliver-Bever, *Medicinal Plants in Tropical West Africa*, 37.

¹³⁶ Hutchinson & Dalziel, *Flora of West Tropical Africa*, 325, 396, 412; Maier, "Nineteenth-Century Asante Medical Practices," 67; a study commissioned by the OAU at the end of the 20th century resulted in the compilation of information about hundreds of medicinal herbs in Ghana, including 46 plants that can be used as antimalarials. See Mshana, N.R. et al. *Traditional Medicine and Pharmacopoeia. Contribution to the revision of Ethnobotanical and Floristic Studies in Ghana* (Organization of African Unity/Scientific, Technical and Research Commission, 2002), 716-19.

¹³⁷ Karen Flint has argued that healers in the Zulu Kingdom maintained an openness to new medical reagents, and were willing to experiment with novel therapies. Flint, *Healing Traditions*, 57.

across the Atlantic to the Americas,¹³⁸ but it is important to note that there is no record of any explicit commerce in medicinal plants native to Africa. As far as we know, none of the many herbal reagents present on the West Coast Africa made the leap from local remedy to transatlantic commodity. And despite the subaltern movement of herbs from the Americas to Africa, there is only one herbal reagent from the New World that was brought back across the Atlantic explicitly for the purposes of trading with Africans. During the slave trade, Europeans brought Central American sarsaparilla root to trade along the Guinea Coast.¹³⁹ Jean Barbot noted in 1780 that Africans boiled the root in alcohol in order to make a cure for venereal disease,¹⁴⁰ and Pieter De Marees noted in his journals:

They often use Salsaparille, which is brought to them by the Dutch ships, against the Pox and the Clap. They boil this Ointment in fresh water and drink it as a draught against the Pox and similar diseases, and also against the Worms which they get in their legs...¹⁴¹

The “Pox” that de Marees presumed to be a venereal disease was probably yaws (known in Ga as *ajito*), an ulceration of the skin caused by bacterial infection.¹⁴² Paul Isert also noticed the endemic nature of yaws and was adept enough to ascertain that it was different from a venereal disease because most of the people he spoke to on the Gold Coast had contracted

¹³⁸ Judith Carney, “African Traditional Plant Knowledge in the Circum-Caribbean Region,” *Journal of Ethnobiology* 2, no. 2(Fall/Winter 2003): 167-185.

¹³⁹ Jones, ed., *West Africa in the Mid-Seventeenth Century*, 97, 150, 322; Barbot, *Barbot on Guinea*, 560.

¹⁴⁰ Barbot, *Barbot on Guinea*, 576.

¹⁴¹ De Marees, *Gold Kingdom of Guinea*, 173-74.

¹⁴² De Marees, *Gold Kingdom of Guinea*, 11. The Ga language distinguishes between yaws and syphilis. *Ajito*, the observable skin disease of yaws, has two other terms associated with it. The first is *ajitofoi*, people who suffer from yaws, indicating that Ga-speakers saw it as a common affliction, and *ajito gbowie*, a seed used for treating skin disorders such as yaws, indicating that it was the focus of healing practice. Syphilis is known by a specific term, the Ewe word for pouch, *gbaja*. The source and reasoning for this loan word is not known. The Latin word for yaws is *frambesia tropica*. This error of diagnosis was repeated ad absurdum in Uganda during the colonial period. See Vaughn, *Curing Their Ills*, 138.

the disease at least one time in their lives.¹⁴³ The mention of “the Clap” was likely a reference to gonorrhoea,¹⁴⁴ whereas the worms that de Marees mentions were almost certainly Guinea worm.¹⁴⁵ The effectiveness of sarsaparilla against these diseases is unquantifiable from a 21st century clinical perspective, but we know that the root was regarded as a strong medicine because it was in high demand around the Atlantic World.¹⁴⁶ It may also have been widely adopted as new medicine for a new set of illnesses: a sailor’s cure for the venereal diseases spread by sailors around the ports of the Atlantic Ocean.

Nonetheless, the presence of sarsaparilla in the documentary record is an anomaly. Though West Africans adopted foreign plants for use in their own systems of healing, there is no other historical record of a trade in herbal reagents between Europeans and Africans. This is surprising considering the efficacy of medicines like cinchona, the South American tree bark that was the progenitor of the drug quinine.¹⁴⁷ Known simply as “Peruvian bark”

¹⁴³ Wisnes, *Letters on West Africa and the Slave Trade*, 144.

¹⁴⁴ The Ga word for gonorrhoea is *babaanso*, from the Ewe-derived term *baba*, meaning skin disease with redness, and *babaaba*, a flowing and gushing out. *Babaanso* might just be a term that describes the visible symptoms of gonorrhoea.

¹⁴⁵ Isert’s letters contain a long tract on aetiology of Guinea worm, in which he deduces that it must be caused by bad water. He includes a number of counter-opinions of its causes, so there was obviously no medical consensus about the aetiology of the disease in the 18th century (Wisnes, *Letters on West Africa and the Slave Trade*, 144).

¹⁴⁶ Sarsaparilla contains phytosterols that create testosterone and progesterone, chemicals that are believed to fight impotency and increase fertility but it is not used today as an antibiotic. Anthony C. Dweck, “The internal and external use of medicinal plants,” *Clinics in Dermatology* 27, no. 2, (March-April 2009), 157; Trade in sarsaparilla is mentioned in: Margaret Makepeace, ed., *Trade on the Guinea Coast. 1657-1666. The Correspondence of the English East India Company* (Madison: African Studies Program, University of Wisconsin, 1991), 9; Heather Flynn Roller, “Colonial Collecting Expeditions and the Pursuit of Opportunities in the Amazonian Sertão, c. 1750-1800,” *The Americas* 66, no. 4 (April, 2010), 435-467.

¹⁴⁷ There is no mention in the documentary records of a demand for cinchona bark in Accra, and no mention of any West Africans adopting the cultivation of the tree. Such an anomaly in medical exchange is difficult to explain because cinchona bark was a valuable trade commodity in the 18th century, and there were ecological zones and altitudes in the Akwapim Hills north of the city that were suitable for its cultivation. It is possible that West Africans never adopted the use of cinchona because they were already familiar with local species of flora (and their associated spiritual forces) with the same antimalarial properties. It is also

by Europeans, cinchona was an indispensable febrifuge in the toolkit of surgeons traveling through West Africa.¹⁴⁸ Taken as a tonic or mixed in Madeira wine, it was the first line of defense against malaria, yet there is no mention in the documentary records of local demand for cinchona bark on the Gold Coast, and no mention of any West Africans adopting the cultivation of the tree.¹⁴⁹ It is possible that the people of the Gold Coast never appropriated cinchona because they used local antimalarials, or because the Spanish restricted the supply of seeds and saplings across the Atlantic in the 17th and 18th centuries,¹⁵⁰ or because the British and the Dutch concentrated their cinchona plantations in India and Java, respectively.¹⁵¹ But despite these explanations, the absence of cinchona, either as a commodity of exchange or as an indigenized plant remains an oddity, considering that West Africans incorporated other foreign medicinal plants into their herbal repertoire and actively traded in sarsaparilla.

Apart from herbal simples, a number of composite spiritual objects (regarded by Europeans at the time as “fetishes”) also appear in European records, and the most prominent of these were oath devices. To guarantee a business deal in Accra, one was often

possible that they never had access to the seeds of the tree because the Spanish controlled the supply of seeds and saplings across the Atlantic in the 17th and 18th centuries (Fiametta Rocco, *Quinine: Malaria and the Quest for a Cure That Changed the World*, (London: Harper Collins, 2003), 110-11). Another reason might be that herbalists on the Gold Coast never gained access to seeds because Europeans bypassed West Africa as a production zone for cinchona, with the British focussing on India and Ceylon, and the Dutch on Java (Rocco, *Quinine*, 246-48, 262). But despite these explanations, the absence of cinchona, either as a commodity of exchange or an indigenized medicinal plant remains an oddity considering the dozens of other adoptions of foreign medicinal flora.

¹⁴⁸ Rocco, *Quinine*, 52.

¹⁴⁹ Cinchona’s use as a medicine was known to Jesuits in the New World by the 17th century, and it appeared in the *materia medica* of the London Pharmacopoeia of 1677. Roy Porter. *The Cambridge Illustrated History of Medicine* (Cambridge: Cambridge University Press, 2001), 254. A detailed example of its use as a fever remedy can be found in James Lind, *An essay on diseases incidental to Europeans in hot climates. With the method of preventing their fatal consequences...* (London, 1792), 54-72.

¹⁵⁰ Rocco, *Quinine*, 110-11.

required to make a pledge before a shrine or a mobile consecrated object. According to Ludwig Ferdinand Rømer, who lived at Christiansborg Castle in the late 18th century, Europeans made use of local oath-taking rituals to guarantee business contracts, employing local ritualists to mediate at the ceremonies:

They have a special way of swearing an oath. We Danes call it 'eating fetish' ... According to the laws of the land, we can force a Negro who has swindled us or stolen from us to eat fetish [to prove that] he had not done it. We pay two rixdaler to [hire] the fetish of our broker Adoui. Together with the fetish there usually come into the Fort a whole swarm of old Negroes, so that it costs us an additional two rixdaler to serve them brandy. This fetish is carried on a mat covered with an old cloth. The fetish consists of a stuffed snake skin, without head or tail, but in their stead, the hair from an elephant's tail, or a cow's or wolf's tail, mingled with the feathers from a cock, so that it looks horrible. By custom it is made like a necklace, with threads at both ends, so that the individual who wishes to wear it can tie it at the back of his neck. This is placed at the feet of the Europeans who are present, the old cloth is taken from the sausage-like fetish and a crumb of dough as large as a pea placed on it. The accused then comes forward, goes down on his knees, holding his hands behind his back, and utters this oath: 'If I have done that' or 'If I have stolen this or that, then let the fetish kill me'. With his mouth he takes the dough from the snake skin, holds it on his tongue, and by opening his mouth, proves that he really has it there. Then he swallows it. He has thereby been freed of the accusation.¹⁵²

In the absence of European courts and legal structures, Europeans were obliged to abide by contract negotiations that drew their power from the supernatural realm, though they may have considered them to be based on superstition. Other ceremonies described by Europeans included the consumption of herbal draughts that were held to be harmless to those who adhered to the letter of the contract, but were believed to be fatal to those who broke their promises.¹⁵³ Poison oracles were prevalent too, as devices to test loyalty and catch thieves, and it was believed that failure to adhere to the taboos associated with such

¹⁵¹ Rocco, *Quinine*, 246-48, 262.

¹⁵² Rømer, *Reliable Account of the Coast of Guinea*, 101.

¹⁵³ Rømer, *Reliable Account of the Coast of Guinea*, 103, Wisnes, *Letters on West Africa and the Slave Trade*, 130; Monad, *Description of the Guinea Coast*, 53-4.



Figure 2.3. A consecrated oath object sketched by Jean Barbot in 1780. The figurine aggregates spiritual and material power through a composition of both local and imported items, including cloth, “glassware, beads, herbs, clay, burnt feathers, tallow and threads of bark from the fetish tree, all pounded and kneaded together.” Though Barbot described the object as being carried in a wicker basket, the brass bowl depicted here may have been a trade item brought south across the Sahara (see Raymond A. Silverman and David Owusu-Ansah, “The Presence of Islam among the Akan of Ghana: A Bibliographic Essay,” *History in Africa*, 16 (1989), 333). This particular oath object appeared to have its residence in Christiansborg Castle and was maintained by an employee there. It would have been one of many different consecrated medicines and shrines in Accra that could be used to seal business contracts or personal relationships. *Source:* Jean Barbot, *Barbot on Guinea*. Fig. 49 between 580-81 & 580-87.

oracles could result in illness or death.¹⁵⁴ Also notable in the records were descriptions of trials-by-ordeal, including burning the skin with a hot knife, or piercing the tongue with an awl.¹⁵⁵ And while many of the so-called oath fetishes were made of local materials like clay, hair and feathers, many others included imported European items, such as cloth, beads, pottery, and glassware, making the composition of the fetishes representative of commerce around the Atlantic Ocean (see Figure 2.3).¹⁵⁶ Oath fetishes are an example of an African curative device that would not properly fit the category of “medicine” in the European context, but the rituals performed around oath fetishes were without question socially medicinal because they forged bonds between business partners in a way that tied the health of the business relationship directly to the health of the body.¹⁵⁷

Oath fetishes were prominent in European accounts of religion in Accra during the 17th and 18th centuries, but the city was also home to hundreds of minor shrines, spirit mounds, and mobile devices, and even lay people could gain access to the minor spirits of the city. An example of the diversity of material objects imbued with supernatural power can be found in an account of a cabinet of “knick-knacks” owned by an associate of Danish Merchant Ludwig Ferdinand Rømer in the 18th century.¹⁵⁸ By chance, Rømer stumbled across the collection while visiting a Ga-speaking caboceer, Noyte, who worked with the Danes at Christiansborg Castle.

¹⁵⁴ De Marees, *Gold Kingdom of Guinea*, 69.

¹⁵⁵ Rømer, *Reliable Account of the Coast of Guinea*, 101.

¹⁵⁶ Barbot, *Barbot on Guinea*, 578-80.

¹⁵⁷ Eating fetish was particularly effective because of the fear of poisoning that was prevalent in Accra. Rømer includes an account of a locally produced poison that created symptoms in the body that mimicked common illnesses. Rømer even suspected involvement of Dutch merchants, who he claimed poisoned each other to steal their possessions (Rømer, *Reliable Account of the Coast of Guinea*, 38-39). De Marees also mentioned poison, in the form of a herbal sap that was used to poison arrows used in battle (De Marees, *Gold Kingdom of Guinea*, 93).

¹⁵⁸ Rømer, *Reliable Account of the Coast of Guinea*, 94-95.

Noyte ... sitting among many thousands of knick-knacks, among which I saw the heads of elephants, oxen, sheep, and other animals. He did not see me before I had stuck my head and half my body in through the narrow door, thus casting a shadow inside. He stood up and asked me to leave. I did not wish to do this, but promised him that I would come no closer, if he would tell me what it all meant. He swore by his father -- a great oath among Negroes -- that he did not know one hundredth part of the amount of good that had come [from the collection of sacred objects], but that all of it (perhaps with the exception of some one hundred items) had been collected by his forefathers, and each piece which I saw had helped his forefathers in some way, because of the help of God and the fetish... This was also Noyte's way of celebrating morning prayers, by sitting for an hour among these knick-knacks and rummaging among them.¹⁵⁹

Their dialogue further revealed that Noyte had protected his collection of objects as part of his ancestral heritage, moving them several times to save them from invading armies and even burying them in the ground for decades to save them from destruction. Rømer challenged Noyte on the value of the items by asking why one particularly innocuous object, a small stone the size of an egg, could be of any use. Noyte claimed that he had once tripped over the stone, and that it had alerted him to bury his collection of objects, a timely reminder because his village was attacked by the armies of the Asante shortly afterwards. Since then he had kept the stone in his pocket and squeezed it when he needed spiritual protection. The stone had been particularly useful for Noyte when he was brought before a magistrate at Christiansborg Castle and accused of an unrecorded malfeasance. Rømer recalled seeing the accused squeeze the stone right before he was declared innocent by the magistrate.¹⁶⁰

A historian could not recount the millions of individual biographies of the many consecrated objects fabricated by the *wulomei*, the *wontsemei*, the *tsosatsemei* and by layhealers in Accra. Even if we were able to unearth Noyte's curio cabinet, the meanings of its contents

¹⁵⁹ Rømer, *Reliable Account of the Coast of Guinea*, 94-95. Though his biography is not offered by Rømer, it is likely that Noyte was a company slave who acted as the caboceer at Teshie. Justesen & Manley, *Danish Sources*, 613, 698, 717.

would be mostly lost. As William Pietz has noted, the production of a consecrated medicine is bound up within a particular timeframe and context -- without an account of its meaning at the particular moment that it was produced, it is rendered a voiceless artifact.¹⁶¹ But Rømer's description of Noyte's collection hints at the diversity of the material culture that fed into the ongoing production of consecrated medicines in Accra. His bones and stones were everyday objects in one sense, but when combined together, their power multiplied. They were vessels for *woji*, and when composed together they made a powerful aggregate *tsofa*. While the *tsofatsemei* demonstrated expertise in drawing healing *woji* out of plants, the *wontsemei/woyei* channeled spirits,¹⁶² and the *wulomei* tended the major shrines,¹⁶³ Noyte played the role of the lay spiritualist, using his cabinet of spiritually charged items to independently manipulate unseen forces to his own advantage. Noyte's fetishes, from the perspective of Rømer, might have been worthless objects imbued with misplaced significance, but in the context of West African healing culture, they were essential tools for managing the vagaries of daily life. In the context of the history of healing in Accra, is it likely that people like Noyte conceived of, fabricated and deployed newly consecrated objects time and time again, in an effort to fight disease, manage health, and facilitate the flow of *bevale*.

Section 5. Partial Adaptation: European Surgeons and European Patients on the Gold Coast in the 17th and 18th Centuries.

¹⁶⁰ Rømer, *Reliable Account of the Coast of Guinea*, 94-95.

¹⁶¹ Pietz, "Problem of the Fetish, 1," 12-13.

¹⁶² Rømer, *Reliable Account of the Coast of Guinea*, 90.

¹⁶³ De Marees, *Gold Kingdom of Guinea*, 67.

Recent histories of the Atlantic slave trade have characterized West Africa as a place of cultural and commercial exchange.¹⁶⁴ By emphasizing participation in the “interchange, circulation, and transmission”¹⁶⁵ of trans-oceanic ideas, practices and goods during the era of the slave trade, historians of West Africa have begun to characterize West Africa via idioms of cultural mixing: as a product of intercultural “dialogue, borrowing, syncretism, and diffusion,”¹⁶⁶ or as the setting for “processes of transculturation.”¹⁶⁷ This model holds true for Accra in many ways. The mixing of ideas about health and healing around the Gold Coast, for instance, were facilitated by inland and sea-borne trade. The exchange in herbal simples around the Atlantic and Indian Oceans is also evidence of this sort of diffusion of ideas and things, as does the joint use of hybrid oath fetishes as business contracts in Accra. However, events on the Gold Coast and in Accra cannot always be lumped together with a broader history of the Atlantic World. To do so would unwittingly privilege European events and agent, and it should be noted that the tropical disease environment posed a major barrier to consistent intercultural contact because it killed off Europeans at a rate of approximately 50% per year.¹⁶⁸ Additionally, the commercial exchange in slaves created

¹⁶⁴ In recent literature, historical trends in West Africa have been increasingly linked to the New World (especially Brazil, because of the extent of trade via Portuguese shipping) and to Europe (in particular Britain, because of its dominance of the maritime trade), see Robin Law and Kristen Mann, “West Africa in the Atlantic Community: The Case of the Slave Coast,” *The William and Mary Quarterly*, 3rd Series, 56, no. 2 (April, 1999), 307-334.

¹⁶⁵ Trevor Burnard, “The British Atlantic,” in *Atlantic history: a Critical Appraisal*, Jack P. Greene and Philip D. Morgan, eds. (Oxford: Oxford University Press, 2009), 111.

¹⁶⁶ Richard Rathbone, “West African: Modernity and Modernization,” in *African Modernities: Entangled Meanings in Current Debate*, ed. by Jan-Georg Deutsch, Peter Probst, and Heike Schmidt (Portsmouth, NH: Heinemann, 2002), 19.

¹⁶⁷ Charles Piot, *Remotely Global: Village Modernity in West Africa* (Chicago: University of Chicago Press, 1999), 23. Piot takes the term ‘transculturation’ from the work of Fernando Ortiz and uses it as a conceptual framework that allows for the unpredictable and contingent creolization of aspects of culture, which can include the inscription of localized meanings on global commodities. Fernando Ortiz, *Cuban Counterpoint: Tobacco and Sugar*, Harriet de Onís, trans. (Durham, NC: Duke University Press, 1995), 98.

¹⁶⁸ Curtin, *Disease and Empire*, 1.

hierarchies of power and ideologies of difference that could serve as barriers to cultural exchange. For instance, despite the long-standing presence of ship's surgeons in the city and the existence of an outwardly pluralistic approach to healing, the residents of Accra did not appropriate European humoral theories or surgical techniques during the 17th and 18th centuries. Likewise, European surgeons could not see through notions of race and fetish to see how African therapies might help them survive on the Guinea Coast. What did happen, however, was that European patients, in their efforts to survive on the Gold Coast, sought help from African healers. This section will show how pluralistic healing was perpetuated on the Gold Coast via the actions of European patients, but was also limited by the practices of European surgeons, who were vulnerable to the disease environment and beholden to the commerce in human beings.

During the era of the transatlantic slave trade, there were never more than a few dozen Europeans living in the port cities of West Africa at any given time, and they were mostly cloistered within the Danish, Dutch and English forts. Most Europeans who visited the coast were struck with fever within a few weeks. On average, half were dead within the first year.¹⁶⁹ Those who survived a bout of malarial fever gained a temporary respite from illness but they were still vulnerable to yellow fever, typhoid, Guinea worm and gastrointestinal illnesses. Waves of illnesses swept through garrisons on the Gold Coast, at times leaving slave forts vulnerable to being overrun by brigands.¹⁷⁰ As Danish Chaplain H.C. Monad noted in 1822: "Europeans never grow very old in Africa, and I know of none who have reached an age of much over 50 years. The climate and the way of life work against

¹⁶⁹ Curtin, *Disease and Empire*, 1. Davies notes an extremely high death rate on the coast for Europeans in the 17th century. K.G. Davies, *Royal African Company* (New York: Octagon Books, 1975), 256.

them.”¹⁷¹ It is no wonder that by the 19th century the Gold Coast became known as the “White Man’s Grave.”¹⁷²

The notoriously unhealthy climate of tropical Africa made it difficult for Europeans to staff their forts with medical professionals.¹⁷³ The training for ship’s surgeons was cursory, based on apprenticeship and the completion of a perfunctory examination,¹⁷⁴ and their chief

¹⁷⁰ Justesen & Manley, *Danish Sources*, 103, 701, 789, 793. Danish factors demonstrated consistent fears that their garrisons, weakened by illnesses, might be unable to resist an attack by African merchants in the nearby village of Osu.

¹⁷¹ Monad, *Description of the Guinea Coast*, 266; Historian Georg Norregard commented that Europeans returned home from the Gold Coast as “human wrecks for the rest of their days, for the most part, skinny, pock-marked, sallow, prematurely aged.” Norregard, *Danish Settlements in West Africa*, 169.

¹⁷² P. D. Curtin, “The White Man’s Grave”: Image and Reality, 1780-1850,” *Journal of British Studies* 1, no. 1 (November, 1961), 103. The phrase “White Man’s Grave” does not have a distinct provenance, but was probably coined during the establishment of Sierra Leone as a British colony during 19th century. See F.H. Rankin, *The White Man’s Grave: a Visit to Sierra Leone in 1834*, 2 vols. (London, 1836).

¹⁷³ Curtin, *Disease and Empire*, 16-17, 52-54. It was very unusual to find a surgeon posted at James Fort in Accra, since it held a small garrison of fewer than 20 soldiers. In October of 1847, Dr. Gordon visited James Fort and found it manned by twenty soldiers of the West India Regiment and five or six men from the Gold Coast Militia. Also, the records of the Royal Africa Company do not indicate any permanent presence of a surgeon at Accra from the late 18th to the early 19th century, during the height of the slave trade. See J.J. Crooks, *Records Relating to the Gold Coast Settlements from 1750 to 1874* (Dublin: Browne and Nolan Ltd., 1923), 79, 132-33. The Danes at Christiansborg Castle had similar problems keeping their white officers healthy and the garrison at full strength. Norregard, *Danish Settlements in West Africa*, 166.

¹⁷⁴ Richard B. Sheridan. “The Guinea Surgeons on the Middle Passage: The Provision of Medical Services in the British Slave Trade,” *The International Journal of African Historical Studies*, Vol. 14, No. 4 (1981), pp. 611-2. The Company of Barber Surgeons was given a charter by Henry the VIII in 1540. Geoffrey Hudson suggests that surgeons sought positions in the navy or merchant marine to escape poverty at home, and that the examination was largely a formality (Geoffrey L. Hudson. “Introduction: British Military and Naval Medicine, 1600-1830,” in Geoffrey L. Hudson, ed. *British Military and Naval Medicine, 1600-1830* (New York: Rodopi, 2007). 10. Paul Kopperman suggests that many surgeons were not examined at all, or were allowed to pass even when they did poorly on the exam (Paul E. Kopperman. “The British Army in North America and the West Indies, 1755-83: A Medical Perspective,” in Hudson, ed. *British Military and Naval Medicine*, 57-8. In the Netherlands, any surgeon wishing to join the Dutch naval fleet required an approval of his skills and experience by reputable surgeons and doctors. Adam Jones, “Samuel Brun’s Voyages of 1611-20,” in *German Sources for West African History, 1599-1669* (Wiesbaden: Franz Steiner Verlag GMBH, 1983), 79.

duty when they reached Accra was to patch up wounded sailors and evaluate the physical health of slaves.¹⁷⁵ Their success as members of an expedition to the West Coast of Africa was evaluated by how many of the crew and the slaves survived the journey, and their reward was a salary and a share of the ship's revenue, often in the form of slaves to sell for their own personal profit.¹⁷⁶ Thus, since so few surgeons could survive long enough to propagate their ways of understanding health and disease amongst West African populations, and because they were co-opted into the trade as slave traders, the influence of European surgeons was necessarily limited.¹⁷⁷

When they did lodge temporarily at the forts, the primary task of the surgeon was economic, not medical; they were there to determine the health, and therefore the value, of slaves, and they often received bonuses if they were able to reduce mortality during the transatlantic voyage.¹⁷⁸ The only permanent members of the British medical staff were housed at Cape Coast Castle, the fort with the largest slave dungeons.¹⁷⁹ Europeans who fell

¹⁷⁵ Robin Law. *Ouidab: the social history of a West African slaving 'port', 1727-1892*, 2nd ed. (Ohio State University Press, 2004), 141.

¹⁷⁶ Hugh Thomas, *The Slave Trade: The Story of the Atlantic Slave Trade: 1440-1870* (New York: Simon and Schuster, 1997), 307. Dolben's Act of 1788: "Surgeons received a premium of £50 if mortality on the Middle Passage did not exceed 2 percent, or £25 if losses did not exceed 3 percent. It also provided that every slave ship should carry a trained surgeon." See "An Act to Regulate the Carrying of Slaves, 28 Geo. III, c. 54," Donnan, *Documents of the Slave Trade*, II, 582-589.

¹⁷⁷ *House of Commons Papers*, no. 228. 1840, in J.J. Crooks. p. 270-4. The death rate was so high that the British sent a former stipendiary-magistrate from the West Indies, Dr. Madden, to investigate health conditions in West Africa in 1841. Unfortunately, as soon as he arrived on the coast he fell ill and had to return to England.

¹⁷⁸ Donnan, "An Act to Regulate the Carrying of Slaves," 582-89.

¹⁷⁹ Accra was a small contributor to the total number of slaves shipped from the Atlantic coast, showing a total of only 17,544 captives embarked in The Trans-Atlantic Slave Trade Database. This may be an underestimate, as other ports such as Anomabo and Commenda show totals of over 100,000 each, but it does point to the fact that the slave forts at Accra probably made substantial profits from other commodities, like ivory and gold. David Eltis et al., *The Trans-Atlantic Slave Trade Database*, accessed March 31, 2010, <http://www.slavevoyages.com> [hereafter TSTD2]. Also, surgeons were largely employed to examine slaves, so it would be normal for them to be stationed at Cape Coast. See Davies,

sick at James Fort in Accra had to sail west along the coast for medical attention, or wait for the service of a ship-borne surgeon.¹⁸⁰ Most slave ships had a surgeon on board when they left European ports,¹⁸¹ but there was no guarantee that the surgeon would survive his visit to Africa. In a study of the Dutch slave trade between 1751 and 1797, Simon J. Hogerzeil and David Richardson found that of the 29 surgeons they found in the shipping records, only one made more than two voyages to West Africa. This meant that they either died during their voyages, or were unwilling to risk their lives in Africa more than once.¹⁸² Thus, the exchange of healing ideas, practices and materials was limited, as European medical professionals simply could not survive in West Africa long enough to propagate their ways of understanding health and disease.¹⁸³

The Royal African Company. Norregard notes that the surgeon at Fort Christiansborg made a meagre salary of 192 rixdollars, but earned extra money for examining slaves. Norregard, *Danish Settlements in West Africa*, 166.

¹⁸⁰ G.E. Metcalfe ed., *Great Britain and Ghana: Documents of Ghana History 1807-1957* (London: Thomas Nelson and Sons, 1964), 210. The surgeons on the Gold Coast were normally holed up in their forts, busy dealing with the various tropical maladies that Europeans suffered on the coast, that is, if they managed to survive malaria. However, there was a belief by some that the mere presence of surgeons on the coast was gift by the British to Africans who lived around the forts. After the slave trade was abolished in 1807, the governors of the colony were desperate to increase revenues on the coast, to justify its existence as a colony. For example, at the capital of the colony, Cape Coast, Governor Winniett Howick imposed a poll tax on the residents of the town, and justified it by claiming that the funds would go to support schools and hospitals for the African residents of the city. The locals responded by rioting, and the idea was abandoned. Though we know little about what the local population thought about Western Medicine, we can tell by their reaction that they were not willing to pay for it.

¹⁸¹ Emma Christopher, *Slave ship sailors and their captive cargoes, 1730-1807* (New York: Cambridge University Press, 2006), 33. By 1788, British merchant ships were required to have a surgeon as part of the crew. Christopher notes that some surgeons even had their medical training paid for by slave ship captains.

¹⁸² Simon J. Hogerzeil and David Richardson. "Slave Purchasing Strategies and Shipboard Mortality: Day-to-Day Evidence from the Dutch African Trade, 1751-1797," *Journal of Economic History*, 67, no. 1 (March 2007), 160-90; see also Donnan, *Documents Illustrative of the History of the Slave Trade*, 446.

¹⁸³ *House of Commons Papers*, no. 228. 1840, in Crooks, *Records Relating to the Gold Coast*, 270-74.

The few surgeons who did work on the coast were ill-equipped to deal with tropical diseases like malaria and yellow fever, the chief killers of Europeans on the coast.¹⁸⁴ Prior to the discovery of microbes and parasites, European surgeons received training based on neoclassical physiological beliefs in humours and they subscribed to the belief that the efficient cause of illness was an imbalance in these internal fluids.¹⁸⁵ Surgeons treated the sick with therapies like phlebotomy (draining purported excesses of blood from the humoural content of the body) and blistering (the practice of burning the skin with an acid or a heated piece of metal in order to draw malevolent humours to the surface of the skin).¹⁸⁶ Bleeding was considered to be a standard preventive therapy, especially in hot climates, while blistering was curative intervention of last resort, applied to the skin only if a person was

¹⁸⁴ In the correspondence of the East India Company on the Gold Coast during the 17th century, there are frequent desperate requests for properly trained surgeons who might be able to check the high death rate on the coast. For example, a factor at Fort Cormantine near Cape Coast requested that the company replace the their surgeon with someone more skilled, more diligent, and better equipped: “The Castle at present is in greate want of a new Chururgery Chest well fitted and furnished with all Sort of medicenall Druggs, Conserues, Surrupps, Electuaryes, with Such like other Fissicall engeradiences fitt for diseased and Sick men, and morouer to Send a good Chururgon that knoweth how to make use of them, for this fellow which wee haue here knows uery little, besides uery Neglegent and Idle, not performeing that Duty which hee ught answerable to those Small abilities hee hat... wee haue buried fower of our Soldirs their names as at foote of letter, and more lyeth Sick and Ill,” from Makepeace, 91. See also Makepeace, 12, 44, 68, 71, 99-100; T. Aubrey, *The Sea-Surgeon, or the Guinea Man's Vade Mecum* (London, 1729), 107-08; Alexander Falconbridge, *An Account of the Slave Trade on the Coast of Africa* (London: J. Phillips, 1788), 261.

¹⁸⁵ The belief that humours influenced health lasted until well into the 19th century. According to Ancient Greek concepts of physiology, the four humours were blood, phlegm, choler (yellow bile), and melancholy (black bile). Surgeons used techniques like leeching, bleeding and purging to create a harmony of these humours within the body. Even though European studies of physiology and anatomy, like the work of Rudolph Virchow and Claude Bernard (see Porter *Cambridge History of Medicine*, 158-162) began to unravel beliefs in humoural medicine, the idea of self-regulation of bodily balance was a fundamental part of medicine in the tropics. Quinine was used as a way to maintain this balance as it prevented fever.

¹⁸⁶ Thomas Hawkes Tanner, *A Manual of the Practice of Medicine* (London: Lindsay and Blakiston, 1858), 56. Surgeons bled patients regularly to prevent illness, while blistering was a curative therapy used only when a patient was very ill.

close to death.¹⁸⁷ These painful manipulations of the body were the stock in trade of ship's surgeons, as evidenced by the surgical practices of Paul Isert, whose program for fighting tropical fevers in the late 18th century had three stages. If the fever was noticed immediately, he bled the patient and gave them an emetic. If the illness continued, he prescribed a decoction of cinchona bark, sulphur, camphor, and musk, steeped in Madeira wine. If this did not work, he proceeded with blistering using vesicant plasters.¹⁸⁸ His accounts of fighting malarial fevers show a lack of confidence in his therapies, and he admitted that only rapid treatment within the first hours could check malarial fevers.¹⁸⁹

Surgeons working in Accra subscribed to a belief that the cause of illness on the coast was miasma, a noxious gas that emanated from an environment putrefied by decomposing matter.¹⁹⁰ Contact with miasma caused inflammation of the constitution,¹⁹¹ and its effects on the human body were thought to manifest themselves differently in each individual. Because the causes of such afflictions were diagnosed at the bedside of the sick person, surgeons were expected to have intimate knowledge of the daily routines and living conditions of their patients, and to offer therapies and dietary regimens to counteract the effects of a malarious environment.¹⁹² Surgeons advised sailors and merchants on the Gold Coast to maintain a

¹⁸⁷ Tanner, *Practice of Medicine*, 56.

¹⁸⁸ Wisnes, *Letters on West Africa and the Slave Trade*, 154.

¹⁸⁹ Wisnes, *Letters on West Africa and the Slave Trade*, 153.

¹⁹⁰ In the words of a surgeon who accompanied the British military expedition to conquer the Asante Empire in 1873, the tropical 'miasmatic' air was a product of "rapid tropical decomposition" that hung in clouds near the ground, waiting to "poison, like so much mephitic gas, those who are exposed to their influence." See Pickstone, "Fever Epidemics," 129.

¹⁹¹ Pickstone, "Fever Epidemics," 138.

¹⁹² Erwin.H. Ackernecht, *Medicine at the Paris hospital, 1794-1848*, (Baltimore: Johns Hopkins Press, 1967), xi-xiii, 8-9. Historian Ackernecht coined the term "bedside medicine" to distinguish a period of individualized health care prior to the aggregation of patients in hospitals in the early 19th century. The physician who was practiced in "bedside medicine" would treat the symptoms of illness experienced by the particular patient as the sickness, rather than abstracting the illness as a generalised disease of humanity.

stable constitution by following a strict diet and a healthy lifestyle, and it was generally believed that an individual who ignored this advice would bring illness upon themselves.¹⁹³

The ship's surgeon was versed in the use of a wide variety of medical tools, including bone saws and tourniquets for amputations, forceps and wrenches for dental procedures, needles and thread for cuts and gashes, and vinegar and tobacco to disinfect the slave quarters. They also travelled with chests of medicines that contained minerals (like calcium carbonate, arsenic and mercury) and plant medicines (like rhubarb, pennyroyal, and opiates). These reagents were used variously as carminatives, purgatives, diuretics and emetics, mostly for the purpose of balancing the humours within the body.¹⁹⁴ The implements of the surgical trade were almost exclusively European in origin and were ill-suited for the treatment of tropical diseases.¹⁹⁵ In particular, ship's surgeons were almost powerless to stop

¹⁹³ Pickstone "Fever Epidemics," 129; Justesen & Manley, *Danish Sources*, 649; French surgeons subscribed to similar aetiologies and advocated good hygiene and healthy lifestyles as checks against tropical fevers. See William B. Cohen, "Malaria and French Imperialism," *Journal of African History* 24, no 1. (1983), 26.

¹⁹⁴ For a complete list of a surgeon's equipment see Leif Svalesen, *The Slave Ship Fredensborg* (Bloomington: Indiana University Press, 2000), 70; Wendy D. Churchill, "Bodily Differences?: Gender, Race, and Class in Hans Sloane's Jamaican Medical Practice, 1687-1688," *Journal of the History of Medicine and Allied Sciences* 60, no. 4 (2005), 391-444. For information on surgeon's medicines see Sheridan, "The Guinea Surgeons," 615; Tanner, *Practice of Medicine*, 76. For an example of a surgical kit used in West Africa in the early 19th century see H. Tedlie, "Materia Medica and Diseases," in *Mission from Cape Coast to Ashantee*, ed. T. Bowdich (1819), 376-79.

¹⁹⁵ European medicines were often in short supply, and there is some evidence of a small-scale trade in European medicines between surgeons and factors along the coast, despite their inefficacy against tropical illnesses (Adam Jones, ed., *Brandenburg Sources for West African History, 1680-1700* (Stuttgart: Franz Steiner Verlag Wiesbaden GMBH, 1985), 198). It should also be noted that neither the tools of European surgery nor the drugs of the European *materia medica* were adopted by African healers, despite evidence that Western medicines were known to the monarchs of the Asante in the 19th century. In 1842, when Asantehene Kwaku Dua I was ill with fever, he requested the services of T.B. Freeman, a Methodist minister adept at healing with Western medicines. Freeman visited the royal compound in Kumasi to find the king in possession of a European medicine chest containing laudanum and other Western medical reagents, which Freeman believed had been captured when the Asante defeated General MacCarthy's army in 1824. Since there were no Asante healers who knew how to use Western medicines, Freeman used some calomel and

severe malarial fevers.¹⁹⁶ Though cinchona bark was available, and was used to break fevers, it was not yet used as a prophylactic and effective curative doses were not standardized until the late 19th century.¹⁹⁷ Nor did surgeons have effective treatments for maladies like the bloody flux (amoebic dysentery), intestinal disorders (such as typhoid fever), sleeping sickness (*trypanosomiasis*), yaws (*framboesia*), or Guinea worm (*dracunculiasis*).¹⁹⁸ Such limitations in medical materiel made European surgeons ill-equipped to withstand the disease frontier of West Africa.¹⁹⁹

The inability of the ship's surgeon to stave off tropical diseases compelled Europeans to rely on the aid of West African healers.²⁰⁰ Willem Bosman, a Dutch merchant who spent 14 years trading along the coast in the 17th century, claimed to have seen several Europeans cured by African healers when the therapies provided by surgeons failed.²⁰¹ In a case from Anamaboe (about 100 km from Accra) in the 18th century, British Surgeon Thomas Westgate tried to heal a prominent West African trader called Amoony Coomah with

tonic draughts from the surgical kit to treat the king until his fever broke. The king later announced that Freeman had saved his life and he publicly lauded the powerful healing qualities of Western medicines, but this incident remains an anomaly in the historical record. T.B. Freeman, *Journal of Various Visits to the Kingdoms of Ashanti, Akeu, and Dabomi* (London, Sold by J. Mason, 1884), 166-67.

¹⁹⁶ Curtin, *Disease and Empire*, 26.

¹⁹⁷ Despite decades of knowledge of its use, Philip Curtin argues that quinine was not understood by European doctors to be a useful prophylactic or cure for malaria until the mid-19th century. Curtin, *Disease and Empire*, 21-23.

¹⁹⁸ Svalesen, *Slave Ship Fredensborg*, 67; Sheridan, "The Guinea Surgeons," 602.

¹⁹⁹ For example, when the Danish slave ship *Fredensborg* visited Accra in 1767, an illness swept through the ship and killed several men including the captain. The disease caused dysentery amongst the crew so the surgeon on board, Joch Christopher Sixtus, used wine as a dehydrator to stop the diarrhoea. He also used a variety of European herbs and powders to try stop the epidemic, but he was unable to halt the spread of the disease. Svalesen, *Slave Ship Fredensborg*, 88-89. Also, Patricia Crimmin notes that the British naval service often could not afford full medical kits for their ship's surgeons. "British Naval Health, 1700-1800: Improvement Over Time?" in *British Military and Naval Medicine*, 191-92.

²⁰⁰ Fisher ed., "R. Miles to Horatio Smith. Cape Coast Castle. Dec. 9, 1778," in *Extracts from the Records of the African Companies*, 99.

²⁰¹ Bosman, *New and Accurate Description of the Coast of Guinea*, 225.

enemas and purging but failed. Coomah abandoned Westgate for a Fante healer, who subsequently helped him recover.²⁰² Christian Tychsen, the governor of Christiansborg Castle from 1766-1768, had a policy of sending his sick to the village of Osu next to the fort,²⁰³ and H.C. Monad also mentioned how Danes patronized African healers who lived near the castle.²⁰⁴ Even ship's captains sent their sick sailors ashore if they felt it would aid in their recovery. William Woodville, the captain of a slave ship who travelled the coast in the 1790s, sent his sick slaves to African healers because he believed that his ship's surgeon was "little acquainted with their modes of life & their habits," and therefore unable to treat them effectively.²⁰⁵ These examples, found within the same sources that denigrate the healing practices of the Guinea Coast as fetish, demonstrate that Europeans not only knew of the existence of local healers but that they needed their help to survive. When out to sea, sailors were beholden to the medical authority of the ship's surgeon, and could not stray from his curative regimen. But if the ship's surgeon failed to produce a cure, and the sailor was within reach of land, he was compelled to seek help from African healers.

Some Europeans living on the Gold Coast went even further, by embedding themselves within Ga society. The majority of the Europeans living on the coast were unmarried men, under 30, who were in dire need of both medical and emotional support.²⁰⁶ Following a

²⁰² Fisher ed., "T. Westgate to R. Miles. Annamaboe. Aug 3 and Aug 6, 1778," in *Extracts from the Records of the African Companies*, 97.

²⁰³ Svalesen, *Slave Ship Fredensborg*, 69; Osu was known to the Danish as the "Negeriet."

²⁰⁴ Monad, *Description of the Guinea Coast*, 53, 204-7. Monad offers details of the sorts of medicines used by Ga healers to cure illness and also gives personal accounts of being tended to by healers in Accra; The 1683 journal of Governor Lykke showed a disdain for the resident surgeon, Nicolas Fentzman, who was considered to be inept and even dangerous. Justesen and Manley, *Danish Sources*, 77.

²⁰⁵ "From Captain William Woodville of the ship Rodney, to Messrs. James Rogers and Company in Bristol dated Bannee [Bonny Island], 16 May 1791, Rogers Papers, Chancery C. 107/14, Box No. 2, No. 21," in Sheridan, "The Guinea Surgeons," 616.

²⁰⁶ Pernille Ipsen, "Intercultural Intimacy in Danish Guinea. 1680-1740," *Historie Netmagasinet*. www.historie-nu.dk (December 16, 2005).

social pattern established by Portuguese merchants on the Gold Coast, many of them arranged temporary relationships with local women (known in the trading dialect of Portuguese as *consa* wives)²⁰⁷ and adopted domestic arrangements known as *cassarerte* (meaning “to take into one’s house”).²⁰⁸ These sorts of unions could be made informally with slaves, but when formed with free women they required marriage fees that linked the man to the kinship group of his wife.²⁰⁹ The practical benefit of marriage into Ga society was that a married man could ask his in-laws to facilitate trade agreements, but there were also less commercially tangible benefits. Being married meant gaining access to nutritious food, a sexual partner, and a sense of intimacy that was simply unavailable in the slave forts. More poignantly, these *cassarerte* relationships speak to the alienation and fear of death that Europeans faced in West Africa, and as Barbot noted, European relationships with women in West Africa went far beyond mere practical needs. In some cases, European men adopted the trappings of so-called fetish: “some Europeans there not only believe this idolatrous worship effectual, but encourage their servants in it, and are very fond of wearing about their bodies some of these consecrated toys or spells of the heathen priests.”²¹⁰ For a vulnerable sailor or soldier living on the West Coast of Africa, sustaining the bodily-self required a significant adaptation of the social-self.

Though there is ample evidence that European patients abandoned the care of their surgeons to patronize West African priests and healers, there are very few instances where

²⁰⁷ Huber. *Ghanaian Pidgin English*, 25.

²⁰⁸ Svalesen, *Slave Ship Fredensborg*, 96-97. Pernille Ipsen has suggested that since the name Cassare has Portuguese roots, that the Portuguese may have started the practice of living with African women in the villages next to the forts. See Ipsen, “Intercultural Intimacy.” Isert claimed that Danish men in Guinea were permitted “to take one wife on condition that he converted her to Christianity and took her back to Europe, if she wanted to go. The authorities looked upon these marriages as an advantage.” Wisnes, *Letters on West Africa and the Slave Trade*, 157, fn. 32.

²⁰⁹ Justesen and Manley, *Danish Sources*, 302.

European surgeons investigated and appropriated the tools and practices of West African healers. This must have been largely because of the staggeringly high death rate for Europeans on the Gold Coast. However, this explanation is not entirely satisfactory for two major reasons. The first is that intimate relationships between European men and African women left many so-called “mulatto” children in Accra, many of whom were either taken to Europe to be educated or educated at the slave forts in European curricula. Surprisingly, there is no evidence that this centuries-long legacy of intermarriage resulted in a transference of medical ideas or surgical techniques. Secondly, there are detailed accounts of European travelers meeting Africans who exposed them to a vast knowledge of the medicinal properties of the flora of West Africa. In 1705, Willem Bosman noted with astonishment the many roots, branches and tree barks that were used by the locals as curatives, and stated that he know of more than thirty “sorts of green Herbs, which are impregnated with an extraordinary Sanative Virtue.”²¹¹ Bosman regretted that “no European Physician has yet applied himself to the discovery of their Nature,”²¹² but his call for further investigation of the medicinal qualities of the plants of West Africa was largely ignored.

There are a few instances when surgeons adapted African reagents into their medicines, but they were rare. Two chaplains at the Danish Christiansborg Castle at Osu, Johannes Rask and H.C. Monrad, reportedly cured many illnesses with “a mixture of Grains of Paradise, Spanish pepper, palm oil, and lemons,”²¹³ and adopted a locally derived anti-

²¹⁰ Barbot, *Barbot on Guinea*, 281.

²¹¹ Bosman, *New and Accurate Description of the Coast of Guinea*, 225.

²¹² Bosman, *New and Accurate Description of the Coast of Guinea*, 216.

²¹³ Svalesen, *Slave Ship Fredensborg*, 70-71. “Grains of paradise” is the European term for *Aframomum melegueta*, a herb native to West Africa with pungent, peppery seeds. “Spanish Pepper” probably referred to the malagueta variety of *capsicum frutescens*, a small, very hot, green chilli pepper, also native to West Africa.

diarrheal made of mashed yam mixed with an unidentified “yellowish root.”²¹⁴ Both of these medicines included local components, but were formulated according to humoral theories with the purpose of balancing the constitution, the first likely used as a purgative and the second probably as an astringent. The surgeon of the slave ship *Fredensborg*, Joch Sixtus, met Rask and Monrad in the early 1800s, and incorporated some of their improvised medicines into his repertoire, as he is later recorded as giving slaves with dysentery a mixture of “millet and Spanish pepper.”²¹⁵ It would not be surprising that he would be open to trying new cures because his medicines had clearly failed him -- over one-third of the *Fredensborg*’s crew died on his voyage.²¹⁶ However, Sixtus was an exception and ship’s surgeons remained largely indifferent to the tools of healing used by the healers of West Africa.

The fact that European surgeons were largely unwilling to exploit the healing potential found in West African plants is also surprising considering that European naturalists elsewhere had actively incorporated medicinal flora from the New World into their pharmacopoeia. As historian Marcy Norton has noted, Nicolas Monardes advocated that 24 new world medicinal plants be added to the European *materia medica* as early as 1565, and the Jesuit order was active in bioprospecting in the Americas throughout the early modern period.²¹⁷ But while many American plants were added to the European medicine cabinet at

²¹⁴ Svalesen, *Slave Ship Fredensborg*, 71.

²¹⁵ Svalesen, *Slave Ship Fredensborg*, 112. Svalsen records the date of their meeting as 1767, but this is not possible as Rask and Monrad were at Christainborg Castle in the first two decades of the 19th century. See Johannes Rask and H C. Monrad, *Two Views from Christiansborg Castle*, translated by Selena Wisnes (Legon, Accra, Ghana: Sub-Saharan Publishers, 2009).

²¹⁶ Svalesen, *Slave Ship Fredensborg*, 9.

²¹⁷ Marcy Norton, *Sacred Gifts, Profane Pleasures: A History of Tobacco and Chocolate in the Atlantic World* (Ithaca: Cornell University Press, 2008), 10-11; Benjamin Schmidt, “Imperfect Chaos’: Tropical Medicine and Exotic Natural History c. 1700,” in *Medicine and Religion in Enlightenment Europe*, eds. Ole Peter Grell and Andrew Cunningham (Burlington, Vt: Ashgate, 2007), 145-71; Junia Ferreira Furtado, “Tropical Empiricism: Making Medical Knowledge in

the height of the transatlantic slave trade (including the significant addition of cinchona bark) only four quasi-medicinal tropical products from Africa were appropriated by European surgeons: Guinea pepper, Gum Arabic, plantain leaf and palm oil.²¹⁸ None of these were significant additions to the European medical repertoire because they were largely stand-ins for more commonly used European reagents.²¹⁹ Gum Arabic and plantain leaf were used merely as astringents in anti-diarrhoeal draughts or as adhesives to bind wounds,²²⁰ while palm oil was used as a lubricant base for salves and Guinea pepper, like Asian or American hot peppers, was taken as a stimulant. Despite the obvious presence of dozens of African cures for the tropical illnesses that wracked the constitutions of Europeans on the coast, the vast knowledge of herbal remedies in West Africa was barely noticed by surgeons.

The exchange of ideas, practices and material cultures of healing between European surgeons and Africans along the Gold Coast was restricted by several factors. The first was the disease environment, which ended the lives of many of those surgeons who may have

Colonial Brazil,” 127-51 and Daniela Bleichmar, “Atlantic Competitions: Botany in the Eighteenth Century Spanish Empire,” 225-52, both in *Science and Empire in the Atlantic World*, ed. James Delbourgo and Nicholas Dew (New York: Routledge, 2008).

²¹⁸ All of these medicinal ingredients would have been widely available in markets along the coast as early as the mid-17th century, but they were minor additions to a larger trade in European derived medicinal reagents. See Jones ed., *West Africa in the Mid-Seventeenth Century*, 186-89. The first listings of these items in European pharmacopoeia were as follows: Guinea Pepper: *The British Dispensatory, Containing a Faithful Translation of the New London Pharmacopoeia* (London: Royal College of Physicians of London, 1747), 128; Gum Arabic: *London Pharmacopoeia*, 128; Plantain leaf: *London Pharmacopoeia*, 132. Plantain leaf was sometimes used to bind wounds. See Bruce L. Mouser and Samuel Gamble, *A Slaving Voyage to Africa and Jamaica: The Log of the Sandown, 1793-1794* (Bloomington: Indiana University Press, 2002), 66; Palm oil: *London Pharmacopoeia*, 131.

²¹⁹ John Murray, *A System of Materia Medica and Pharmacy* (W. Laing, et al., 1810). Murray’s *System of Materia Medica* likewise mentions gums and aloes, and notes that the tropical gum of *euphorbia officinalis* as useful vesicant. Only Lindley’s *Flora Medica*, published in 1838, contains any speculation about the potential value of West Africa herbal medicines, and is still limited to discussions of peppers and gums. John Lindley, *Flora Medica: A Botanical Account of All the More Important Plants Used in Medicine, in Different Parts of the World* (Longman, et al., 1838), 28-29, 139-40, 485.

aspired to investigate the “sanative virtues” of African healing that Bosman had heralded. The second was the slave trade, a commercial imperative that compelled surgeons to focus exclusively on the health of slaves at the coastal forts and on ships during the middle passage. A third impediment was the chauvinism expressed by the average ship’s surgeon, which reduced African healing practices to worthless superstitions. And finally, the efficacy of surgical practice during the 17th and 18th centuries must not have been impressive to people living in cities like Accra. African priests and spirit mediums had never ventured into internal surgery, and most minor incisions were the practices of layhealers anyway. And most people living in Accra must have known that opening wounds in the tropical environment of the Gold Coast could quickly lead to infection, so it is not surprising nobody adopted surgical interventions such as the extraction of bullets or the lancing of abscesses.

But despite these limits, transculturation did occur, driven by the need for survival. European patients sought refuge in homes in Accra, adopting patterns of home care and marriage that they desperately needed to keep them alive. They also quickly abandoned European medicine if they felt that a better cure could be affected by an African doctor on shore. For their part, European surgeons adapted some local reagents into their therapies, as a means of keeping their humoral medical system intact while sojourning in the tropics. Thus, despite the commercial, political and racial forces that tended to delineate the European from the African in Accra, some common ground was found when it came to healing.

Conclusion

²²⁰ Jones ed., “Samuel Brun’s Voyages of 1611-20,” in *German Sources for West African History*, 85.

After the fall of Ayawaso, Little Accra on the coast grew into a polyglot, multiethnic urban centre. It became the new capital of the Ga, politically, socially and culturally, but it did not produce a quintessential Ga healing culture. Rather, Little Accra became a place where diverse aetiologies of disease, multiple practices of healing, and a dynamic material culture of healing converged. Concepts of health and healing were voiced mostly in the Ga language, through a mixture of terms incorporated into the healing lexicon from around the Gold Coast, but other ethnic groups offered different ways to understand the causes of illness. At no time did Ga healing in Accra constitute an ethnomedicine that could be enumerated as a set of static traditions. Rather, practices of healing in Accra became a diverse collection of traditions and customs that drew on ideas from other ethnic groups, and that incorporated practices of deity worship, spirit possession, animal sacrifice, pouring of libation, and ritual scarification.

The pluralistic healing culture that developed in Accra belies the racist tropes of fetish worship propagated in European travelogues of West Africa. Barbot's stereotypical portrayal of the patient suffering the guile of charlatans only holds true in the sense that the patient had the option to dismiss a healer who could not offer a cure. Though patient narratives are rare in the documentary record, the few instances that we have demonstrate the agency of patients picking and choosing between a plurality of spiritual and secular therapies. If they were feeling ill, they might choose to visit a shrine, a spirit medium, or the administrator of a consecrated device. Or they might even fashion their own cure for their problems, by making up a herbal remedy, or a personalized consecrated medicine (as Noyte did with his talismanic stone). The world of religion and healing in Accra was clearly open to change, either through dramatic social processes like the fall of Accra or via small acts by patients, day in and day out.

In the 17th and 18th centuries, Accra was a welcoming environment for novel healing ideas, but European medicine was a relatively weak therapeutic option. Ship's surgeons brought humoral aetiologies, surgical practices, and medicine kits to the city, but they were so vulnerable to the disease environment that they either became sick, died, or left before Africans could pick up their techniques. Even if surgeons could have established their practices on the Gold Coast, they would have had the additional task of lifting the veil of fetish before they would be able to comprehend the healing practices of the people of Accra. Thus, though surgeons were major characters in the transatlantic slave trade, they were bit players on the Gold Coast. African healers, on the other hand, did play a role in maintaining flow of trade in the region by healing the European patients who fell ill on the Gold Coast.

Chapter 3. Pluralistic Healing in the New Capital of the Gold Coast, from the 1850s to the Bubonic Plague Epidemic of 1908.

The official abolition of the transatlantic slave trade by Britain in 1807 weakened the economy of the city of Accra.¹ An illicit commerce in slaves did continue but the British bought up all of the slave forts along the Gold Coast and patrolled the sea lanes, dramatically reducing the maritime slave trade. In order to survive as a major port in West Africa, the merchants in the city were compelled to make a transition towards commerce in palm oil, ivory, and rubber, products much less lucrative than slaves.² However, the economic outlook for the residents of the city changed favourably in 1877, when the British decided to relocate the capital of the Colony of the Gold Coast from Cape Coast to Accra, increasing government activity city and enlarging the ranks of the African merchant classes. The primary reason behind the move to Accra was a desire to create an urban enclave for colonial officials that would be healthier than the miasmatic rainforests that surrounded Cape Coast Castle. The new capital at Accra, located in the dryer climate of the Accra Plains, was established on the premise that an orderly, sanitary, capital might ameliorate the health of both the colonizers and the colonized alike.

The three major histories of colonial medicine in the Gold Coast present the early colonial period as a foundational era for medical practice on the Gold Coast. David Scott

¹ The slave trade was abolished by Denmark in 1803, Britain in 1807, Holland in 1814 and Portugal in 1836. David Eltis argues that the Dutch, Danish and British navies were able to reduce slave trading along the Gold Coast, though the business did continue in Ewe-speaking territories to the east. David Eltis, *Economic Growth and the Ending of the Transatlantic Slave Trade* (New York: Oxford University Press, 1987), 168.

² Brazilian merchants continued a small-scale business in slave trading in the city, and an internal slave trade (largely tolerated by the British) also continued, see Amos & Ayesu, "I

places the growth of medical services within an evolutionary trajectory, with the early colonial period as the starting point for the “continuing process of evolution” in the fight against disease.³ Similarly, K. David Patterson argues that the late 19th century witnessed the inauguration of “modern medical services” on the Gold Coast, a time when the responsibility for the health of the population was taken out of the hands of District Officers and given to the physicians running the Gold Coast Medical Department.⁴ Stephen Addae positions the period of 1880-1919 as the first phase in the development of “modern medicine,” a time when the Gold Coast Government funded hospitals, hired physicians, nurses and dispensers, embarked on sanitation projects in urban centres, and began scientific work at the Accra Laboratory.⁵ And all three authors highlight the bubonic plague epidemic of 1908 as a definitive moment in establishing the authority of colonial medicine on the Gold Coast. In sum, the medical historiography of Ghana emplots the early colonial period as the start of a modern medical era -- a transition from a time when ships surgeons were marginal figures in the healing culture in the city and to a new era when medical officials began to alleviate the disease burden of both the colonizers and the colonized alike.

Clearly, a whiggish narrative of medical evolution continues to hold sway within Ghanaian medical historiography, but many scholars of European medicine have become increasingly skeptical about the triumphs of medicine. In the 1970s, sociologists like Eliot Friedson, Irving Zola and Ivan Illich demonstrated how medicine could combine with political and economic power to become an institution of social control, rather than a

Am Brazilian', 42; K. B. Dickson, “Evolution of Seaports in Ghana: 1800-1928,” *Annals of the Association of American Geographers* 55, no. 1 (March, 1965), 104.

³ Scott, *Epidemic Disease in Ghana*, 203.

⁴ Patterson, *Health in Colonial Ghana*, 30, 11.

⁵ Addae, *Evolution of Modern Medicine*, 55.

universal panacea.⁶ These ideas were historicized elegantly by Michel Foucault, who repudiated the idea that universal truths of medical science were gradually discovered during the modern era and instead argued that the formation of medical knowledge had changed in a way that allowed physicians to assert epistemological authority over the human body and the health of society.⁷ This was the dawn of an era of “biopower,”⁸ a time when state control of subject populations could be legitimized by medical and scientific discourses. Biopower, as an analytical concept, has been extended to Europe’s colonies by historians of South Asia like David Arnold, who have argued that British imperial hegemony in India was dependent on the internalization of medical discourses of social control by colonial subjects.⁹ Poonam Bala, editor of a more recent collection of articles on the subject has argued that “imperial hegemony was expressed through a network of professional and colonial medical institutions, in the form of bureaucracies, clinics and hospitals.”¹⁰ The “clinical gaze,” according to Bala, was appropriated by Indian-born, British-trained doctors who operated as middlemen during colonial rule. The analysis of medical discourses was extended to colonial Africa by Meghan Vaughn, whose book about colonial medicine and psychiatric care in East Africa demonstrated how colonial subjects could become the “raw material” for the elaboration of medical theories.¹¹ In South Africa, Maynard Swanson recognized that a “sanitation syndrome” caused by the bubonic plague epidemic of 1900 resulted in racial

⁶ Eliot Friedson, *Professional Dominance: The Social Structure of Medical Care* (New York: Atherton Press, 1970); Irving K. Zola, “Medicine as an Institution of Social Control,” *Sociological Review* 20, no. 4 (1972), 487-504; Ivan Illich, *Medical Nemesis: The Expropriation of Health* (Toronto: McClelland and Stewart, 1975).

⁷ Foucault, *Birth of the Clinic*.

⁸ Foucault, *History of Sexuality Vol.1*, 140.

⁹ David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993).

¹⁰ Poonam Bala, *Biomedicine as a Contested Site: Some Revelations in Imperial Contexts* (Lanham, MD: Lexington Books, 2009), 2.

segregation in Cape Town, while Alexander Butchart argued that the disciplinary authority of medicine was a bulwark to the power of the apartheid state in South Africa.¹² In the context of the Gold Coast, elements of biopower are indeed recognizable in the discourses of the colonial government (which contain commentaries that decry the unhealthiness of the tropical environment, accounts of a so-called unclean “native” population, and reports that express the desire to channel colonial subjects toward medical institutions), but this analytical approach has never been employed by historians of medicine in Ghana.

For historians of medicine in Africa, the historiographical burden of these two approaches is significant. In the first instance, we are asked to search for the roots of medical culture during this early colonial period, and lay out the building blocks that would eventually become the Ghana Health Service. In the second instance, we are asked to locate key moments in the past when the tentacles of medical power began to reach into the lives of colonial subjects. In the case of Accra, we do know that a new type of colonial medicine emerged in the 19th century, as a hybrid mix of sanitary reforms and scientific medicine that contained some elements of medical beneficence and some shadows of coercive biopower. But the facts show that colonial medical initiatives during this period had more to do with making the colony a safe place to live for the colonizers than ameliorating or determining the health of the “natives.” Two recent articles by historians of imperial medicine have already exposed the weaknesses inherent in the early colonial medical project. In his 1995 article comparing sanitary reforms in urban centres in West Africa, Thomas Gale demonstrates how public health reforms in the colonial Gold Coast were underfunded, poorly executed,

¹¹ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Oxford: Polity Press, 1991); Butchart, *Anatomy of Power*.

¹² Swanson, “The Sanitation Syndrome,” 399; Butchart, *Anatomy of Power*, ix.

and focused largely on the health of Europeans.¹³ And in a more recent 2014 article, Ryan Johnson shows that physicians in the employ of the colonial medical services had little standing with colonial governors, and were rarely able to convince them to implement sanitary reforms.¹⁴ Thus it is anachronistic to think of the early colonial period as foundational because, at the time, colonial medical services operated (to borrow a phrase from Ronald Robinson's assessment of indirect rule) "on the cheap"¹⁵ -- as piecemeal attempts to reduce death rates amongst colonial officials, conducted half-heartedly by governors who were more interested in commerce than public health.

But the most important historical point to be made about the early colonial period in Accra is that European-derived healing practices were only one of five major therapeutic options in the city. Moreover, colonial medical services reached only a sliver of the population of the city, while African remedies served the vast majority of residents in the city. Other major healing cultures were emerging amongst the new Christian and Islamic populations of the city, within a burgeoning literate society interested in purchasing and consuming imported patent medicines. The presence of non-European healing traditions is mostly lost within the histories of medicine on the Gold Coast, which were written exclusively by British-trained physicians. Scott entirely silences the presence of African or other therapies. Patterson grudgingly admits in one sentence that some African "traditional" remedies might have worked, but then asserts that "high incidence of disease and the low life

¹³ Thomas S. Gale, "The Struggle against Disease in the Gold Coast: Early Attempts at Urban Sanitary Reform," *Transactions of the Historical Society of Ghana* 16 (January, 1995), 185-203.

¹⁴ Ryan Johnson, "The West African Medical Staff and the Administration of Imperial Tropical Medicine, 1902-14," *Journal of Imperial and Commonwealth History* 38, no. 3 (2010), 419-39.

¹⁵ Ronald Robinson, "European Imperialism and Indigenous Reactions in British West Africa, 1880-1914," in H.L. Wesseling, ed. *Expansion and Reaction: Essays on European Expansion and Reaction in Asia and Africa* (Leiden: Leiden University Press, 1978), 163.

expectancy show the general weakness of local pharmacopoeias and practitioners.”¹⁶

Stephen Addae also admits that some African remedies were “allegedly” successful, then on the same page argues that Africans followed disorderly methods of “trial and error” that spread diseases rather than curing them.¹⁷ It is evident that much work needs to be done to overcome the burden of the medical historiography of Gold Coast/Ghana in order to reveal the texture of the multiple healing cultures present in Accra during the early colonial period.

This chapter is divided into five sections. The first section, based on evidence found in colonial court records, demonstrates the presence of a network of healers offering forms of therapy that followed Ga and Akan traditions, and also demonstrates a continuing pluralistic ethic of healing amongst patients from the 1850s to 1908. The second section discusses the establishment of Islamic and Christian ideas about health and healing in the city. During the 19th century, Muslim soldiers serving in the British Army and ex-slaves from Brazil created a new avenue of therapy based on the healing powers resident in the Quran. This section also covers a brief spurt of medical missionary activity in the city, and outlines the foundation of new Christian concepts of spiritual health established in the city by the lay-preachers of the Basel and Wesleyan missions. Though their congregations grew slowly, and though their medical work was limited, Christian missionaries laid the groundwork for future independent churches that would use the Ga translation of the Bible for faith-healing. The third section discusses the arrival of imported healing products, in the form of pills and bottled medicines. These portable curatives were brought to Africa by Europeans, but their presence in Accra increased the possibilities for Africans to buy and sell imported medicines. The fourth section chronicles the expansion of colonial medicine in the city, including the construction of a colonial hospital and the implementation of public health policies that

¹⁶ Patterson, *Health in Colonial Ghana*, 28.

divided the city into African urban spaces (which were regarded as unsanitary) and a segregated European reservation (which was built to facilitate a healthy environment for British officials). During the late 19th century, European understandings about the causes of disease were shifting away from humoral theory, which asserted that a balance of humours within the body constituted health, toward scientific medicine, which specifically identified the biological agents as the causes of disease. This paradigm shift in disease aetiology occurred in a staggered fashion, and in Accra, physicians and medical officers used both old and new disease causalities to justify intervention in the day to day activities of colonial subjects. The emergence of biopower in the words and actions of colonial officials was most evident during bubonic plague epidemic of 1908, a crisis that allowed the British to take measures that expanded the power and the reach of European-derived medical practices, some of which were readily adopted by residents of Accra. However, even with the help of an Accra-born, Western-trained doctor and some powerful chiefs, the plans to rebuild the city according to sanitation guidelines were resisted by local residents, severely hindering the power of the Gold Coast Medical Department.

¹⁷ Addae, *Evolution of Modern Medicine*, 13.

1891	16,267
1901	14,842
1911	15,313
1921	38,049
1931	60,726
1943	101,360
1948	133,192
1960	338,396

Table 3.1. Population Change in Accra. The 19th century and the first two decades of the 20th century was a period when the population of Accra either declined or stagnated. In the 1920s, both the domestic population and immigration began to increase exponentially. *Source:* data taken from Ione Acquah, *Accra Survey*, 31; A. W. Cardinall, *The Gold Coast, 1931* (Accra, Gold Coast: Government Printer, 1931), 158; Marion Kilson, *African Urban Kinsmen: The Ga of Central Accra* (London: Hurst, 1974), 8.

1891	493
1901	716
1911	1,339
1921	1,454
1931	1,839

Table 3.2. European population in the colony of the Gold Coast. When the British Colonial Office chose Accra as the new capital of the Gold Coast, the European population increased sharply, then continued to grow slowly. It then doubled in the 20th century, as the cocoa and gold economies began to grow. This table does not include populations of people from the Middle East, labeled as Syrians, who numbered in the hundreds in the early part of the 20th century. *Source:* Robert R. Kuczynski, *Demographic Survey of the British Colonial Empire*, 1 (New York: Kelley, 1977), 439-40.

Section 1. Continuing Pluralism within West African Healing Ideas and Practices.

The activities of African healers and patients in Accra are not immediately evident in the historical record of the 19th century. After abolition, there are no European travel diaries that document the practices of local healers and only a few official records contain any evidence of Ga, Akan or other types of local or regional therapeutics in Accra. This leaves a significant gap in the documentary record. What is available are records of cases brought before British magistrates at Christiansborg Castle, starting in 1850, some of which offer fragments of secondary evidence about healing practices. This section includes information drawn from the written records of trials brought in front of magistrates in Accra from 1850 to approximately 1910, numbering in the thousands. Many of the cases resulted in truncated records without much detail. The vast majority of those with detail contained no mention of healing practices or medicines. What was left, amounting to just over 100 records, were trials that did include bits and pieces of information related to health and healing in the city. The small acts of healers and patients found in these records offer ideas about what the African residents of the city were thinking about health and healing, and some evidence about how healing practices had adapted to changing political and economic circumstances in Accra by the start of the 20th century.

What the court records prove is that, during this early colonial period, local and regional West African healing traditions of healing were dominant in the city, interwoven into all contexts of Accra society. Healing involved the manipulation of both the material world (through the fabrication of herbal concoctions that could both cure and harm) and the spirit world (through rituals known to specialists like spirit mediums), and it affected kinship relations, business agreements, reproduction, categories of free and unfree labour, and rights to property. In other words, there was a richness of disease aetiology, ritual, and material

culture within African healing that could not be matched by any other therapeutic option in Accra at the time. Though Europeans continued to reduce African practices to the idiom of ‘fetish’ in these documents, it is clear that the so-called fetish priests were the majority providers of health care in the city. In fact, some African healers even appear in these records, and are given the opportunity to voice their opinions on matters of health and healing.

This is not to say that things did not change. The dynamic and adaptable nature of West African therapies is evident in these records too. For instance, payments for therapies were increasingly monetized, using new forms of currency and gifts in kind, and the obligation to heal people was changing as people fell out of the category of slave and into one of client. Witchcraft appears here too for the first time, as a malicious force people suffered from and tried to combat. The authority of colonial medicine is also present in these records, and this section will highlight one case when a physician’s expert opinions about the states of health and the progress of disease trumped those put forward by a so-called “native doctor.” Nonetheless, during the early colonial period, the vast majority of African residents in Accra still viewed healing from a perspective that connected individual health to the health of kinship groups, the health of society and the health of the spirit world.

One of the key insights these court records provide is that patients continued to embed themselves within “therapy management groups” that moved from healer to healer.¹⁸ When someone became sick in Accra in the last half of the 1800s, there was no direct authority that coerced them into a prescribed type of therapy, so they were likely to take advice from friends and family who cared for them. In 1877, when a man named Odonkor

¹⁸ Janzen, *The Quest for Therapy*,” xviii, 8-11.

was stabbed in a knife fight, he was taken by his family to a number of different healers in Accra, and when his condition did not improve, he travelled north to the Akwapim Ridge to seek help from a shrine priest in the village of Larteh. The therapy he received there did not work, so the family continued to search for help. Unfortunately, after weeks of searching for a cure, Odonkor died from his injury, and his family continued to dispute who would pay for the expenses incurred in front of the British magistrate.¹⁹ In another case about outstanding debts for healing services, a man fell sick and was taken by his wife to a nearby healer. She paid for the therapy, but the man did not get better, so a friend of the sick man paid another healer to cure him.²⁰ The man died, but not after his friends and family pursued multiple therapeutic options. This group approach to finding treatments for the sick shows how patients and their family and friends worked collectively to source healing options, and that patients followed a pattern of “healer hopped” that was similar to patient behavior described by Jean Barbot in the 18th century.²¹

Most payments to healers in Accra continued to be made in local goods, following longstanding traditions that placed exchange value in goods such as gold dust and cowries and valued the ritual and practical uses of cloth, livestock, eggs and knives.²² But in the early colonial era, the exchange and use value of good began to change quickly. For instance, after the abolition of the slave trade, human beings lost value as commodities, and after the Abolition of Slavery Act was passed in 1833, it was technically no longer legal to deal in

¹⁹ PRAAD SCT 2/4/12. 5th May 1877 - 28th May 1879, 92.

²⁰ PRAAD SCT 2/4/57. 16th Feb. 1912 - 19th Sept. 1914. “Lutterodt vrs Amartefio,” Jan. 10, 1914, 115-16.

²¹ In another case, a man who had passed away was said to have taken ‘native medicines’ from at least two healers. See PRAAD SCT 2/4/1. 6th Jan 1857 - 15th May 1861. May 21, 1858, 112-13.

²² PRAAD SCT 2/4/5. 23rd June 1868 - 3rd Aug. 1869, 453-55.

human beings within the British Empire.²³ European currencies were becoming more widely used. These changes in the terms of exchange directly affected religious and healing services in the city. In 1862, a man cursed by a “fetish priest” had to provide a tribute to the priest that included two slaves, a puncheon and eight bottles of rum, two pieces of cloth, two sheep, some gold dust and other petty goods that totaled 1024 heads of cowries, a massive expense that probably bankrupted the man.²⁴ The price of removing the curse became even more expensive when the British magistrate was informed that the payment involved slaves. The magistrate convicted him of slave trading and he was held at James Fort, where he received thirty-nine lashes and six weeks of hard labour on a chain gang.²⁵ In another case in 1859, the British magistrate ordered a slave master to pay for the treatment of his former slave (who was freed during the trial) at the cost of 12 heads of cowries paid to a local healer. This was also a hefty fee (equal to 12 bottles of imported rum) but it was a typical price for a basic healing ceremony during the late 19th century.²⁶ Another change in payment that was occurring, but more slowly, was the inclusion of British Pounds and Liberian Dollars (which were pegged to the American Dollar) as payment. The presence of these currencies, which were less vulnerable to fluctuations in supply, became a stable form of payment for healing during the early colonial period. In other words, healers conducted their business in a manner that adjusted to changing circumstances, and did not remain within an enchanted world of fetish.

²³ Paul Lovejoy and Jan S. Hogendorn, *Slow Death for Slavery: The Course of Abolition in Northern Nigeria, 1897-1936* (Cambridge: Cambridge University Press, 1993). Lovejoy notes that laws against slavery and the slave trade were applied only if political expedient for administrators in Nigeria. Instances of slavery and slave trading were also evident on the Gold Coast.

²⁴ PRAAD SCT 2/4/2. 15th May 1861 - 10th Feb. 1864. May 15th, 1861, 5.

²⁵ PRAAD SCT 2/4/2. 15th May 1861 - 10th Feb. 1864. May 15th, 1861, 5.

²⁶ PRAAD SCT 2/4/1. December 6, 1859, 229. The slave had been purchased for 32 heads of cowries.

Also prevalent in the court records was the continuity of a rich material culture of local and regional African therapies, which included potions, salves, powders and other aggregations of local medicinal ingredients. In many instances, these mixtures came in the form of *ti*, the consecrated carbonized dust made from herbal ingredients. In one case, a healer manufactured and consecrated some *ti*, and then blew it into the face of his patient to counter the malicious spirits that caused his illness.²⁷ In another instance, a healer treated a woman with convulsions using a potion of rum and *ti*, advising the woman to take the remedy orally over the course of three months.²⁸ In 1877, to cure a patient who was suffering from a snakebite, a *woyoo* prepared a *ti* comprised of the “candlewood, guinea pepper, the feather of a fowl and other objects,” which she administered as a purgative,²⁹ and in a case from 1897, a healer shaved the head of a sick patient and rubbed a liquid suspension of *ti* on their scalp.³⁰ Unfortunately, few of the ingredients of these herbal reductions are known. Many of them would likely have been made up of basic reagents like *nyanyara* and *biatso*, but the practice of utilizing multiple ingredients in order to harness multiple healing spirits is also evident in these records. Some recipes of *ti* were simple cures, while others were contingent improvisations designed to challenge the spirits causing the illness.³¹

²⁷ PRAAD SCT 2/4/2. 15th May 1861 - 10th Feb. 1864. May 21st, 1861, 16.

²⁸ PRAAD SCT 2/4/18. 29th Sept 1892 - 15th Jan. 1894. “Afia Aba vrs Dodoo,” Oct. 10, 1892, 95-111.

²⁹ PRAAD SCT 2/4/12. 5th May 1877 - 28th May 1879. “Chief Labetia Allotey and Korkor vrs police,” October 12, 1877, 226.

³⁰ PRAAD SCT 2/4/25. 25th Mar 1897 - 30th Aug. 1897. Ama Aku vrs Peter Martin Yoroahie (illeg.). August 5, 1897, 577-79.

³¹ Several of the post-mortem cases handled by W.J.R. Simpson during the bubonic plague epidemic of 1908 showed evidence of ritual inoculations with consecrated herbal *ti*, William John Ritchie Simpson, *Report on Plague in the Gold Coast, 1908* (London: J+A Churchill, 1909), 33-34.

Deep spiritual concerns were also evident in cases related to healing. One of these was a fear of infertility.³² In a city where infant mortality rates were high due to disease, one of the most important roles of the healer was to link together the generations by aiding conception with fertility medicines, caring for pregnant mothers, ensuring healthy deliveries, and conducting puberty rituals.³³ Not surprisingly, concerns about reproductive problems also featured prominently within the court records. In some cases, people in Accra placed the blame for infertility on curses affected by “fetish priests.” As a means of defending themselves against such curses, some patients sought medicines from beyond the Accra Plains, as demonstrated by an 1874 case of a man who purchased a healing object (at the cost of ten times the normal price for a local remedy) from an itinerant trader who had brought it from “very far in the interior.”³⁴ The expense was worthwhile in this instance because the object cured him and one of his wives gave birth to twins shortly afterwards.³⁵

Another perceived cause of infertility was witchcraft, and women in Accra regularly sought out healing devices to protect themselves and their children from the ravages of covens of invisible witch spirits. In one case, a herbal potion used to wash children after birth was briefly mentioned as a therapy that acted as an inoculant against witchcraft.³⁶ In another case, a man described how he bought a herbal prophylactic to ward off witchcraft and prevent his wife from delivering another stillborn child.³⁷ Though witchcraft was likely present in the city centuries before, it is associated in these cases very closely with infertility,

³² See Hepper, *West African Herbaria*; Field, *Religion and Medicine of the Ga People*, 54-57; Kilson, *African Urban Kinsmen*, 25, 192.

³³ Field, *Religion and Medicine*, 161-84; Interview, Bentum, June 17, 2003; Interview, Thunder, June 6, 2006; Interview, Joyce Ayile Quaye, June 18, 2003.

³⁴ PRAAD SCT 2/4/11. 31st July 1874 - 18th June 1875. Nov. 24th, 1874, 177-79.

³⁵ PRAAD SCT 2/4/11. 31st July 1874 - 18th June 1875. Nov. 24th, 1874, 177-79.

³⁶ PRAAD SCT 2/4/2. 15th May 1861 - 10th Feb. 1864. May 15th, 1861, 15; see also see PRAAD SCT 2/4/2. 15th May 1861 - 10th Feb. 1864. Mar 31, 1862, 323.

which may represent a change in the way that reproductive health was understood in Accra. There are no data tracing the rise and fall of witchcraft panics in Accra, but the rise of anti-witchcraft shrines in the Akan regions during the late 19th century suggests that an increasing amount of attention might have been focused on combating the forces of witchcraft on the Gold Coast during this period.³⁸

Despite prevalent anxieties about infertility and its association with witchcraft, there is also evidence that women aborted some pregnancies. William F. Daniell, a traveler and ethnographer who visited Accra in the 1850s, reported to the ethnological society of London in 1856 that abortions in Accra could be “secretly induced by the assistance of powerful emmenagogues indigenous to the country.”³⁹ Daniell noted that the demand for abortifacents was driven by the fear that pregnancy out of wedlock would “degrade the girl in estimation of the public” by creating “an indelible stain” to her reputation.⁴⁰ This theory was borne out in a scandal in 1899, when Basel Mission catechist Carl Christian Reindorf was accused of procuring an abortion for his daughter Christiana.⁴¹ The details included in these cases are sparse, but they offer evidence that not all pregnancies were welcomed, especially amongst families who adhered to the Victorian norms colonial society.⁴² Evidence from 21st century interviews with healers indicates that concoctions fabricated as

³⁷ PRAAD SCT 2/4/31. 6th March, 1900 - 39th Sept. 1900. “Larson versus Bruce,” May 10th, 1900, 377.

³⁸ John Parker, “Witchcraft, Anti-witchcraft and Trans-regional Ritual Innovation in Early Colonial Ghana: Sakrabundi and Aberewa, 1889-1910,” *Journal of African History*, 45 (2004).

³⁹ William F. Daniell, “On the Ethnography of Akkrah and Adampe, Gold Coast, Western Africa,” *Journal of the Ethnological Society of London*, 4 (1856), 13.

⁴⁰ Daniell, “On the Ethnography of Akkrah,” 13.

⁴¹ John Parker, “Mankraloi, Merchants & Mulattos – Carl Reindorf and the Politics of “race” in early Colonial Accra,” in *The Recovery of The West African Past: African Pastors and African History in the 19th Century*, C.C. Reindorf and Samuel Johnson, ed. Paul Jenkins (Basel: Baseler Africka Bibliographien, 1998), 41.

abortifacents were commonly known by Ga healers, and were derived from herbal ingredients found in the markets of Accra.⁴³ In Accra today, women can make confidential visits to herbalists or female spirit mediums to purchase and learn how to use abortifacents, and there is also evidence from the 1920s that shows the women had access to herbal concoctions that they could use to terminate pregnancies.⁴⁴ This evidence suggests that although fertility may have been traditionally prized amongst the inhabitants of Accra, elite Christian women living in 19th century Accra might have been compelled by family patriarchs to have abortions to maintain bourgeois norms.

While the use of herbal remedies were ubiquitous during this period, not all concoctions made by herbalists were regarded as healthy. In the late 19th century, accusations of poisoning were common within court proceedings, with some plaintiffs expressing a fear of being killed by the very medicines that were supposed to heal. In these instances, the black powdered *ti*, which was usually regarded as having healing properties, appeared as a poison, and the herbalists who produced it had to defend themselves from accusations of fetish or the production of obnoxious medicines. In one case from 1900, a Mr. Larson claimed the he had been poisoned by Mr. Bruce, a man who had previously prepared healing draughts for Mr. Larson, including a potion to aid digestion and a fertility potion for his wife.⁴⁵ Mr. Larson claimed that he had fallen ill after sharing a drink of beer

⁴² Another case from the court records (unrelated to Reindorf's case) includes a brief mention of an abortion, but only in passing. PRAAD SCT 2/4/18. 28th July 1891 - 28th Sept. 1892, 329-33

⁴³ Interview, Woyoo Joyce Ayile Quaye, June 18, 2003; Interview, Nurse Evelyn Gilbertson, April 16, 2004.

⁴⁴ Interview, Woyoo Joyce Ayile Quaye, June 18, 2003; Interview, Nurse Evelyn Gilbertson, April 16, 2004; Sally Craddock, *Retired Except on Demand: The Life of Cicely Williams* (Oxford: Green College, 1983), 57-58.

⁴⁵ SCT 2/4/31. 6th March 1900 - 39th Sept. 1900. "Larson versus Bruce," May 10th, 1900, 369-98. The ancestry of Mr. Larson and Mr. Bruce is not given in the case, but they were

with Bruce, he was certain that some “black stuff,” or *ti*, had been placed in the beer to change the “weight of the drink.”⁴⁶ Mr. Bruce took the stand to defend himself, telling the magistrate that he was a practiced herbalist and had never made any poisons. The magistrate found Mr. Bruce not guilty because the plaintiff could not prove that there was a chemically active substance added to his beer, but within the colonial court setting, it was easy for the stereotype of the duplicitous “fetish priest” to emerge because patients always feared that the curative power of *ti* could be converted into poison. On the other hand, Mr. Bruce appeared at the trial to offer a forthright defense of his skill at making herbal remedies. In this case, someone who in the past might have been disregarded within European journals as a charlatan was able to contest the assertions of Mr. Larson and defend the integrity of indigenously-generated therapies.

Nonetheless, accusations of poisoning found in the court records demonstrate how the African residents of Accra feared that some African therapies could be used to harm rather than heal. In 1858, a man named Mr. Annang was accused of killing a young woman named Adjuah by giving her poisoned rum. Adjuah’s family singled out Mr. Annang as the culprit, claiming that he had prior knowledge of poisons used to kill animals. Annang denied the charges, but paid 80 heads of cowries to the court of the Ga paramount chief to appease Adjuah’s family. However, Annang was later accused of threatening to poison the father of Adjuah, and was brought in front of the British magistrate. He was held under suspicion, but later released without a trial.⁴⁷ In a later case in 1872, an employee at the Basel Mission accused two fellow workers of trying to poison him. The plaintiff, Theodor Wulff, claimed

likely considered mulatto (the term used for the offspring of European traders and African women) or descendants of white traders.

⁴⁶ SCT 2/4/31. 6th March 1900 - 39th Sept. 1900. “Larson versus Bruce,” May 10th, 1900, 369-98.

⁴⁷ PRAAD SCT 2/4/1. “Barker versus Annang,” April 13, 1858, 98.

that the defendants, Lartey and Addor, bought a pot of herbal reagents from a local *tsofatse* named Tettey Amoye and paid him a large sum of money to prepare a deadly poison from the ingredients. Wulff claimed that Lartey and Addor planned to place the medicine in his drink to kill him. Fortunately, the *tsofatse* refused to participate in the plan and exposed the plot in front of the colonial magistrate:

I was promised thirty-two dollars to poison plaintiff. I did not agree so I came and reported to you. I did not agree because I had no bad feeling against you. I reported the matter to you about three times...I am a native doctor. I never practice Fetish. I never practice Fetish in this town. I do not know any medicine to injure peoples life. I have no medicine to poison people I do not know any poison...⁴⁸

In this statement, Amoye contested the insult of being referred to as a “fetish” practitioner by declaring that he only healed people, and never took measures that would harm. His argument was reinforced by the fact he had refused Lartey and Addor’s offer of 32 Liberian Dollars, worth approximately one month’s wages.⁴⁹ He continued his testimony by detailing how the perpetrators, Lartey and Addor, had brought him the ingredients for the poison because they did not know how to activate the dangerous powers within it themselves. He explained that they believed that the substance needed to be drawn out of the material by a ritual expert in order for it to become poisonous. In the context of the colonial courtroom, the derogatory meaning of fetish, inherited from Bosman and other European writers of the 17th and 18th century prevailed, and cropped up again and again. Some healers were under suspicion simply because they were known to be able to traffic in dangerous herbal medicines and occult powers. But the voice of the healers also appear in these records,

⁴⁸ PRAAD SCT 2/4/10. 22nd Oct 1872 - 31st July 1874. “Theodore Willif versus John A. Swaniker,” December 10, 1872, 85.

⁴⁹ This estimate is made by comparing the CPI and the average daily wage as calculated on <http://measuringworth.com/calculators/uscompare>, a cliometric currency calculation service established by Lawrence H. Officer of the University of Illinois and Samuel H. Williamson

demonstrating that it was the African residents of Accra who were determining who was a legitimate healer and who was not.

Another echo of past practice found in the court records of the early colonial period was the use of consecrated medicines in trials-by-ordeal to determine the guilt or innocence of a person accused of spiritual malfeasance. In the late 18th century, Ludewig Ferdinand Romer had described how the Danes hired a broker named Adoui to conduct the practice of “eating fetish” in order to broker trade deals or render judgments and in the 19th century, evidence of similar practices emerges from the court records. The residents of Accra participated in these trials beyond the purview of the colonial justice system, and most accusations were likely resolved without appeal to colonial courts, but anecdotal evidence of the use of trials-by-ordeal did creep into the court proceedings during the late 1800s. In 1867, a woman from Labadi accused a woman from Accra of stealing wood, and cursed her at a shrine so that she would die if she ate kenkey (a staple food made from fermented corn dough). In an attempt to save her life and clear her name, the accused went through a trial-by-ordeal. She failed the trial, and the fetish priest found her guilty, ordering her to pay a fine of two sheep, two chickens and two flasks of rum to the accuser.⁵⁰ The defendant brought the case before a British magistrate, pleading that her accuser had defamed her. The magistrate accepted her plea and ordered the woman from Labadi to pay a small fine to the court. Another example of a common trial-by-ordeal during this time was the ‘Arkah truth fetish’.⁵¹ Unfortunately, the rich detail of who administered these trials and how they worked is absent from court proceeding because the details were not relevant to the cases. However, what these small pieces of information show is that petitioners were using the

of Miami University. The dollars may also have been Liberian dollars, which were pegged to the value of the US dollar.

⁵⁰ SCT 2/4/11. October 19, 1874, 125.

colonial court as a secondary dispute mediator after having failed to solve their issues with the help of African brokers. Though the magistrate was not able to rule on the validity of charges levied by a shrine priest, or even recognise their authority, he could offer residents of Accra an alternative route justice outside the circles of African religious and healing power in Accra.

What is strikingly absent from the colonial courtroom are therapeutic options other than therapies generated within Ga or other regional African cultures. There is no mention of Christian ideas about healing, Islamic therapies, or imported European medicines in the court records. This may have just happened by chance because the court cases that mention healing are only samplings of the disputes that occurred within Accra society and do not represent a quantifiable random sampling of healing practices. We might also take the absence of healing alternatives as evidence that Ga therapies, and other therapies indigenous to West Africa, were simply more prominent in the city. European-derived healing methods are also almost completely absent from these records, reflecting the fact that few African residents in the city were patronizing surgeons and physicians. However, one particular case, the inquest into the death of a fisherman named Commey, does include evidence about the role of surgeons in relation to African healers. In this trial, for the first time, a surgeon appears as an expert witness offering his opinions about how and why Commey died. His testimony demonstrates that, in early colonial Accra, patients could access different assessments of health from practitioners with different healing traditions. It also shows that European medical experts, when bulwarked by power of a colonial court, could assert epistemological authority over states of health of the subject peoples of the colony.

⁵¹ PRAAD SCT 2/4/2. 15th May 1861 - 10th Feb. 1864. May 15th, 181, 5-7.

In December of 1877, a fistfight broke out between two prisoners at James Fort, one of whom was a fisherman named Commey. After the fight, both men walked away, seemingly uninjured, but in the days that followed Commey's ribs became swollen and sore. He was taken to a "native doctor" who washed his wounds and rubbed them down with herbs. The "native doctor," who was most likely a *tsofatse* trained in healing with herbal remedies, attended to his patient for seven days but Commey's torso swelled so dramatically on the last day that he died. Because the incident occurred at a colonial prison, the government required an investigation into the death, and the transcript of the hearing offers an example of the asymmetry of African and European aetiologies and practices in the late 19th century.

During the inquest, the presiding officer brought forward Dr. Anderson, Assistant Surgeon of the Gold Coast Colony, to determine whether the cause of death was the wound itself or the therapy provided by the *tsofatse*. The British surgeon took the stand and told the presiding officer that the injuries sustained by Commey might have been complicated by a chest infection of pleurisy and pneumonia.

It is possible that the ... injuries which he is said to have suffered from the [beating] might have disguised the pain -- I knew an instance where a man had a rib broken by gunshot his shoulder was also shattered and the injury to the shoulder might have disguised the pain of the rib. I have not known another instance where there was not pain felt very soon. There might have been internal injuries, but there are no symptoms described, whereas all the symptoms, the difficulty of breathing, the inability to sit up in bed, and the bloody spit all point to Pleurisy probably complicated with Pneumonia.⁵²

Dr. Anderson made this assessment as a military surgeon, based on his experience treating soldiers with bullet wounds. When he was asked if the herbal remedies of the local healer might have complicated Commey's injuries, he admitted that it would be difficult for him to comment because he did not know what sorts of herbs had been used, though he did

⁵² PRAAD SCT 2/4/12. 5th May 1877 - 28th May 1879. "The Queen against [illegible]," 4th of Dec, 1877, 361-62.

mention that it was unlikely that the herbal remedy hastened the death considering it was applied on the outside of the body. In a city where surgeons rarely ventured outside the slave forts, Dr. Anderson might not have ever spoken to an African healer because of the language barrier involved, and even if he had, there is nothing in his testimony that shows knowledge of the local healing arts.⁵³

After questioning Dr. Anderson, the presiding officer brought the (unnamed) *tsofatse* to the stand to inquire if his herbal therapies had hastened the death of the patient:

Q. What medicine was used?

A. The medicine was root of the tree Oblijo.

Q. What was the purpose of applying the medicine?

A. Because he was [injured] and that was the proper medicine in such cases that is why I applied it.

Q. Was it to make him cool or hot?

A. It was to get down the swelling.

Q. Does it make the body hot or cold?

A. It makes him hot.

Q. Did you apply hot water or cold water?

A. Cold water. Hot water first, then cold water, then the medicine.

Q. Was there any peculiarity about the breathing?

A. He breathed like a sick man who is not expected to live.⁵⁴

This dialogue contains two differing aetiologies of disease. On the one hand, the presiding officer is asking questions about the fever of the patient with the presumption that the health of the patient depended on controlling and regulating the body temperature. The *tsofatse* was responding without understanding the motive behind the questions. His answers are brief for several reasons. Firstly, they were likely truncated by the court recorder.

Secondly, the *tsofatse* probably excluded information about how he healed Commey. For

⁵³ PRAAD SCT 2/4/12. 5th May 1877 - 28th May 1879. "The Queen against [illegible]," 4th of Dec, 1877, 353. Even the brother of Commey, who was also questioned during the trial, admitted that he did not know what sorts of medicines that the *tsofatse* had used on his brother.

⁵⁴ PRAAD SCT.2.4.12. 5th May 1877 - 28th May 1879. "The Queen against [illegible]," 353, 356, and 360-62. The original appeared clustered as one paragraph, without "Q" or "A" to distinguish between the responses. I have altered the passage to make it easier to read.

example, he did not discuss his method of preparing the herbal remedy, the spiritual significance of the *obilijo* medicine, or his opinions on the spiritual causes of the illness.⁵⁵ He may have excluded this information because he was aware that a British magistrate might find him culpable in the death of Commey, emphasizing instead that the patient was on his death bed anyway, and that the application of the *Obilijo* remedy was a last ditch attempt to save him. Whereas Dr. Anderson felt comfortable speculating about the causes of death in front of the colonial legal authorities as a government authorized medical expert, the *tsofatse* did not. The herbalist's careful release of information might have saved him from incriminating himself because the magistrate concluded that the cause of death had nothing to do with the treatments of the *tsofatse*.

What is interesting about this inquest is that it shows the existence of parallel evaluations of the health of the same patient. Dr. Anderson's post-mortem assessment of pleurisy complicated by pneumonia was a judgment of the symptoms of the illness rather than its causes. Pleurisy was a term used at this time to describe the inflammation of the lining of the lungs, a condition that caused a constriction of the chest, while pneumonia was a term for a lung infection (more broadly understood as the "inflammation" of the constitution).⁵⁶ Both are broad, unspecific categories for pathologies of the chest cavity and, as a physician wedded to the humoral theories of the 19th century, Dr. Anderson would have thought of them as the symptoms of an imbalance of the constitution caused by the trauma of the rib injury. The *tsofatse* would have conceived of the injury in a different manner, initially relying on the virtues of local herbs like to cool Commey's body, then perhaps later offering therapies to check the power of the spirits that caused the accident to happen.

⁵⁵ Hepper, *West African Herbaria*, 30.

The evidence from cases during the late 19th and early 20th century do not offer a complete picture of the healing culture of Accra society. Absent are the richly detailed illness narratives that historians would prefer to use as the basis of historical analysis. However, this collection of anecdotes offers a surprising amount of detail about local and healing practices in Accra. What is evident here is a continuation of a rich tradition of West African healing, patronized both by the elites who had the financial capacity to bring their cases in front of a British magistrate, and by other classes of society, who appear as secondary characters in these fragmented anecdotes. This data offers us evidence of the therapeutic networks in the city, which intertwined with many other aspects of life in the city. The voices of the actual “fetish priests” or “native doctors” also are heard in some of the trials, speaking back to colonial authority in a way that asserts their authority as the bearers of healing tradition in the city, and that dispels the clichés born of the idiom of fetish.

This is not to say that healing practices derived from Ga and other West African cultures had not changed. For instance, payments for healing services were in flux because multiple currencies and imported goods were in circulation. Also, the abolition of slavery threw into question who was obligated to heal who, within a new system where one person could no longer be the property, and therefore the responsibility, of another. Witchcraft too, seems to have become prominent during this period as a cause of sickness and spiritual illness appears. This does not mean that there were no earlier instances of witchcraft, but it does show that by the start of the 20th century witchcraft was a powerful force in Accra. Another point of potential change here was in the realm of reproduction and fertility. In an African

⁵⁶ Michael Bliss, *William Osler: A Life in Medicine* (New York: Oxford University Press, 1999), 106-7. In this case it is likely that Anderson would have believed that if the rib healed, the chest problem would also heal.

society where fertility and large numbers of children were much cherished, women appeared to be asserting control over their reproductive rights, perhaps influenced by Christian or colonial bourgeois norms of reproduction. And finally, the case of Commey offers direct evidence of parallel, incommensurable, evaluations of health at play in the city of Accra. Surgeons remained bit players within the larger healing culture of the city, but within the confines of the colonial legal system, European-derived medical knowledge determined the states of health of colonial subjects. But these changes should not be read as proof of the diminishing power of African practitioners. Rather, they should be understood as examples of the vibrancy of African healing in the city and evidence that local practitioners were adjusting to the economic and political changes taking place in the city.

Section 2. The Emergence of New therapies: Islamic and Christian Communities in Accra.

While healing practices born of Ga and other West African traditions continued to flourish in Accra, two other types of healing cultures, based on the power of a supreme deity, began to emerge in the city. In Accra today, therapists who draw their knowledge from healing from Islamic practices are prominent in several Muslim-dominated suburbs, while Charismatic Christian congregations, with their emblematic faith-healing services, have established churches in all corners of the city. While there are sources that demonstrate the rise of Islamic and Christian healing in the mid-20th century,⁵⁷ little has been done to trace its roots back to the 19th century. The historiography of medicine on the Gold Coast effectively secularizes the story of healing in Accra, reducing missionary medicine to a series of brief mentions and footnotes, and silencing the growth of faith-healing in the 20th century.⁵⁸

⁵⁷ Acquah, *Accra Survey*, 144, 149; Baeta, *Prophetism in Ghana*, 50-54.

⁵⁸ Patterson, *Health in Colonial Ghana*, 17; Addae, *Evolution of Modern Medicine*, 111.

Admittedly, the source materials on these communities is sparse, but they must be read through in order to gain insight into how enclaves of followers of the major religions were established, and how these communities became springboards for new healing cultures.

Prior to the 19th century, the presence of Islam is not mentioned in any European accounts of Accra, nor are there any Islamic influences that are deeply embedded in the Ga language.⁵⁹ None of the Galenic surgical techniques common to the Sahel regions, such as cupping, bleeding, variolation, and male circumcision, are mentioned in European travel accounts from the 17th Century, and there is no mention of Islamic prayer, or the use of Quranic passages in geomancy, slate wash, or amulets. In fact, Peiter De Marees stated explicitly that no “barbers” existed on the Gold Coast, and did not mention the presence of Islam.⁶⁰

The presence of Islamic healing practices may have come to the city in the late 18th century, when Isert reported the widespread use of leather amulets in the 1780s, as well as the use of variolation (a technique that, he believed, dramatically reduced incidences of smallpox along the coast).⁶¹ And by the start of the 19th century, it is highly probably that Muslim apotropaics were known of in Accra, considering their strong presence in the urban centres of the Kingdom of Asante. European envoys to Kumasi, the capital of the kingdom of the Asante, reported the presence of Islamic healing practices. They noted that Kumasi contained a large Muslim population with a wide array of nationalities (including Gonjas,

⁵⁹ Mary Esther Kropp Dakubu notes only a few contributions from Arabic to the Ga language, suggesting that terms like *shika* and *klamo* might have Arabic (perhaps via Mande) roots. Dakubu, *Korle Meets the Sea*, 141; Dakubu, *Ga-English Dictionary*, 81, 144.

⁶⁰ Marees, Pieter de; Dantzig, A. Van; Jones, Adam (ed. and trans.) *Description and Historical Account of the Gold Kingdom of Guinea* (1602) (Oxford: Oxford University Press, 1987), 173.

⁶¹ Wisnes, *Letters on West Africa and the Slave Trade*, 132.

Dagombas, Mamprussis, Hausas, and Wangaras),⁶² and that their priests used Arabic script in the fabrication of charms and amulets, sometimes in combination with local herbal remedies.⁶³ Extant folios of documents in Arabic script used in Kumasi contain instructions for how to make amulets that protected the wearer from specific illnesses such as smallpox or leprosy, or conditions such as sexual impotency, infertility, migraine headaches, and bed-wetting.⁶⁴ As David Owusu-Ansah has shown in his analysis of these Arabic manuscripts, amulets were in demand everywhere in Kumasi (“from the Asante palace to the slave’s hut”) but soldiers in particular were willing to pay for protective war charms. In 1807, British Governor of the Gold Coast, George Torrane, noted that every Asante soldier had a form of body armor fashioned out of a “little square cloth enclosing some little sentences” of the Quran.⁶⁵ There is no direct evidence of the use of such charms by the residents of Accra, but since the residents of the city engaged in battles against the Asante, they would have been aware of their use and manufacture. In 1826, thousands of Asante soldiers poured onto the Accra Plains to fight in what became known as the Battle of Katamanto, where many of them were killed and captured. The Ga armies engaged in that battle managed to recover an Asante charm made from the skull of Sir Charles McCarthy “enveloped in two folds of paper, covered with Arabic characters,” which was handed over to British officers.⁶⁶ Additionally, a collection of Arabic manuscripts from the Asante, many of them taken from

⁶² Deborah Pellow, “The Power of Space in the Evolution of an Accra Zongo,” *Ethnohistory* 38, No. 4 (Autumn, 1991), 424.

⁶³ Joseph Dupuis, *Journal of a Residence in Ashantee* (H. Colburn, 1824), 72-75, 94-98, 178-80; see also Maier, “Nineteenth-Century Asante Medical Practices,” 79; Silverman & Owusu-Ansah, “Presence of Islam,” 325-339.

⁶⁴ David Owusu-Ansah, “Prayers, Amulets and Healing,” in Nehemia Levtzion and Randall L. Pouwels. *The History of Islam in Africa* (Athens: Ohio University Press, 2000), 482.

⁶⁵ Ivor Wilks, *Asante in the Nineteenth Century: The Structure and Evolution of a Political Order* (London: Cambridge University Press, 1975), 257; for an example of a description of one of these amulets, see W R. Taylor, “An Arabic Amulet,” *Muslim World* 25, no. 2 (1935), 161-165.

amulets, were archives at the Danish fort of Christiansborg in the early 19th century, and eventually deposited in the Royal Library at Copenhagen.⁶⁷

However, it was only in the mid-19th century that the presence of a Muslim community in Accra can be verified via documentation. The first and most prominent group of migrants were Hausa-speaking soldiers from the Slave Coast (Nigeria), who were brought by the British Army to fight against the Asante during the wars of 1823-31 and 1873-4.⁶⁸ The marshalling point for the early battles against the Ashanti was Accra, so it is highly likely that Muslim healing influences were present in the city during these expeditions. Sometime in the 1850s, the Hausa population in Accra increased to the point where they were able to form their own neighborhood, or *zoyu* (from the Hausa term *zango*, meaning camp),⁶⁹ and in 1881 they appointed their first leader, Idris Naino, a priest from Katsina in Hausaland, who was known through oral tradition as the first Muslim to settle in Accra (probably around 1850).⁷⁰ The Hausa population was supplemented by the arrival of Yoruba migrants from Abeokuta (including Brimah the butcher, who would later become a leader in the community).⁷¹ By 1891, the Gold Coast Census stated that Muslims made up eight percent of the population of Accra, living mostly along the eastern side of Ussher Town, and by 1900, some members of the Ga community began to convert to Islam.⁷² Most Muslims worked as merchants in the livestock or kola nut trades, but some of them were priests of

⁶⁶ "Copy of a dispatch from lieutenant-colonel Purdon to the Earl of Bathurst, colonial records, no. 267," in J.J. Crooks, *Records Relating to the Gold Coast*, 232-33.

⁶⁷ David Owusu-Ansah, "Islamic Influence in a Forest Kingdom: The Role of Protective Amulets in Early 19th Century Asante," *Transafrican Journal of History* 12 (1983), 100.

⁶⁸ Dakubu, *Korle Meets the Sea*, 134-15.

⁶⁹ Spelling from Dakubu, *Ga-English Dictionary*, 76.

⁷⁰ Odoom, "Document on Pioneers," 3; Sulemana Mumuni, "A Survey of Islamic Non-Governmental Organizations in Accra," in Holger Weiss, *Social Welfare in Muslim Societies in Accra* (Uppsala: Nordic Africa Institute, 2002), 140.

⁷¹ Mumuni, "Islamic Non-Governmental Organizations," 141.

the Tijaniya Sufi brotherhood,⁷³ who offered Islamic education for the poor and marginalized of the city in order to attract converts.

The early aggregation of Hausa and Yoruba Muslims might have allowed for the presence of the so-called *wanzamai*, surgeon/healers who offered barbering, circumcision, ritual scarification, herbal remedies, apotropaics – services common to all Hausa communities around West Africa.⁷⁴ The *alufa*, who are described by J.D.Y. Peel as Yoruba holy men who used the spiritual power of quranic charms to influence events, may also have been present in Accra in the late 19th century.⁷⁵ Unfortunately, the sources on this subject are limited; they offer no textual evidence of any particular school of thought about healing or any specific evidence of the use of prophetic medicine.⁷⁶ This means it is not clear which sort of spiritual concepts these priests and healers might have adopted, considering that the majority of them came from a region of both Islamic revival under the Sokoto Caliphate, and a region where the multiplicitous *bori* spirits were understood to affect the human health.⁷⁷ However, considering the strength of the Muslim community in Accra, and

⁷² *Gold Coast Census*, 1891; Sulemana Mumuni notes that the first Ga man, Kwashi Solomon, converted to Islam around 1900, see “Islamic Non-Governmental Organizations,” 142.

⁷³ Mumuni, “Islamic Non-Governmental Organizations,” 143.

⁷⁴ Pellow, “Power of Space,” 436; Stock notes that Hausa healers were found throughout West Africa and throughout the Sahel in 20th century, practicing forms of fetish making, therapies derived from the Quran (like *rubutu* – tr. slate washing), minor surgery, and divination. See Stock. “Traditional Healers in Rural Hausaland,” 363-68; Ismail Hussein Abdalla, *Islamic Medicine and its Influence on Traditional Hausa Practitioners in Northern Nigeria*, Ph.D Dissertation, University of Wisconsin (1984), 89. Abdalla includes the *wanzamai* as one of many different types of subgroupings of Hausa healers.

⁷⁵ Peel, *Making of the Yoruba*, 198-99.

⁷⁶ There is no specific reference, for instance, to the *Tibb-ul-Nabbi* (Medicine of the Prophet), a set of guiding principles and practices for Muslim doctors, or *Unani Tibb*, the Greco/Islamic tradition of healing. For the difference between these two traditions, see Projit Mukharji, “Lokman, Chholeman and Manik Pir: Multiple Frames of Institutionalising Islamic Medicine in Modern Bengal,” *Social History of Medicine* 24, 3 (2011): 720.

⁷⁷ For a review of the Bori spirits from Hausa territories in Nigeria, see Umar Habila Dadem Danfulani, “Factors Contributing to the Survival of the Bori Cult in Northern Nigeria,” *Numen* 46, no. 4 (1999), pp. 412-447.

considering the prevalence of Islamic medicines in Asante, some sorts of Islamic healing practices were almost certainly present in Accra by the mid-1850s.

Another group of Muslims who influenced healing practices in Accra were the “Tabon,” migrants from Brazil who contributed to the cultivation of herbal reagents in Accra.⁷⁸ The first Afro-Brazilians arrived in 1829, and were received by the chief of Ussher Town, who gave them land in the Otoblohum quarter of the city.⁷⁹ They were followed by about 200 freed slaves from Bahia in 1836, and thereafter by slave traders in the mid-19th century. According to interview evidence found in the work of Alcione M. Amos and Ebenezer Ayesu, many of the Brazilian immigrants cultivated herb gardens. One particular immigrant, Abotchei Nassu, used herbs that he grew in his own garden to make a cure for Guinea worm, which would have been a medical innovation in a city where there is no prior record of a cure for this painful disease.⁸⁰

In the 19th century, the Muslims of Accra began to form what Deborah Pellow has characterized as a “diverse collectivity,” comprised of various ethnic groups and backgrounds, united though Islamic forms of worship.⁸¹ They also came to share a common language of Hausa, which became the lingua franca of Muslims in Accra, along with common notions of the healing authority vested in the word of God via the Quran. Practices such as divination via geomantic squares, slate washing of Quranic script made with consecrated black ink, verbal incantations and recitations with the goal of healing or remedying social ills, were present in nearby regions of West Africa and may all have been present in the city; indeed, it is possible that non-Muslims patronized these sorts of therapies

⁷⁸ Amos and Ayesu, “I Am Brazilian”, 41.

⁷⁹ Edward Carstensen, *Governor Carstensen's Diary. 1818-1850* (Legon: University of Ghana, 1965), 19-20 (13 May, 1845).

⁸⁰ Amos & Ayesu, “I Am Brazilian”, 45-46.

in order to acquire spiritual armour for battle, protection from malicious spirits, or perhaps for many of the other common concerns of the residents of Accra: fertility, prosperity, security.

Another emerging religious force on the Gold Coast in the 19th century was Christianity, but growth of Christian congregations was severely limited by the tropical disease environment. The staggered growth of Christian churches in Accra in the 19th century is dealt with in other sources,⁸² but what has not been emphasized is how Christian missions added three new elements to the healing culture of Accra. Firstly, missionaries established an association between Christianity and European medicine (though, as we will see, this was difficult to sustain). Secondly, missionaries in Accra translated the Bible into Ga, providing a vocabulary of healing that Ga-speakers would utilize in the 20th century. And thirdly, they reinforced distinctions between European religious practice and fetish worship, continuing a discursive assault on the authority of African religion and healing that had commenced in the European travelogues of the 17th and 18th centuries.

The first mission station in Accra was built by the Basel Mission Society in 1827, as a distinct Christian community just north of the village of Osu next to the Christiansborg Castle, but the German and Swiss lay-preachers who arrived in the city were barely able to sustain it because of the high death rate due to malaria and other diseases. The Basel missionaries intended to train African converts in European surgical techniques but they had

⁸¹ Deborah Pellow, "Muslim Segmentation: Cohesion and Divisiveness in Accra," *Journal of Modern African Studies*, 23, no. 3 (1985), 419.

⁸² C.C. Reindorf, *History of the Gold Coast*; Hans W. Debrunner, *History of Christianity in Ghana* (Accra: Waterville Publishing House, 1967); F.L. Bartels, *The Roots of Ghanaian Methodism* (Cambridge: Cambridge University Press, 1965); Noel Smith, *The Presbyterian Church of Ghana, 1835-1960* (Accra: Ghana Universities Press, 1966); Birgit Meyer, *Translating the Devil: Religion and Modernity Among the Ewe in Ghana* (Cambridge: Edinburgh University Press, 1999); Kemp, *Nine Years at the Gold Coast*; Paul Jenkins, ed., *The Recovery of The West African Past: African*

trouble finding missionaries with surgical knowledge who could survive long enough to train members of the congregation.⁸³ One convert who did learn some surgical practices was Carl Christian Reindorf, an Accra-born catechist who learned how to dress the wounds of soldiers during the Awuna War of 1866 and the war against the Akwamu in 1870. During these conflicts, Reindorf received a crash course in surgery; as family legend has it, after one battle Reindorf extracted 300 slugs from the wounds of soldiers.⁸⁴ Reindorf also demonstrated an aptitude for herbal medicine, collecting recipes from healers in Akwapim and Accra which he developed into a remedy that cured several Europeans of dysentery. Later in his career, he trained several other catechists in both surgical and herbal therapies. These men later employed themselves as medical missionaries in the villages around Accra and in the Akwapim region.⁸⁵

In his later years, Carl Christian Reindorf later wrote what has become a foundational history of the Gold Coast, making him a towering figure in both the history and historiography of Accra. But his 1895 *History of the Gold Coast and Ashanti* did not include information about missionary medicine and his attempts to create hybrid therapies do not seem to have had a lasting effect. The Basel Mission never established a hospital in Accra, and Reindorf worked mostly with Twi speakers outside of the city, in the villages to the north. His remedies for dysentery were never written down, and though he trained other Christians in surgery, no indigenous school or system of apprenticeships in European surgical techniques emerged. What is more, there is no evidence that European medical knowledge amongst Basel mission converts was actively sustained -- for some reason the

Pastors and African History in the Nineteenth Century, C.C. Reindorf and Samuel Johnson (Basel: Baseler Africka Bibliographien, 1998);

⁸³ C.C. Reindorf, *History of the Gold Coast*, 10.

⁸⁴ C.C. Reindorf, *History of the Gold Coast*, 10, 13.

⁸⁵ C.C. Reindorf, *History of the Gold Coast*, 15.

knowledge that Reindorf accumulated and passed on seems to have petered out. This result stands in contrast to other missions in Africa, where even basic medical services, such as lancing boils or pulling teeth, became an essential part of attracting converts.⁸⁶ Despite the fact that Basel Mission community grew rapidly at the end of the 19th century (to 12 European missionaries, 22 African employees, and a congregation over 1,000),⁸⁷ without a program of medical training, the link between surgery and evangelism petered out. When Accra became the capital of the Gold Coast, institutions like the colonial army and Gold Coast Medical Department took on the role of propagating European-derived medical techniques.

Though the Basel Mission in Accra did not use the practice of medicine as a tool of conversion, the missionaries did establish a series of key concepts about the healing power of the Holy Trinity within the Ga language. Johannes Zimmerman's translation of the Bible in 1866 (with the aid of African catechists like C.C. Reindorf)⁸⁸ offered Ga-speakers three new terms with which to conceptualize healing. The first was his translation of the Supreme Deity as *Nyoyimo*, a Ga word for both rain and a deity associated with the sky. At the end of

⁸⁶ For instance, missionary medicine figures prominently in studies of the London Missionary Society by Jean and John Comaroff and Paul Landau, Nancy Rose Hunt's work on the Church Missionary Society in the Congo, and Derek Peterson's analysis of Presbyterian evangelism Tumutumu mission in Kenya. Jean Comaroff, "The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body," in *Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life*, ed. Shirley Lindenbaum and Margaret Lock (Berkeley: University of California Press, 1997); Jean and John Comaroff, *Of Revelation and Revolution*, vol. 1 (1991) and vol. 2. (1997); Paul Landau, *The Realm of the Word: Language, Gender, and Christianity in a Southern African Kingdom* (Portsmouth, NH: Heinemann, 1995); Hunt, *Colonial Lexicon*; Derek R. Peterson, "Gambling with God: Rethinking Religion in Colonial Central Kenya," in *The Invention of Religion: Rethinking Belief in Politics and History*, ed. Derek R. Peterson and Darren R. Walhof (New Brunswick, N.J.: Rutgers University Press, 2002), 35-58.

⁸⁷ Rev. Henry Otis Dwight, Rev. H. Allen Tupper, Jr, and Rev. Edwin Munsell Bliss, *Encyclopedia of Missions: Descriptive, Historical, Biographical, Statistical, 2nd Ed* (Funk & Wagnalls Co., London, 1904), 163.

⁸⁸ Smith, *Presbyterian Church of Ghana*, 55.

the 18th century, Paul Isert had previously noted that Ga-speakers believed that *Nyonyimo* was actually a *deus otiosus*, a prior godly power “too eminent to be concerned with the activities of people,” so it is a matter of speculation about why Zimmerman elevated *Nyonyimo* to the status of creator.⁸⁹ In a dry area like the Accra plains, he may have wanted to choose a term that would associate the Supreme Deity with the health of the land.

When Zimmerman translated Holy Spirit, he faced a different challenge. In Ga, the word for spirit is *woji*, an invisible force that can be harnessed to both harm and heal. In order to imbue the Holy Spirit with the purifying capacities of a divine force, while at the same time eliminating any possibility of malicious action, Zimmerman chose the term *mumo keronkron*, a joining of the word for “breath” with a doubling of the word for “unadulterated purity.”⁹⁰ To Zimmerman, this would have been an invisible and unmitigated force that cleansed the soul, but in Ga it could be understood as a powerful healing entity, and in the churches of the 20th century it would be appropriated as a force that could clear spiritual blockages in the body and increasing the flow of *bemale*.⁹¹ When translating the name for the son of God, Zimmerman needed to avoid any confusion with ancestral spirits,⁹² which is likely why Zimmerman simply imposed the Greek name for Jesus Christ, *Yesu Kristo*, creating a new singular ancestral character with which all Christians could identify, irrespective of their ethnic or kinship ties.⁹³ By the end of the 19th century, a small subsection of the inhabitants of Accra, numbering only the hundreds, had been exposed to these

⁸⁹ Wisnes, *Letters on West Africa and the Slave Trade*, 128.

⁹⁰ Dakubu, *Ga-English Dictionary*, 94 & 109.

⁹¹ By comparing and analysing the sermons and publications of several famous Charismatic pastors in the 1990s, Paul Gifford showed how references to increasing success and health were prominent, as were corresponding promises that the Holy Spirit could remove blockages. Gifford, *Ghana's New Christianity*, 46.

⁹² Meyer demonstrates the confusion wrought by debates about whether Jesus was an Ewe ancestral spirit. See Meyer, *Translating the Devil*, 78-79.

terminologies of the Holy Trinity, but Zimmerman's translations provided the tools Christians would later use to create a culture of faith-healing in the 20th century.

With these new conceptions of God, the son and the Holy Spirit, the tiny Christian congregation of Osu was able to distinguish itself from what they regarded as fetish worship. The leaders of the Basel and Wesleyan missions followed a policy of separating their congregations from local populations. The Basel Mission "Salem" (as it was known by the missionaries) was built as a Christian refuge purposely divided from the beliefs and practices of the Ga, and members of the congregation who mixed Christianity with African practices risked expulsion from the church.⁹⁴ The Methodist Church also railed against the indigenous religions of the people of Accra, declaring them to be primitive forms of superstition. Reverend Dennis Kemp, the General Superintendent of the Wesleyan Mission in the Gold Coast in the 1890s, recognized the desire to communicate with the spirit world amongst the followers of African religions, but considered their practices to be a degenerate form of worship.

The religion, which is one of the lowest forms in existence, consists mainly of superstitious beliefs -- largely aided by witchcraft -- which have been handed down from generation to generation by a succession of priests, who delude the credulous minds of the people by their fraudulent practices. Fetishism is essentially spirit worship, but of so debasing and demoralizing a type as to be hardly distinguishable from devil worship.⁹⁵

For Methodist missionaries, fetish was equated with spiritual corruption, and they forbade their followers from participating in the "traditional dancing, polygamy, ancestor-worship

⁹³ Johannes Zimmerman, *Grammatical Sketch of the Akra or Ga Language including a Vocabulary of the Akra or Ga Language with an Adangme Appendix* (Stuttgart, 1858).

⁹⁴ Jon Miller, *Missionary Zeal and Institutional Control: Organizational Contradictions in the Basel Mission on the Gold Coast 1828-1917* (Cambridge: Routledge, 2003);

⁹⁵ S.K. Odaamtten, *The Missionary Factor in Ghana's Development (1820-1880)* (Accra: Waterville Publishing House, 1978), 223.

and all the rites and beliefs which had come to be known as fetishism.”⁹⁶ Both the Basel Mission and the Methodist missionaries believed that their converts had to be reborn through the word of God, and to be socially separated from their Ga culture in their newly built African salem.

In the process of building their Christian community, converts were asked to divorce themselves from African therapies that drew on the healing spirits but this posed a conundrum for the new Christians, as they did not have any other readily available therapeutic regime to adopt. There were no clinics or hospitals at the Basel Mission, no missionary doctors, and the colonial medical system, as we will see in Section 4, had only one poorly-staffed, badly-equipped hospital. Practically speaking, they were left in a healing no-man’s-land. As John Peel has noted, Yoruba Christians in the 19th century filled this cultural vacuum by bringing down the blessing of God on imported medicines. In one case Peel mentioned how an African catechist used Holloway’s Ointment, a general purpose patent medicine for skin ailments, combined with an appeal to God to sanctify the medicine: “the medicine I use is God’s and to render it efficacious I must ask God’s blessing upon it.”⁹⁷ In Accra, Reindorf’s initiatives to practice surgery combined with herbalism might have followed this hybrid model, but we simply have no records to show this. What is available for sources about the use of medicines at the Basel Mission are frustratingly thin, consisting of only one reference to the use of imported salicylic acid (aspirin) to fight fevers.⁹⁸ It is hard to believe that the residents of the new Salem at Osu could have wholesale abandoned African-derived therapies, but there is the possibility that the therapeutic gap created by the

⁹⁶ Bartels, *Roots of Ghanaian Methodism*, 54, 137.

⁹⁷ Peel, *Making of the Yoruba*, 222.

⁹⁸ Basel Mission Archives, C-10.56.02. "MSS notes in German on the use of Salicylpulver [Salicylic Acid = active ingredient in aspirin] as medicine for fever." Author unknown. August 25, 1875.

rejection of so-called fetish would eventually be filled by either imported patent medicines, colonial medicine, secularized herbal therapy or Christian faith-healing. As we shall see, all of these therapeutic options became viable in the 20th century.

Though the source material describing the new outlooks on healing that Muslims and Christians brought to the city in the 19th century is limited, the emergence of these two new therapeutic avenues is an essential part of the pluralistic narrative of healing in Accra, one that has been silenced by an emphasis on colonial medicine. Muslims brought a new culture of herbalism to the city, and probably engaged in other practices, such as amulet production, related to improving the well-being of their clients. Christian missionaries were exposed to European surgical practices, and refused to perpetuate Ga religious practices, making room for the growth of other therapeutic streams. Though small in number during the early years, the Muslims and Christian communities of Accra would grow rapidly in the 20th century, dramatically influencing the healing culture of the city.

Section 3. New Tools for Healing: Patent Medicines

In the late 19th century, innovations in industrial production in the United Kingdom resulted in a flourishing of mass produced, branded commodities like garments, hats, alcohol, wine, foodstuffs and toiletries, as well as patent medicines. These goods were markers of distinction, especially in the British colonies where their rarity and value was much higher than in England. The trade in imported medicines does not figure prominently in economic accounts of the legitimate trade of the 19th century, which is dominated by the discussion of cloth and alcohol.⁹⁹ Nor are patent medicines part of the metanarrative of the

⁹⁹ Jean and John Comaroff, *Of Revelation and Revolution: Christianity, Colonialism and Consciousness in South Africa*, vol. 1 (Chicago: University of Chicago Press, 1991), 222; Jean Allman, ed., *Fashioning Africa: Power and the Politics of Dress* (Bloomington: Indiana University Press, 2004),

expansion of European medicine because they were bought and sold beyond the purview of physicians and medical officials. But for Europeans living West Africa, access to these medicinal goods were perceived as vital to their survival on the Gold Coast, and they packed with them all manner of drugs and medicines when they traveled around the empire. This section marks the transition point, from a time when European *materia medica* took the form of medicinal reagents used exclusively by ship's surgeons, to a time when branded, packaged, patent medicines were bought and sold around the British Empire. For Africans too, patent medicines fitted in nicely with other imported goods as expressions of wealth and sophistication, and in the late 19th century that patterns of self-medication could be used to define ones role in a growing, urban, colonial society.

As we have seen in chapter 2, most of the medicinal components used by European ship's surgeons were of little use in the tropics, but the one herbal reagent that was essential to the survival of Europeans in West Africa was quinine. In 1823, American chemists synthesized Jesuit's bark as quinine sulfate, and began to process it in the shape of tiny granules for sale around the world.¹⁰⁰ During the Niger expedition of 1841, the British Army used quinine sulfate to ward off malaria amongst its soldiers, but the dosage was so low that it was ineffective.¹⁰¹ Despite a lack of knowledge of the appropriate dosage to check malaria, the British maintained faith in quinine as a tool that would keep their soldiers in Africa healthy. In 1845, the Medical Department of the British Army sent a circular to all British

4-6; Joanne B Eicher and Tonye V. Erekosima, "Why do they call it Kalabari? Cultural Authentication and the Demarcation of Ethnic Identity," in *Dress and Ethnicity. Change across Space and Time*, ed. Joanne B. Eicher (Washington, DC: Berg, 1995) 147-49; Akyeampong, *Drink, Power, and Cultural Change*, 44-45; van den Bersselaar, *King of Drinks*, 38-65.

¹⁰⁰ Rocco, *Quinine*, 182.

¹⁰¹ Curtin, *Disease and Empire*, 21. There was a 30% mortality rate and an 80% morbidity rate from malaria.

governors in West Africa recommending quinine as a prophylaxis,¹⁰² and during the campaign against the Asante in 1873-4, the rates of malaria were lowered because soldiers were ordered to take large quantities of quinine per day.¹⁰³ At this point, quinine became a global commodity, available as an ingredient in patent medicine or simply in a standardized pill form.

Like their military compatriots, European merchants and missionaries in West Africa also started to take quinine pills to prevent malaria, though without any standardization of dosage.¹⁰⁴ Methodist minister Dennis Kemp recalled that, during his tenure on the Gold Coast, the amount of quinine one took varied according to individual preference:

[When wet] take five or ten grains of quinine -- the exact quantity will depend on your general use of it. [There are] those who are able to boast that they can dispense with the drug for five or six months at a time. Others take small quantities frequently -- in the wet season, daily. A medical friend, of considerable experience and success, tells me that fifty grains, taken during three consecutive days once a month, gives a sudden and salutary check to all malarial tendencies.¹⁰⁵

As Kemp noted, the use of quinine as a curative or a prophylaxis depended on the strategy devised by the physician (or in the absence of the physician, the patient and his/her caregivers). The variation in dosage was attributable to the fact that patients did not understand that they were ingesting grains of quinine as a weapon against the parasite *plasmodium falciparum*, a concept that would have been inconceivable considering that the microbe was not discovered until 1898.¹⁰⁶ Rather, they took quinine to restore a balance of humours within the body, and they had to be careful in its application -- too much quinine produced side-effects known as “quininism,” which included vertigo, tinnitus, nightmares

¹⁰² Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the 19th Century* (New York: Oxford University Press, 1981), 68.

¹⁰³ Curtin, *Disease and Empire*, 60-70.

¹⁰⁴ Cohen, “Malaria and French Imperialism.”

¹⁰⁵ Kemp, *Nine Years at the Gold Coast*, 37-40.

and nosebleeds.¹⁰⁷ As Kemp recalled, breaking a malarial fever often required “heroic doses of quinine” because the cure was almost as bad as the disease.¹⁰⁸ Though quinine had been commodified, its dosage was not yet standardized because it was not yet known as a weapon to target the specific pathogen of the malaria parasite.

By the mid-19th century, European missionaries and colonial officials began to travel with their own medicine kits, which included quinine along with assorted proprietary medicines.¹⁰⁹ Branded medicine chests, like the Burroughs Wellcome Tabloid Medicine Chest, were mass produced in the 1890s and became *de rigueur* for colonial officials and missionaries traveling to Africa. These chests contained branded medicines like Warburg’s Tincture, Dover’s Powder, Easton’s Syrup, and Livingston’s Rouser.¹¹⁰ During his travels through the Gold Coast in the 1860s, Richard Burton passed through Accra with quinine, as well as a kit containing two patent medicines, Chlorodyne and Warburg’s Tincture. Chlorodyne, devised by a British doctor in India as a treatment for cholera, was an addictive tonic made from opium, cannabis, and chloroform that became an essential component of all medicine kits for British officials in Africa.¹¹¹ Burton likely used it as a painkiller, but it

¹⁰⁶ For an account of the discovery of malaria by Ronald Ross, see Rocco, *Quinine*, 250-80.

¹⁰⁷ “Quininism,” *Lancet* (January 13, 1838), 550-51.

¹⁰⁸ Kemp, *Nine Years at the Gold Coast*, 37-40.

¹⁰⁹ Raymond E. Dumett, “John Sarbah, the Elder, and African Mercantile Entrepreneurship in the Gold Coast in the Late Nineteenth Century,” *Journal of African History* 14, no. 4 (1973), 653-79; Raymond E. Dumett, “African Merchants of the Gold Coast, 1860-1905 -- Dynamics of Indigenous Entrepreneurship,” *Comparative Studies in Society and History* 25, no. 4 (Oct., 1983), 661-93.

¹¹⁰ Dover’s Powder contained ipecacuanha and opium, Easton’s Syrup was a mixture of strychnine, iron phosphate, and quinine, and Livingston Rouser was a recipe attributed to David Livingstone that probably contained quinine. Ryan Johnson “Tabloid Brand Medicine Chests: Selling Health and Hygiene for the British Tropical Colonies,” *Science as Culture* 17, 3 (2008), 249-268; *Extra Pharmacopoeia Martindale*, 1, 24th ed. (London: The Pharmaceutical Press, 1958), 812.

¹¹¹ Chlorodyne was a mix of alcohol, chloroform, morphine, marijuana and other trace vegetable elements. William Hale-White, *Materia Medica, Pharmacy, Pharmacology and Therapeutics*. (Toronto, Macmillan, 1914), 280; Chlorodyne was recommended as an essential

was advertised as a cure-all for a wide variety of ailments, including diarrhoea and headaches. According to Burton, his use of Chlorodyne attracted so much interest during a visit to Axim (a small port town on the Gold Coast) that someone stole four large bottles from his medicine kit.¹¹² For fevers, Burton used Warburg's Tincture, a bitter concoction of quinine and various "aeromatic substances"¹¹³ that he purchased directly from Dr. Warburg, an Austrian chemist living in London in the 1870s.¹¹⁴ Burton advocated the use of Warburg's Tincture amongst his friends and associates, because he claimed it had saved his life and the lives of many other travelers in the tropics.¹¹⁵ He even claimed it had been bought by the crate for the navy and army during the Anglo-Asante war of 1873-4. Methodist missionary Kemp also believed in the efficacy of Warburg's Tincture, despite its reputedly "vile" taste.¹¹⁶ In the case of stubborn fevers, Kemp also used Anti-Febrin, an analgesic containing acetanilide (considered too toxic for regular use by the late 20th century).¹¹⁷ Whether Chlorodyne, Warburg's Tincture, or Anti-Febrin were for sale in shops in Accra is unknown, but missionaries, colonial officials and European merchants did come to rely on them for survival in the African tropics.

The first patent medicines were produced and sold in the United States and Britain as home remedies, but by advertising in journals and newspapers, the manufactures of bottled

medicine for colonial officials in the *West African Pocketbook* (Great Britain, Secretary of State for the Colonies, London, Waterlow and Sons Ltd., 1905, 43-45.)

¹¹² Richard F. Burton and Verney Lovett Cameron. *To the Gold Coast for Gold. A Personal Narrative*. vol. 2 (London: Chatto & Windus, 1883), 231-32.

¹¹³ Warburg's Tincture contained rhubarb, saffron, fennel, myrrh, camphor, angelica seeds, as well as nine grains of quinine added per ounce (*American Journal of Pharmacy* 49 (1877), 269-71); Burton and Cameron, *To the Gold Coast for Gold*, 231.

¹¹⁴ Burton and Cameron, *To the Gold Coast for Gold*, 231-32.

¹¹⁵ Burton and Cameron, *To the Gold Coast for Gold*, 232.

¹¹⁶ Kemp, *Nine Years at the Gold Coast*, 37-40.

¹¹⁷ Oxford University, "The Physical and Theoretical Chemistry Laboratory: Chemical and Other Safety Information," accessed July 9, 2009, <http://msds.chem.ox.ac.uk/AC/acetanilide.html>.

remedies were able to expand their sales to all corners of the globe.¹¹⁸ Vegetable pills, bought by mail order and taken for gastrointestinal illnesses, became a common type of patent medicine on the Gold Coast. Archeological evidence shows that Perry Davis Vegetable Pills (a pain killer that likely included opiates) were consumed in the 19th century in the African section of Elmina, a major coastal trading center 250 kilometres down the coast from Accra,¹¹⁹ and Dr. De Roos Vegetable Pills¹²⁰ were advertised in Gold Coast newspapers in the 1880s. These brands were the progenitors of a burgeoning mail-order pill market, reflected in an 1881 advertisement in the *Gold Coast News* that listed throat lozenges, quinine powder, laudanum, liver pills, iodine, and a variety of pain killers for sale.¹²¹ Far from their physicians at home, the Europeans living in Accra consumed imported medicines in an effort to stay healthy because the Gold Coast was still a dangerous disease environment for them to inhabit.¹²² They had to live with the fear that a slight chill in the afternoon could lead to a raging fever at night, and death by morning, so they relied heavily on word-of-mouth knowledge about tropical medicine (and a kitbag full of quinine and patent medicines) keep themselves alive.

There is little direct evidence that Africans were also buying and consuming patent medicines during the late 19th century and the early 20th century, but the rapid growth of

¹¹⁸ Daniel Pope, *The Making of Modern Advertising* (New York: Basic Books, 1983), 6, 187; J. George Frederick, *Masters of Advertising Copy* (New York: Frank Maurice, 1925), 32

¹¹⁹ Christopher DeCourse, *An Archeology of Elmina: Africans and Europeans on the Gold Coast, 1400-1900* (Washington: Smithsonian Institution Press, 2001), 148; David C. Stuart, *Dangerous Garden: The Quest for Plants to Change our Lives* (Harvard: Harvard University Press, 2004), 67.

¹²⁰ *Gold Coast News*. April 25, 1885, in Dumett, “John Sarbah, the Elder,” 673. The *Gold Coast News* was published by English lawyer, W.C. Niblett, and only lasted for a few months. David Owusu-Ansah, *Historical Dictionary of Ghana* (Lanham, Md.: Rowman & Littlefield, 2014), 159.

¹²¹ *Gold Coast News*. April 25, 1885, in Dumett, “John Sarbah, the Elder,” 673.

¹²² Kemp, *Nine Years at the Gold Coast*, 213-15, 223. Kemp referred to the colony as the “Land of Death,” and malaria as the “King of Terrors.”

their import indicates that they had penetrated the African market. In 1890, an estimated £3000 worth of drugs and medicines were imported into the Gold Coast, a small quantity that was likely consumed exclusively by Europeans and African elites. By 1900, this number had doubled and by the 1910s had reached £20,000.¹²³ Since the European population of the Gold Coast was just over 1000 people in 1911 (see Table 3.2), it is most likely that Africans on the Gold Coast had become consumers of patent medicines. This assertion is supported by the one definitive fact that we have, which comes from 1912, when the Chief Medical Officer of the Gold Coast noted that educated Africans were using patent medicines to cure gonorrhoea, in conjunction with locally-derived remedies.¹²⁴

There are many reasons to suggest why Africans might have adopted patent medicines in the late 19th and early 20th centuries. Firstly, the markets of Accra were already well established as clearinghouses for transcontinental herbal reagents and remedies, and it is possible that these items found their way into local commercial channels. Secondly, patent medicines and medicine chests could be ordered by mail.¹²⁵ Thirdly, there is parallel evidence that African consumers were already buying imported medicinal products in the form of distilled alcohol.¹²⁶ J.H. Henkes promoted their “Star Brand” gin by claiming on the label that it was “highly recommended by the medical faculty as a household remedy for the alleviation and cure of: Rheumatism, Gout, Gravel, Flatulency, Dyspepsia, Dropsy, Diseases of the Kidneys, Bladder, etc.”¹²⁷ Another distiller, Blankenheym & Nolet, attached a medical

¹²³ In 1901, the colonial government started to apply a 10% duty to drugs and medical supplies that were not for colonial operations. *Gold Coast Colony Blue Book* (Accra, Ghana: Government Printer, 1901)

¹²⁴ Robert R. Kuczynski, *Demographic Survey of the British Colonial Empire*, vol. 1 (New York: Kelley, 1977), 472.

¹²⁵ J. K. Crellin, *A Social History of Medicines in the Twentieth Century: To Be Taken Three Times a Day* (New York: Pharmaceutical Products Press, 2004), 73.

¹²⁶ van den Bersselaar, *King of Drinks*, 179.

¹²⁷ van den Bersselaar, *King of Drinks*, 205.

certificate to every bottle that they exported to West Africa, hoping that their gin could carve out a niche in the market as a medicinal tonic.¹²⁸ Since these spirits were produced to specifically serve African consumers, and since they were both available in Accra, it suggests that Africans were looking for imported goods that were considered healthful.¹²⁹ Fourthly, Gold Coast newspapers contained print ads for patent medicines. Though literacy rates were low amongst the general populations, newspapers like the Accra Herald, the Gold Coast Echo, and the Gold Coast Times were published by prominent Africans and read by a burgeoning class of African merchants and professionals.¹³⁰ These periodicals offered news, commentary and advertising to what Stephanie Newell has called a “reading public,” a literate West African community that included many professionals who had traveled around the continent and to Britain.¹³¹ Moreover, these newspapers may have been read aloud to those who could not read, expanding the market for patent medicine advertising orally.¹³²

Unfortunately, the limits of historical source materials once again constrain what we can say about how the African population of the Gold Coast in the 19th and early 20th centuries might have appropriated patent medicines. But though Africans may not have been the target market for such items, they were clearly available in Accra and there are plenty of hints to suggest that they were sought after. Because there were no regulations governing their

¹²⁸ van den Bersselaar, *The King of Drinks*, 205.

¹²⁹ Dumett, “John Sarbah, the Elder,” 673.

¹³⁰ K.A.B. Jones-Quartey, “The Gold Coast Press: 1822-c 1930, and the Anglo-African Press: 1825-c 1930 – The Chronologies,” archival document held at Michigan State University, accessed June 28, 2014, <http://archive.lib.msu.edu/DMC/African%20Journals/pdfs/Institue%20of%20African%20Studies%20Research%20Review/1968v4n2/asrv004002004.pdf>.

¹³¹ Stephanie Newell, *The Power to Name: A History of Anonymity in Colonial West Africa* (Athens: Ohio University Press, 2013), 44-61.

¹³² There were several schools in Accra by the 1880s, operated by the Basel Mission, the Wesleyan Mission and the Government. The numbers of literate students numbered in the hundreds and the city was also home to educated professionals from around West Africa.

distribution or consumption, patent medicines fitted nicely into a stream of therapeutic self-medication with herbal remedies that had been established for centuries, and could be acquired as a way of distinguishing oneself as a wealth consumer or someone who followed the self-healing practices of European missionaries and travelers. As we will see in chapter 2, patent medicines became even more significant in the 20th century, when they could be conspicuously consumed as a means to distinguishing oneself as modern colonial subject, and when they became imbued with local meanings relating to the health concerns of the residents of Accra.

Section 4. Sanitary Science, Scientific Medicine, and Biopower in Colonial Accra.

When the British chose Accra as the capital of the Gold Coast in 1877, they did so in accordance with prevailing European notions of the relationship between sanitation and urban design. The British thought that Accra would be a dry, healthy location for a capital city, as evidenced in a speech to the House of Lords by the Earl of Carnarvon, who lamented the miserable health conditions in Cape Coast:

The soil is saturated through and through with sewage. There is decaying vegetable matter everywhere about, and the houses are crowded on one another It deserves more than perhaps any other place the appellation of the white man's grave. (Hear!) This being the case, there must be a change; the seat of government must be moved, but for obvious reasons it must be on the sea coast. Now there is a choice of one or other of two places -- Accrah on the east and Elmina on the west. Accrah appears to be a desirable place as regards health.¹³³

See, C. K. Graham, *The History of Education in Ghana from the Earliest Times to the Declaration of Independence*, (London: Routledge, 1971), 112-18.

¹³³ Metcalfe, *Great Britain and Ghana*, 365, from speech by Earl of Carnarvon. House of Lords, 12 May, 1874, reprinted in *The Times* (London), May 13, 1874.

The colonial officers on the Gold Coast agreed with the Earl, and they petitioned London to move away from the miasmatic Cape Coast to the dry open plains of Accra.¹³⁴ The move to Accra was part of a larger, century-long, period of sanitary reform in Britain, largely motivated by the ravages of cholera epidemics that had killed millions in South Asia and thousands of people in the UK. After several decades of urban renewal by cities in Europe, parliament passed the Public Health Act in 1875, which made sanitation laws a national, and by extension, an imperial concern.¹³⁵

But just as sanitation theory began to dominate the discourse of health and illness in Accra, a different perception about disease began to emerge in Europe. Starting in the 1880s, teams of laboratory scientists began to isolate specific microbes as the causes of epidemic diseases like anthrax, tuberculosis, cholera, diphtheria, bubonic plague, and malaria, and then conduct research to create vaccines to prevent these illnesses. The search for microscopic pathogens broke from a long tradition of individualized patient care when physicians took the time to study the particular temperaments and humoral constitution of each client.¹³⁶ This revolution in scientific medicine increasingly aggregated the sick in clinics and hospitals, where they could be observed *en masse* by medical officers rather than personal physicians.¹³⁷

¹³⁴ In 1869, the Chief Medical Officer of the Gold Coast stated that the “barbarous and unhealthy customs of the natives” might lead to a disastrous outbreak of cholera. Kuczynski, *Demographic Survey*, 365; Gale, “The Struggle against Disease,” 187; Colonial records also stress the importance of having a place to play polo, the most popular sport for colonial officers in West Africa, see Gann and Duignan, *Rulers of British Africa*, 249-50.

¹³⁵ “The Public Health Bill, 1875,” *British Medical Journal* (April 3, 1875), 450; Arthur Swinson, *The History of Public Health* (Exeter: A.E. Wheaton, 1965), 71; George Rosen, *A History of Public Health* (Baltimore: Johns Hopkins University Press, 1993), 208; for a discussion of

¹³⁶ Foucault, *Birth of the Clinic*.

¹³⁷ Steven Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), 41-49.

Historians of medicine in Europe, such as Paul Rosen and Arthur Swinson, have celebrated the unification of sanitary theory and laboratory science as ushering in an era when medicine could become a progressive social force,¹³⁸ and the historiography of medicine in Ghana follows suit.¹³⁹ A countervailing viewpoint, put forward by historian Michel Foucault, is that the rise of sanitation theory and medical science began an era of “biopower,” a historical period when the state began to monitor and control the health of populations via state institutions like clinics, hospitals and asylums.¹⁴⁰ The evidence presented in this section will show some elements of both of these narratives at work. In some instances, African residents in the city seem to have sought out colonial medicine because of its perceived benefits. In other instances, they appear to have been channeled toward colonial medical services. However, both approaches overestimate the significance of the work of the Gold Coast Medical Department due to the need to locate the early colonial period as a starting point of colonial medical activity. Following on the work of Thomas Gale and Ryan Johnson, this section will show that government of the Gold Coast, forced to conform to the dictates of the colonial economy, underfunded public health reforms in a manner that was “insensitive”¹⁴¹ to the health concerns of both Europeans and Africans on the Gold Coast.¹⁴² As a result, the medical infrastructure of the new colonial capital was, at best, makeshift, and the public health measures taken were piecemeal and

¹³⁸ Swinson, *History of Public Health*, 67; Rosen, *History of Public Health*, 289.

¹³⁹ Addae, *Evolution of Modern Medicine*, 29-33; Patterson, *Health in Colonial Ghana*, 11.

¹⁴⁰ Foucault, *Birth of the Clinic*.

¹⁴¹ Gale, “The Struggle against Disease,” 199.

¹⁴² Johnson, “West African Medical Staff.”

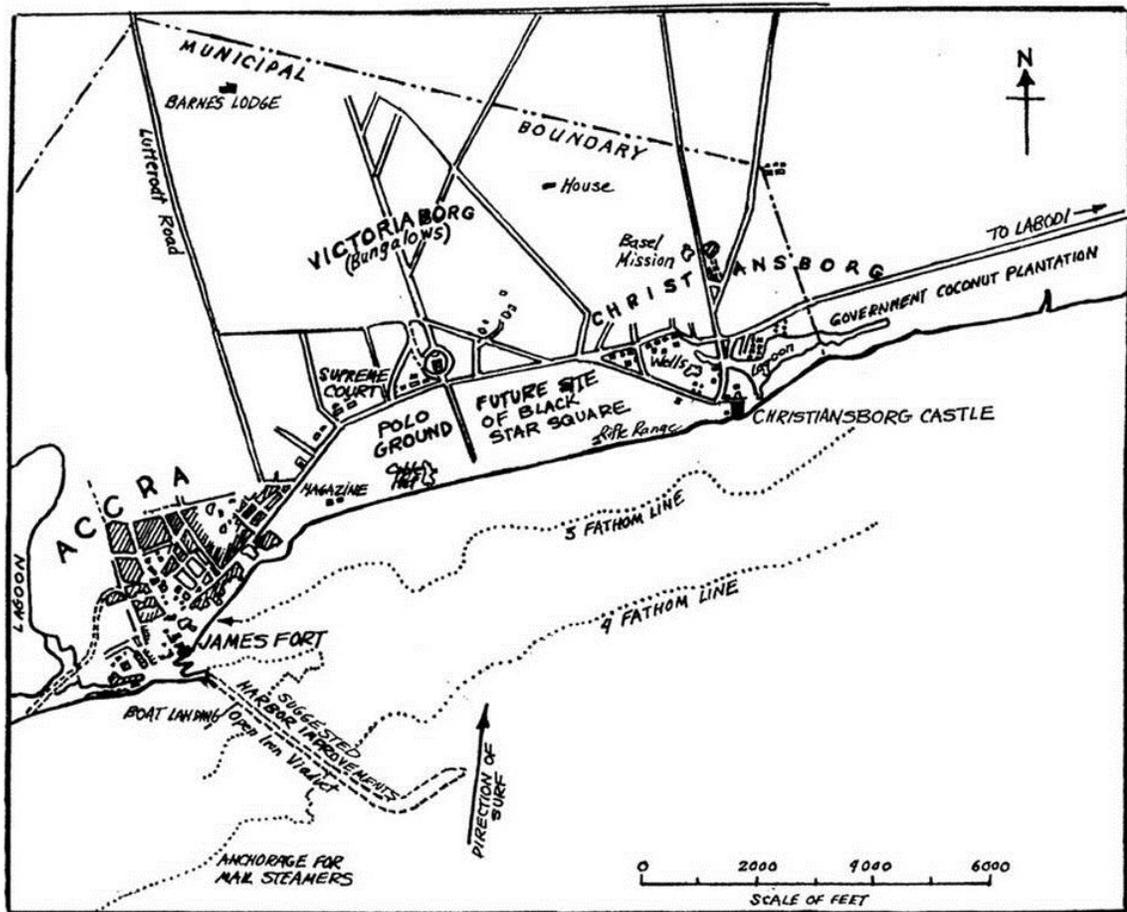


Figure 3.1. Accra, 1903. This map displays the built up area of Ussher Town and James Town in contrast to the surveyed grounds of Victoriaborg, Christiansborg and the Ridge. The open spaces between delimited the boundaries between the “native quarter” and the “European reservation.” Both the governor’s residents (Barnes Lodge) and Basel Mission “salem” were located on open ground north of the former slave forts, a way of distancing them from African neighborhoods. The colonial hospital was initially housed in buildings near the James Fort, but was later moved to a bungalow across from the polo grounds (site of the present day Supreme Court), squarely between the African and European halves of the city. *Map from: Ione Acquah, Accra Survey* (London: University of London Press Ltd., 1958), Figure 2.



Figure 3.2. Colonial Hospital, Accra, 1883. The first official colonial hospital was located in a bungalow in Victoriaborg. It was poorly equipped, inadequately staffed, and shunned by Europeans. The majority of patients at the hospital were African, many of whom were in the employ of the government or European merchants. *Source: Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir (1973), 45.*

largely targeted at protecting the health of government officials. The limited reach of colonial medicine meant that ample room remained for other therapeutic alternatives in the city to flourish.

When the British made Accra the capital of the Gold Coast, the only hospital was a cluster of huts with some beds beside the James Fort.¹⁴³ In 1882, the Medical Department shifted this rudimentary hospital into the former home of George Lutterodt, a Danish merchant.¹⁴⁴ Very little information exists about the early days of the hospital, but it was evidently small, sparsely equipped, and staffed by only one doctor. In 1883, Governor Rowe initiated the construction of the first official Colonial Hospital building inside an old bungalow in Victoriaborg, and placed the institution under the direction of Colonial Surgeon-in-Charge, Dr. McCarthy. When the hospital opened, it contained 16 beds, segregated into two wards, one with four beds for Europeans, and another with twelve beds for Africans. It also contained a small dispensary and living quarters for the nursing staff.¹⁴⁵ The mentally ill were separated into a building on High Street that had briefly been used for the High Court. Facilities at this asylum were very basic, with no psychiatric care or drug therapy, but the mental hospital served the purpose of isolating the violent mental patients from the prison population where they had previously been held (either in Ussher Fort or James Fort).¹⁴⁶

¹⁴³ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 46.

¹⁴⁴ For information concerning the Lutterodt family, see John Kwadwo Osei Tutu, *The Asafoi (Socio-military Groups) in The History of Politics of Accra (Ghana) from the 17th to the mid-20th Century*. Ph.D. Thesis, Norwegian University of Science and Technology, 2000, 100.

¹⁴⁵ PRAAD ADM 5.4.12. "Gold Coast Hospital. Accra. Opening Ceremony by His Excellency Brig.Gen. Sir Frederick Gordon Guggisberg, K.C.M.G. D.S.O., R.E.," October 9, 1923, 5; Ghana. *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 14.

¹⁴⁶ E.B. Forster, "A Short Psychiatric Review of Ghana," *American Journal of Psychotherapy* 16 (1962), 29;

Information about the conditions at the colonial hospital is scarce but the few accounts remaining indicate that it offered only the most basic of services. In 1896, a young nurse arrived in Accra to find the hospital in a dilapidated state:

I was thunderstruck when I saw the hospital: the floor was clean, and that is all that could be said for it; the beds were such as an educated native would not sleep on in these days, very few bed-clothes, and what there were, all in rags, a few plates, knives, and forks, and I remember one man had brought in his own egg-cup. I was very much struck with the bare look, not only of the hospital, but all round, not a garden or tree to be seen, nothing but thick low bush, which I was told, and found afterwards, was full of snakes. I thought I had come to the most God-forsaken place on the earth.¹⁴⁷

Supplies at the hospital were continuously short, to the degree that the nurses had to provide tea and sugar from their own supplies. Though the hospital did have a theatre for surgical services, it was not kept in good condition, and the surgical equipment was sometimes covered in rust.¹⁴⁸ One doctor even described the hospital as “primitive and disgusting.”¹⁴⁹ Moreover, the physical limitations of the building were worsened by the low quality of the physicians working there. According to Principle Medical Officer Dr. Henderson, the hospital was only able to attract the “dregs of the profession” -- doctors who were unable to find work in England and who were often dismissed from the West African Medical Service for “discreditable causes.”¹⁵⁰

But despite its limitations, the demand for services at the hospital was steady, and by the 1890s, the Medical Department added several more beds.¹⁵¹ Colonial officials and European merchants used it only as a last resort, preferring to sail to Britain when they suffered from a serious illness so it was the African population of the city who filled the majority of the beds

¹⁴⁷ “A Nurse Arriving on the Coast in the Good Old Days,” an anecdote by an unnamed nurse (initials M.B.), in Lady Clifford (Mrs. Henry de la Pasture), *Our Days on the Gold Coast* (London: John Murray, 1919), 43.

¹⁴⁸ Clifford, *Our Days on the Gold Coast*, 127.

¹⁴⁹ Patterson, *Health in Colonial Ghana*, 19.

¹⁵⁰ Kuczynski, *Demographic Survey*, 479.

of the hospital. On average, there were only two beds available for Europeans, while the hospital eventually expanded to forty beds for Africans. We do not have records to show who exactly attended the hospital, so it is difficult to explain how demand for such a simple medical facility was sustained. One possibility is that the African merchant classes attended the hospital in order to associate themselves with the medical practices of British elites, but considering the deplorable state of the facility, and considering its public status, it is more likely that physicians made house calls to the homes of wealthy Africans. A second, more likely possibility is that African employees of the colonial government went to the hospital because they felt compelled to go there. In the late 19th century, there were hundreds of Gold Coast subjects working for the colonial government, cooking and cleaning for colonial officials, and enlisted in the Gold Coast Constabulary,¹⁵² and if they were absent from work because of illness they were required to present paper records of their attendance at the hospital.¹⁵³ This argument is supported by the fact that the vast majority of patients at the hospital were males, who were far more likely to be working in the colonial service. Women, as K. David Patterson argues, had fewer direct contacts with the colonial establishment and were averse to seeking help from white male doctors and so were much less likely to include the colonial hospital as a therapeutic option. A third possibility is that African residents of Accra were conveyed to the hospital by force. For example, the diary of Kwaku Fri, a palm oil and rubber merchant, includes two cases of people who were injured in violent disputes

¹⁵¹ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 46.

¹⁵² Gold Coast Colony, *Gold Coast Handbook* (Government Press, Accra, Gold Coast, 1923), 350. The Gold Coast Constabulary later became the Gold Coast Regiment, part of the West African Frontier Force; Patterson, *Health in Colonial Ghana*, 19.

¹⁵³ Although there is no paper trail of 'doctor's notes' from the early years of hospitals in the city, Twumasi conjectures that African employees were required to go to European hospitals to get health certificates to prove they were sick. See Patrick A. Twumasi, "Colonialism and International Health: A study in social change in Ghana." *Social Science & Medicine* 15B (1981), 148.

and then taken to the hospital by police. In 1900, a murderer fleeing the scene of the crime fell into a pit and was injured. He was arrested by police, sent to the Colonial Hospital until he healed, and hanged shortly afterwards. In another case in 1905, a young woman was injured by a stone and taken to the hospital by the police.¹⁵⁴ Yet a fourth possibility is that the beds in the hospital were filled with the destitute residents of Accra; according to colonial medical regulations, paupers were allowed to stay at the colonial hospital for free.¹⁵⁵

But even after considering the push factors that compelled African patients into the colonial hospital, the expansion to 40 beds does suggest that some patients may have sought out European healing at the hospital, making it another option within the plurality of therapies in the city. Though most European medical techniques were no more efficacious than other types of therapy in Accra and though European doctors and nurses did not minister to the spiritual needs of their patients, the hospital may have been a good option for procedures like the setting of bones, the surgical removal of foreign objects, and for extreme cases of trauma which required interventions such as amputations. Unfortunately, the data are weak here and it is not possible to make a strong assertion about the popularity of particular therapies at the hospital.

Though the patients at the colonial hospital were mostly African, only European physicians and nurses were eligible to work for the Medical Department.¹⁵⁶ One notable exception to this rule was Sierra Leone-born, European-trained, Dr. John Farrell Easmon, who was hired in 1885 as the personal physician of Governor Brandford Griffith.¹⁵⁷

Historian Adell Patton has noted that the presence of an African doctor led to a spike in

¹⁵⁴ Marion Kilson, ed., *Excerpts from the Diary of Kwaku Niri (alias J.Q. Hammond) 1884 – 1918* (University of Ghana, Legon: Institute of African Studies, March, 1967), 28, 36.

¹⁵⁵ *Gold Coast Colony Blue Book* (Accra, Ghana: Government Printer, 1891), A12.

¹⁵⁶ Clifford, *Our Days on the Gold Coast*, 127-28.

¹⁵⁷ Patton, *Physicians, Colonial Racism*, 103.

attendance because African patients were more comfortable being treated by a black doctor,¹⁵⁸ but this remains speculation because no other black doctors were given the opportunity to work at the institution. Accra-born, Edinburgh-trained physician Dr. Benjamin William Quartey-Papafio,¹⁵⁹ who had gained experience training under the Colonial Medical Officer Dr. J. Desmond McCarthy, had petitioned since 1888 to take a post as Colonial Medical Officer but was consistently denied based on the argument that white patients would never accept the medical authority of a black doctor.¹⁶⁰ While in the 17th and 18th centuries it was the disease environment that limited the exchange of ideas between European medical professionals and Africans in Accra, in the 19th century it was the colour bar that stifled the appropriation of European medical culture by African elites. Unlike in British India, where historians David Arnold and Poonam Bala have identified a cadre of Indian-born physicians who played a role in extending the reach of colonial medical hegemony,¹⁶¹ West-African born physicians found themselves largely excluded from the colonial hospital, and were completely barred from the upper reaches of colonial medical power.

When he realized that he could not advance up the ranks of the West African Medical Service, Dr. Quartey-Papafio had no choice but to establish a private medical practice in Accra, the first ever in the city. Quartey-Papafio found that he had a near monopoly on

¹⁵⁸ Adell Patton, Jr. "Dr. John Farrell Easmon: Medical Professionalism and Colonial Racism in the Gold Coast, 1856-1900," *International Journal of African Historical Studies*, 22, no. 4 (1989), 611.

¹⁵⁹ For a biography of Dr. B.W. Quartey Papafio, see Magnus J. Sampson, *Gold Coast Men of Affairs (Past and Present)* (London: Dawsons, 1969), 202-05.

¹⁶⁰ Terence Johnson, "Imperialism and the Professions: Notes on the Development of Professional Occupations in Britain's Colonies and the New States," *Sociological Review Monograph*, 20 (University of Keele, December, 1973), 288.

¹⁶¹ Arnold, *Colonizing the Body*; Bala, *Biomedicine as a Contested Site*.

private medical practice in Accra.¹⁶² In 1905, he built a clinic across from Cocoa House on High Street with the provocative slogan “*Domi Abra*” painted above the door (a phrase intended as a snub to the colonial government -- it translates literally as “if you love me, come”).¹⁶³ Remarkably, his practice prospered. We have no records of who his patients were, or why they sought him out for healing. Considering his experience as a colonial surgeon, he may have attracted clients who needed specific procedures of internal surgery that African healers could not provide, but this could only amount to a small part of his practices. In fact, in an era before arsenic injections, sulfa drugs, and penicillin, it is difficult to argue that Quartey-Papafio’s practice was driven by the efficacy of his cures. What is more likely is that he attracted clients from among the wealthy African families in Accra, many of whom were trained in England and who sought to associate themselves with European healing practices. In this way, Dr. Quartey-Papafio is the first physician to genuinely insert European medicine into the pluralistic healing culture of the city as a legitimate option for well-to-do patients and people suffering from traumatic injuries that European surgery was best suited to deal with. However, as successful as he might have been in private practice, he was still excluded from the most lucrative positions in the colonial medical service.

Though structural racism existed within colonial government, Europeans merchants and their African employees lived in close quarters at the end of the 19th century. For practical reasons, Europeans worked in offices around the surf boat landing below the old slave forts and lived in buildings on High Street or in James Town along the edge of the city core. White merchants mixed freely with the African population, despite the fact that urban Accra

¹⁶² Adell Patton, Jr. “Dr. John Farrell Easmon,” 618.

was circumscribed by colonial medical officials as an unhealthy space. During a visit to Accra in 1852, William F. Daniell, a Scottish surgeon of the British Army Medical Staff, described the city as an unsanitary maze:

With the exception of the main thoroughfare and a few open clearances at irregular intervals, the streets were necessarily narrow, tortuous and intricate the close proximity of the various domiciles producing a perplexing diversity of bypaths, that, in similitude, approached the dubious windings of some mysterious labyrinth. Formed by the contracted spaces between the opposite walls and projecting roofs, their due ventilation and cleanliness was more or less impeded; consequently, they always continued in a dirty condition, and were likewise subject to that fetid effluvia, generated by the accumulation of filth and other domestic refuse thrown out by their occupants, who, from a constitutional indolency or love of ease, were neither impressed with the necessity of adhering to any sanitary precautions, nor yet endeavoured to obtain the salubrity that would spring from the removal of such morbid agents.

Daniell depicted Accra as a crowded bazaar, reflecting concerns about the miasmatic sources of cholera that were prevalent in the mid-19th century. He also reinforced racial stereotypes that portrayed Africans as either unaware of the squalor within which they lived, or too lazy to deal with it. Yet despite the claims that Accra was unhealthy for Europeans to inhabit, and despite paper plans to separate the so-called races, there was no funding and little interest in altering living arrangements according to race in the 19th century. Daniell's clichés of the indolent African and depictions Ussher Town as a site of filth reverberated through the 19th century, where they appeared in the journals of Henry Stanley¹⁶⁴ and into the 20th century, within the discourses propagated by medical officials in Accra.

¹⁶³ Interview, Dr. Barnor, August 29, 2003. Dr. Quartey-Papafio wrote his slogan in Twi because the language was common in the city by this time, and because he needed to attract new clients from outside the Ga community.

¹⁶⁴ Henry Stanley reinforced the trope of the unsanitary “native” when he wrote that “the huts of the natives have been established everywhere, without regard to order or to any symmetrical arrangement. The consequence is that the streets are uniformly narrow, crooked, and oppressive from the filthy habits of the natives...hundreds of thatched roofs, in all stages of decay and native improvidence.” Henry M. Stanley and Melton Prior,

Though the hospital was built shortly after Accra became the capital of the Gold Coast, it took longer to initiate sanitation measures in the city. Though reports of the Medical Department declared the old neighborhoods of Accra to be a health hazard because of its slaughter houses, smelly fish smoking industry, and in particular, its miasmatic lagoon, the colonial government was reluctant to spend money to rehabilitate the city. Salaga Market was considered especially dangerous because it was prone to flooding, as one medical officer had noted in 1883:

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...it is not surprising the natives get guinea worm when compelled to drink this semi-fluid.¹⁶⁵

What the British saw as a cesspool was actually the only reservoir of drinking water for animals in the neighbourhood during the dry season, and though it may have bred mosquitoes, the inhabitants of Accra relied upon it to sustain their livestock. In 1889, the Public Works Department finally resolved to eliminate the pond as a health hazard, and the assistant-surveyor sent in a team of labourers to fill it with debris from a recently demolished building. A crowd gathered to protest, but the Public Works team continued their work under a police guard. When the crowd threatened to attack, the police called in the Gold Coast Constabulary, and after some pushing and shoving and some minor injuries, the police arrested several people believed to have instigated the protest. The situation calmed down by the end of the day, and the hole was later filled in.¹⁶⁶

Filling the pond at Salaga Market counted as a minor victory for colonial health authorities, but the resistance offered by the residents of Bukom discouraged the colonial

Coomassie and Magdala: The Story of Two British Campaigns in Africa (London: Sampson Low, Marston, Low, & Searle, 1874), 77-9.

¹⁶⁵ *Gold Coast Colony Blue Book* (Accra, Ghana: Government Printer, 1883).

government from making further plans to improve sanitation in the older quarters of Accra. Instead, Governor Nathan passed the Town's Ordinance Act in 1892, which devolved responsibility for sanitation to an urban council comprised of three African and three European members appointed directly by the Governor, and three representatives named by local chiefs.¹⁶⁷ The Ga *mantsemei* officially protested their minority representation on the council during an audience with Governor Bradford Griffith in 1896, where they informed him that they would not accept the imposition of new taxes because they were already supporting the colony through indirect tariffs on imports and exports.¹⁶⁸ The chiefs agreed that the city was in poor sanitary condition, but they pointed out that towns and villages in the interior remained much cleaner than those on the coast, insisting that the unhealthy living conditions of Accra were due to urban growth caused by the presence of the colonial government. Governor Griffith ignored their concerns. Two years later, the first attempt to collect taxes caused a riot, and the government sent out police to quell street violence.¹⁶⁹ For several years after this, the residents of Accra adopted a policy of non-compliance, and simply refused to pay their taxes. The Colonial Government built some drains and latrines in Ussher Town and James Town, and reduced the number of pigs living in the city, but otherwise avoided responsibility for sanitation.¹⁷⁰ In 1900, an observer from the Liverpool School of Tropical Medicine noted that the Ussher Town quarter of Accra remained a "noisome and pestilential district."¹⁷¹

¹⁶⁶ *Gold Coast Echo*, March 9, 1889, 3.

¹⁶⁷ Quarcoopome, "Impact of Urbanization," 95-97; *Gold Coast Colony Blue Book* (Accra: Government Printer, 1908), L1, H2.

¹⁶⁸ Gale, "The Struggle against Disease," 195.

¹⁶⁹ Gale, "The Struggle against Disease," 196.

¹⁷⁰ Patterson, "Health in Urban Ghana," 252.

¹⁷¹ Patterson, "Health in Urban Ghana," 252.

Official concern about public health in Accra emerged again when a yellow fever outbreak caused several deaths between 1894-6, terrifying the white community.¹⁷² The Gold Coast Government blamed the epidemic on the conditions in Bukom, the most densely populated quarter of Ussher Town, which it described as a “virtual cesspool,” inhabited by people who were “naturally dirty.”¹⁷³ In 1901, Governor Nathan drew up plans for a new residential area for colonial officers and European merchants, a suburb that would have its own water supply, away from the crowded dwellings in the core of Accra.¹⁷⁴ Nathan justified his policy of urban segregation by referring to epidemiology studies that suggested that African towns and villages formed “native reservoirs” of disease.¹⁷⁵ Black bodies, according to Nathan, harboured diseases that threatened a white population that was not racially adapted to the tropics and he believed that keeping Europeans a healthy distance from African populations was the key to preserving their health.¹⁷⁶ To prevent infection from malaria-bearing mosquitoes, the prescribed distance that had to be inserted between the white and black populations of the city was the distance of a mosquito flight, estimated

¹⁷² Rupert Boyce, “The distribution and prevalence of yellow fever in the Gold Coast,” *Transactions of the Royal Society of Tropical Medicine and Hygiene* 4, no. 2 (1910), 33-59.

¹⁷³ Gold Coast Government. *Annual Report on the Gold Coast* (1898), 27.

¹⁷⁴ The British built the Victoriaborg Reservoir in 1888. E.A. Boatens, *A Geography of Ghana* (Cambridge: Cambridge University Press, 1959), 5; Patterson, “Health in Urban Ghana,” 252.

¹⁷⁵ Gwendolyn Wright, *The Politics of Design in French Colonial Urbanism* (Chicago: University of Chicago Press, 1991), 266. The division of the city according to racial lines was initially suggested in 1896 by African physician Dr. John Farell Easmon, who described Accra as “a sink of filth” and recommended segregation to protect Europeans (who he considered as particularly vulnerable to malaria and yellow fever). See Patterson, “Health in Urban Ghana,” 252.

¹⁷⁶ Dumett, “The Campaign against Malaria,” 171; Nathan’s opinions were in accord with those of S.R. Christophers and J.W.W. Stephens, two malariologists from the Liverpool School of Tropical Medicine, who had argued in 1900 that “to stamp out native malaria is at present chimerical, and every effort should rather be turned to the protection of Europeans,” see S.R. Christophers and J.W.W. Stephens, “Destruction of *Anopheles* in Lagos,” in Royal Society, *Reports of the Malaria Committee of the Royal Society*, 3. (London, 1900), 19.

to be one quarter of a mile.¹⁷⁷ Like in South Africa, where the government exiled Africans to suburbs based on the belief that blacks polluted the cities with disease, Nathan employed racialized notions of sanitation as a means of defining healthy and unhealthy spaces. But unlike the cities of South Africa, where blacks were segregated into “locations,”¹⁷⁸ it was the whites of Accra who were exiled to the periphery of Accra.

Nathan authorized the zoning of two exclusively white neighbourhoods, known as Victoriaborg and The Ridge. The government set aside these areas (located on slightly higher ground to the east of Ussher Town) as healthy “European reservations” for the bungalows of colonial officials.¹⁷⁹ African workers were allowed to come to the offices at Christiansborg and European homes in the reservation, but they were required to leave by nightfall, and the space between the white and black sections of Accra was to remain uninhabited. On her first visit to the city, Decima Moore, the wife of the future governor of the colony, Gordon Guggisberg, described the stark transition of moving from the so-called “native” quarter of Accra to the European suburb of Victoriaborg:

The native quarter, through which we first passed, was an unimposing ramshackle collection of weather-beaten white-washed houses and huts, with naked children playing about in front and often a man or woman sitting and working a sewing-machine in the doorways. Further on the broad red road was lined with traders’ stores, some belonging to European firms and some to natives -- the various signboards showing a most interesting and diverse variety of names, such as Miller Brothers, Swanzy’s ... The Basel Mission Store, and the Bank of British West Africa ... After running through the town for over half a mile our road led on some open plains and we entered Victoriaborg, the European Government quarter. We passed several large buildings -- the Hospital Club, High Court, Secretariat, Treasury, and numerous cool looking bungalows occupied by Government officials.¹⁸⁰

¹⁷⁷ Dumett, “The campaign against Malaria,” 171-2.

¹⁷⁸ Butchart notes that ‘locations’ outside of Cape Town were initially constructed as temporary camps during the bubonic plague, but later became sites for the resurgence of disciplinary surveillance of African bodies. Butchart, *Anatomy of Power*, 128-29; Swanson, “The Sanitation Syndrome,” 399.

¹⁷⁹ Boyle, *Diary of a Colonial Officers Wife*, 152.

¹⁸⁰ Moore and Guggisberg, *We Two in West Africa*, 45-46. This account is from 1908.

Moore's description of moving from an African world, complete with dilapidated buildings and naked bodies, toward a European landscape of colonial architecture, vividly describes the way that Governor Nathan and the Gold Coast Government had transformed race into space. The designated meeting place for the two groups was in the middle, a no-man's land where commerce could be freely conducted.

When Governor Rodger arrived to replace Governor Nathan in 1903, he applauded the outgoing leader of the colony for his dedication to public health, celebrating the fact that the European death rate in the colony had been cut in half since the move from Accra to Victoriaborg.¹⁸¹ But in hindsight, it is difficult to see how segregation actually improved the health of European employees. In the absence of passbooks and strict police control over the movement of people in the colony, Africans and Europeans continued to mingle together, even in the evenings when the mosquitoes were out. And as Thomas Gale has argued, it might well have been due to a more accurate use of quinine as both a prophylactic and a cure.¹⁸² In fact, biopower, as it played out in the late 19th century in Accra, was limited in its impact, and it ironically exercised more control over those who perpetuated its discourses than those who resisted them. The resistance to the Town's Ordinance Act made it impossible to co-opt African urban residents into endeavours to sanitize the city and the scuffle over filling the pond showed just how hard it was to send sanitary crews into the heart of Ussher Town. The Medical Department largely abandoned attempts to reengineer Ussher Town and James Town and decided to segregate the white population instead.

¹⁸¹ Gale, "Struggle against Disease," 198.

¹⁸² Gale, "The Struggle against Disease," 198; by the turn of the century, the suggested prophylactic dose for quinine was four to five grains taken in tonic water, while the suggested cure was 10 to 30 grains at once. See "Cinchona," in *Encyclopaedia Britannica*, 11th ed. (Cambridge: Cambridge University Press, 1911), 369-70.

European medical practices and ideas had certainly asserted themselves during this period, extending far beyond the confines of the slave forts where surgeons had been confined in the past. It may be that Africans had started to choose European-derived medical practices as a therapeutic option, by going to the hospital or Dr. Quartey-Papafio's clinic when they were sick. But European forms of medicine were still far from dominant, and the era can hardly be counted as a time either the benefits of medicine began to reveal themselves to the African population or a time when medicine the state began to use medicine as an oppressive force. Gale's note about the insensitivity of the Gold Coast government towards the health of its employees and subjects certainly rings true, but a more appropriate term might have been disingenuity -- quite simply, it was neither politically expedient nor financially prudent to sanitize Accra and build an adequate medical infrastructure for its residents. As a result, the healing culture of the city remained robustly pluralistic.

Section 5. The Bubonic Plague Epidemic of 1908: Catalyst or Colonial Crisis?

In 1908, a global pandemic of bubonic plague offered the Gold Coast Government an unprecedented opportunity to implement the public health reforms that had eluded them in the 19th century. Starting in Central Asia in the 1890s, the plague spread through China and India causing the death of approximately 13 million people.¹⁸³ Just when it seemed it was receding globally, the plague struck at Accra. K. David Patterson, David Scott, and Stephen Addae have described the bubonic plague epidemic as a foundational event in the history of public health and medical practice. Patterson argued that the "shock of the bubonic plague" was a catalyst that replaced "official lethargy and fatalism" with a sense of

¹⁸³ Echenberg, *Black Death*, 16.

purpose.¹⁸⁴ Scott, who includes a whole chapter on the plague in his book, noted that during the epidemic the government enhanced medical research in the city when it built the Accra Laboratory.¹⁸⁵ Addae too emphasized the importance of the plague epidemic, emphasizing the significance of the Accra Laboratory, and the efficacy of the inoculation campaign.¹⁸⁶ All three authors assume that the anti-plague measures halted the spread of the disease, and they privilege the epidemic as an event that spurred the advancement of European medical ideas, techniques and material culture in the city.

This section will reposition the anti-plague campaign as a brief expression of biopower on the Gold Coast, one that created a flurry of colonial medical activity in the city of Accra with few long term effects. The fight against plague, which was conducted according precepts of sanitation and laboratory medicine, represented a struggle against a “colonial disease” -- an illness that was not indigenous to Accra but was spread by connections to other parts of the British Empire. As such, it was never directed at permanently establishing a regime of public health in the city. The panic that ensued during the epidemic did introduce the residents of the city to the medical enterprise of mass inoculation, allow the formerly excluded middleman figure of Dr. Quartery Papafio to participate in a coordinated anti-plague campaign, and temporarily weaken the network of African healers, but it did not usher in a new era of colonial medical hegemony. The utilitarian outlook of the Medical Department remained firmly in place, and when the disease receded, the political will to rebuild the city receded too.

At the time of the plague outbreak, Governor Rodger was in England on furlough, which left the administration of the colony in the hands of the next in command, Major H. Bryan

¹⁸⁴ Patterson, “Health in Urban Ghana,” 252.

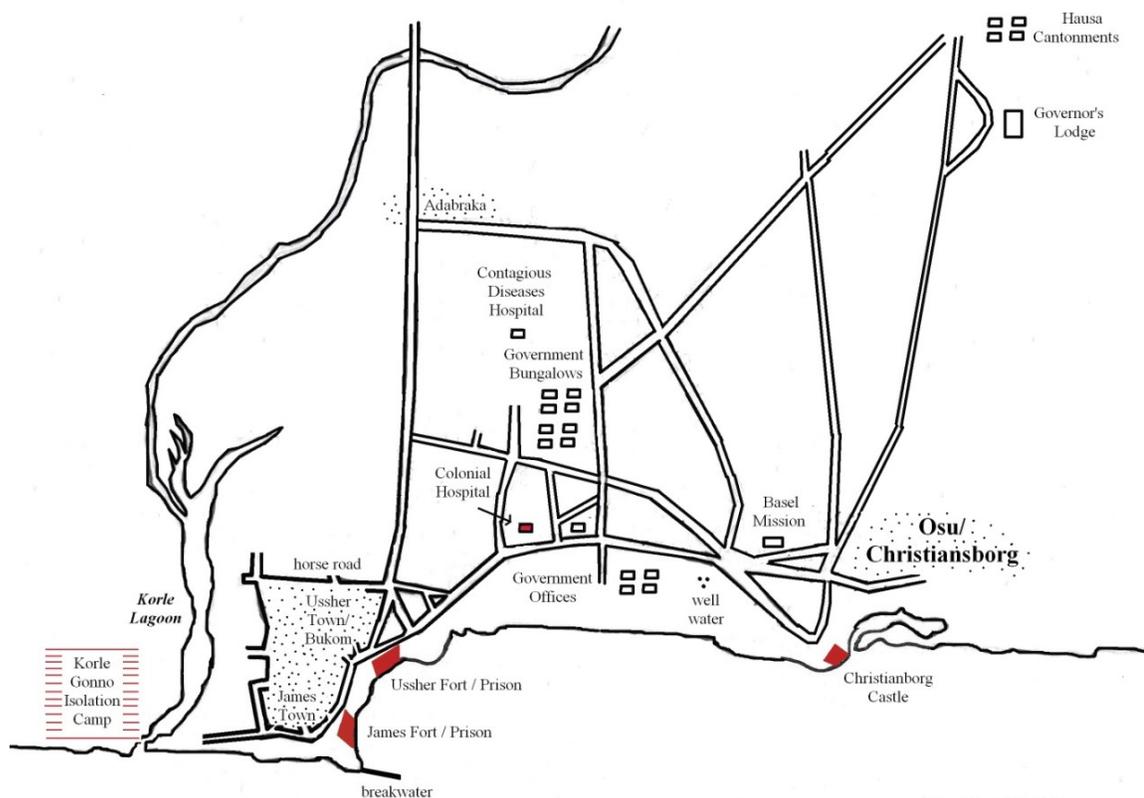
¹⁸⁵ Scott, *Epidemic Disease in Ghana*, 7.

¹⁸⁶ Addae, *Evolution of Modern Medicine*, 338.

of the Gold Coast Regiment. Bryan's first goal was to gain the confidence of the residents in the most densely populated urban quarters of the city. To this end, he asked Dr. Benjamin William Quartey-Papafio, who had for decades been denied access to work in the colonial service, to play the role of advisor to the Gold Coast Medical Department. The details of that discussion were not recorded, but Quartey-Papafio agreed to help, perhaps because he sensed the real dangers of a plague epidemic. Bryan's second step was to organise a meeting of the Ga *mantsemei* at Government House to discuss the measures the government would take to prevent its spread. When the chiefs were assembled, they demanded that Bryan do something to halt the epidemic, because the death rate of the disease was increasing dramatically and African healers seemed to have no cure for it.¹⁸⁷ Quartey-Papafio reassured the *mantsemei* that, despite the mounting death toll, the disease could be controlled if they followed the orders of the government health officers. The chiefs were not convinced, and they questioned Bryan on what sort of plague fighting tactics would be used. Bryan had not yet formulated a plan to fight the plague, so he delayed by telling them that such information could not be released until the colony received word from London. When they asked him if local African healers might be involved in the plague fighting campaign, Bryan told them that since their own healers had no cure for the disease, they would not be of any use.¹⁸⁸

¹⁸⁷ William John Ritchie Simpson, *A Treatise on Plague: Dealing with the Historical, Epidemiological, Clinical, Therapeutic, and Preventative Aspects of the Disease* (Cambridge: Cambridge University Press, 1905), 15.

¹⁸⁸ PRAAD ADM 11/1/1747. "The Acting Governor to the Secretary of State," February 7, 1908, 24.



Accra 1908

Figure 3.3. Map of Accra in 1908. Displayed again here are the divisions between the European Reservation and the densely populated areas of James Town and Ussher Town. The spatial influence of colonial medical biopower was still limited to small outposts, but they now included the colonial hospital and the isolation camp at Korle Gonno, which was eventually rebuilt, according to British sanitary regulations, as a suburb of Accra. The Governor's Lodge was still located north of the city, as were the barracks of the Gold Coast Constabulary (locally known as the Hausa Constabulary), who were employed in moving suspected plague carriers to the isolation camp. Ussher Fort and James Fort, which were used as prisons at the time, were temporarily converted to hospitals for patients suffering from the plague. *Source:* map by author.

The minutes from the meeting record that the *mantsemei* had “promised their loyal assistance,” but their line of questioning indicates that they were concerned about the extreme measures that Bryan might take to control the epidemic.¹⁸⁹ Their fears were not unfounded. Shortly after the meeting, the Acting-Governor passed an Order-in-Council that allowed a newly-formed Sanitary Committee the right to inspect any dwelling suspected to harbour plague,¹⁹⁰ to demolish any house they deemed infected,¹⁹¹ and to quarantine anyone who had contact with the disease.¹⁹² The chiefs were required to co-operate with upcoming anti-plague campaign because anyone who obstructed or interfered with the work of an appointed sanitary officer could be jailed or fined. The terror of the epidemic presented the colonial government with an unprecedented opportunity to transform the discourses of biopower into practice.

When Major Bryan wired London to announce that the city was infected with bubonic plague, the Secretary of State consulted with Sir Patrick Manson, the founder of the London School of Tropical Medicine, to determine how the British should respond.¹⁹³ Manson suggested William John Ritchie Simpson, a veteran of the bubonic plague epidemics in India and South Africa, would be the best man to stamp out the plague in Accra. In the 1890s, Simpson had been a member of the British India Plague Commission, a board of physicians and epidemiologists that studied endemic plague in Hong Kong and Singapore. The Commission was divided between those who advocated vaccinations and those who

¹⁸⁹ PRAAD ADM 11/1/1747. “The Acting Governor to the Secretary of State,” February 7, 1908, 24.

¹⁹⁰ PRAAD ADM 11/1/1747. “Executive Council. Order in Council,” January 11, 1908, 27-28.

¹⁹¹ PRAAD Gold Coast Government. *Government Gazette*. “Infectious Diseases Ordinance, 1908,” March 25, 1908, 273.

¹⁹² PRAAD ADM 11/1/1747. Correspondence. Executive Council. Order in Council. January 11, 1908, 27-28.

advocated sanitary reforms, and Simpson preferred the latter. He remained loyal to established practices of quarantine and the demolition of infected neighbourhoods. In 1901, while fighting plague in Cape Town, he advocated the destruction of infected dwellings and the strict isolation of infected bodies. The practical outcome of his approach to urban disease control was the demolition of poor black quarters of Cape Town and the creation of African “locations” on marginal lands outside the city.¹⁹⁴

When the Cape Town epidemic receded, Simpson’s measures were deemed a success, and he became renowned as the most experienced plague fighter in the British Empire. He returned to London to write the *Treatise on Plague*, a field manual for colonial sanitation officials that contains a confusing mix of miasmatic and microbial aetiologies. In it, Simpson recognized that the bacteria that caused plague, *Yersinia pestis*, was transmitted by rat fleas, but he also argued that the disease could be spread through infected food, infected clothes, and cuts on the feet, betraying his pre-bacteriological beliefs about the putrefaction of decomposing matter in the soil.¹⁹⁵ Simpson did not necessarily distinguish between miasma and bacteria because his practical concern was to hedge his bets and take whatever measures necessary to prevent the spread of the disease. Notably absent from his book were methods for dealing with the complicated social issues that surrounded any plague fighting campaign. For example, Simpson advocated burning infected dwellings to save the expense of fumigating them with sulfur, without comment on how the homeless would be cared for.¹⁹⁶

¹⁹³ PRAAD ADM 11/1/1747. “Sir Patrick Manson to Mr. Antrobus,” January 14, 1908, 4.

¹⁹⁴ Elizabeth Van Heyningen, “Cape Town and the Plague of 1901,” *Studies in the History of Cape Town* 4 (Cape Town: University of Cape Town, Centre for African Studies, 1981), 72.

¹⁹⁵ Simpson, *Treatise on Plague*, 381.

¹⁹⁶ Simpson, *Treatise on Plague*, 360, 381; As Michael Worboys has pointed out in his discussion of the development of tropical medicine in West Africa, colonial medical officers were quite happy to live with conflicting notions of disease causality provided they had a strategy to fight disease. See Michael Worboys, “Germs, Malaria and the Invention of Mansonian Tropical Medicine: From ‘Diseases in the Tropics’ to ‘Tropical Diseases’,” in

In an attempt to get the disease under control before Simpson arrived, Acting-Governor Bryan dispatched the local Sanitary Committee to lay rat poison in the drains of the infected neighbourhoods, and to fumigate infected houses.¹⁹⁷ Bryan asked the Sanitary Committee to demolish some houses deemed impossible to disinfect, but their actions were halted by the threat of legal action by the owners. To isolate plague victims from the rest of the city, they were conveyed under armed guard to the asylum (which they shared with mentally ill patients held in hand-cuffs and leg irons). To prevent people from moving back into their infected houses, the Sanitary Committee enlisted constables from the colonial police force to guard all evacuated dwellings, but trying to restrict the mobility of the residents of James Town stretched the limit of the abilities of the colonial police force, and many people continued to sneak back into the town at night to sleep.¹⁹⁸ The police escorted those who had contacted the sick across the lagoon to a temporary camp at Korle Gonno, land that had been granted to them by Chief Kojo Ababio IV of James Town (an arrangement that the chiefs of Ussher Town protested because they argued that the land across the lagoon belonged to them).¹⁹⁹

When Simpson arrived, he pushed through a plan to demolish a large part of James Town and Ussher Town, at an estimated cost of £3,000. The government felt it could count on the support of the residents of Accra because they had the help of Ussher Town-born

David Arnold, ed. *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500-1900* (Atlanta, Ga: Rodopi, 1996), 185.

¹⁹⁷ PRAAD ADM 11/1/1747. "Executive Council. Memoranda of Action Taken," January 11, 1908, 29-30; PRAAD ADM 11/1/1747. "Acting Governor to Secretary of State. Enclosure 3," February 22, 1908, 87.

¹⁹⁸ PRAAD ADM 11/1/1747. "Acting Governor to the Secretary of State," March 16, 1908, 79.

¹⁹⁹ PRAAD ADM 11/1/1747. "Acting Governor to the Secretary of State," January 21 and February, 22, 1908, 52. Ababio was favoured by the British because he was literate (educated at the Methodist School) and because he supported the Asante Expedition of 1895-6 by providing 1,400 men as carriers. See Gocking, *Facing Two Ways*, 119.

Dr. Quartery-Papafio, who was a strong believer in sanitary science.²⁰⁰ But when Dr. Graham of the Sanitary Committee led a group of sanitary officials, including Dr. Quartery-Papafio, into Ussher Town to destroy infected houses the residents stoned them and forced them to retreat. The colonial records claim that “fetish priests” encouraged the people of Ussher Town to rebel, demonstrating the power that the *nulomei* and the *wontsemei/woyei* continued to have in the urban core of the city. However, there are political reasons that indicate that the chiefs of Ussher Town were also involved in the protests.²⁰¹ Korle Gonno, the land given to the British for an isolation camp, was disputed territory, and the Ussher Town chiefs may have teamed up with the priests of Nai, Korle and Sakumo to resist any expropriation of the political and spiritual centre of the city by the Sanitary Committee. In the face of such vigorous resistance, Simpson delayed his project to rebuild the city, and focused on a mass inoculation campaign.

In May of 1908, Simpson and the anti-plague team ordered thousands of doses of Haffkine’s prophylactic, an inoculant against the plague bacillus, from laboratories in London.²⁰² To ensure a positive start to the inoculation campaign, the Sanitary Committee opened four vaccination stations in the city with great fanfare. Acting-Governor Bryan and his wife were the first to be publicly injected, followed by members of the Ga *mantsemei*. It is likely that Simpson started the campaign with some trepidation considering that the Haffkine’s prophylactic had become contaminated with tetanus during initial trials in India in

²⁰⁰ Patterson, *Health in Colonial Ghana*, 48.

²⁰¹ PRAAD ADM 11/1/1747. “Acting Governor to the Secretary of State,” March 16, 1908, 79; PRAAD ADM 11/1/1747. “Medical Department Report,” June 5, 1908, 153.

²⁰² Gold Coast Government. *Ordinances of the Gold Coast Colony* (London: Stevens and Sons, 1903), 518; Ashitey, *Epidemiology of Disease Control in Ghana*, 4; Patterson, *Health in Colonial Ghana*, 70.

1902, resulting in the deaths of 19 people,²⁰³ but to the relief of Dr. Garland and Dr. Simpson, no one fell ill after taking the injection in Accra. According to Simpson's reports, the residents of the city subsequently crowded the stations to receive the prophylaxis. Acting-Governor Bryan also declared that the campaign was an overwhelming success:

I am glad to be able to report that the natives at Accra have not only offered no objection to inoculation, but that they are presenting themselves in such large numbers as to throw a heavy strain on the medical staff. I was inoculated on Thursday last ... and several other officials were publicly inoculated by Professor Simpson...the courtyard, entrances, and passages of the building were packed with natives of all classes who were so eager to present themselves that the police on duty had some difficulty in clearing a passage through the crowd to enable me to see Professor Simpson...²⁰⁴

Simpson would later proudly state that his team had inoculated over 16,000 people. This may have been an exaggeration, considering the population of the city stood at approximately 15,000, though there is a possibility that people from outside Accra came to town to take the prophylactic.²⁰⁵

If we are to believe Simpson's reports, the demand for Haffkine's prophylactic reached a tipping point where everyone absolutely felt they needed to get the injection. There are three reasons why the rush to the inoculation stations occurred. The first is that the act of piercing the skin was not new to the inhabitants of Accra. As mentioned in chapter 2, ritual scarification, involving cuts on the skin rubbed with consecrated herbal powders, were a

²⁰³ Ronald Ross, "Letters to Editor - The Inoculation Accident at Mulkowal," *Nature* 75 (21 March 1907), 486. During an inoculation campaign in Mulkowal in India, Waldemar Haffkine, the inventor of the bubonic plague prophylactic, neglected to sanitize the bottles containing the serum with carbolic acid, leading to the death of 19 patients from tetanus.

²⁰⁴ PRAAD ADM 11/1/1747. "Acting Governor to Secretary of State," February 29 and March 7, 1908, 58, 73.

²⁰⁵ Simpson, *Statement on the Outbreak of Plague*, 608; PRAAD ADM 11/1/1747. "Acting Governor to the Secretary of State," February 22 & February 29, 1908, 57; PRAAD ADM 11/1/1747. "Third and Final Report of the Committee of Public Health," May 19, 1908, 169; PRAAD ADM 11/1/1747. "Minutes of a meeting of the Committee of Public Health," April 17, 1908, 140. After inoculating all who would accept the needle in Accra,

common method used by African healers to protect their patients from spiritual assaults. Secondly, the residents of Accra may have understood Haffkine's prophylactic as a direct intervention against illnesses in the blood, a concept congruent with Ga aetiological understandings of illnesses caused by spoiled or dirty internal fluids.²⁰⁶ And thirdly, it seems that the inoculation campaign became a social happening that attracted the participation of almost all of the residents of the city. Simpson noted that the demand for the prophylactic grew so dramatically that the Sanitary Committee established a new inoculation station where a "better class of residents" could pay two shillings to avoid the "crush and delay" of the stations that inoculated free of charge. The Sanitary Committee inoculated approximately 500 people at the pay-for-service station, raising over £44 while at the same time making the bubonic plague epidemic an event where those with means could assert their social standing.²⁰⁷

The success of Haffkine's prophylactic stands in sharp contrast to the failure of African healers to treat the plague. When the epidemic began, local healers were completely unfamiliar with the illness. In fact, it can be considered a "colonial disease" because it was brought to the city via colonial channels, because it was not indigenous to West Africa and because there was no known African cure.²⁰⁸ According to Simpson's report, the African healers in the city considered the plague so dangerous that they charged exceptionally high

Simpson and his crew visited other villages and towns nearby, including Labadi where 600 were inoculated, and Dodowa where a further 2,000 accepted the Haffkine's prophylactic.

²⁰⁶ Senah, *Money Be Man*, 161.

²⁰⁷ PRAAD ADM 11/1/1747. "Acting Governor to Secretary of State," February 29 and March 7, 1908, 58, 73.

²⁰⁸ Lyons, *Colonial Disease*. Maryinez Lyons notes that Africans living in Equatorial Africa began to think of trypanosomiasis as a disease caused by colonialism because it became an epidemic during the colonial era and because of the draconian measures (including isolation camps and spinal taps) that were taken by Belgian medical officials control it.

fees to treat it, so that it soon became popularly known as the “one pound disease.”²⁰⁹ The reason for this is that the plague appears to have jumped from a bubonic stage (where persons could be infected through the bite of the rat flea) to the pneumonic stage (where persons could be infected via breath and sputum), making it both dangerous to treat and impossible to cure. There were several recorded cases of local priests and herbalists dying from the disease. In one instance, a woman described as a fetish priest (who was almost certainly a *woyoo*) declared that she had made “ju-ju” to prevent the reoccurrence of the plague. The next day, while distributing consecrated healing objects to the Ga *mantsemei*, she collapsed and died of pneumonic plague.²¹⁰ Not only were healers dying from plague, they were spreading it. In the outlying villages, the *wontsemei*, *woyei* and *tsofatsemei* took their trade to places where the people needed their assistance, and ended up bringing the disease with them. When the disease turned pneumonic, the mobility of African healers made them vectors for the disease, demonstrated by the following anecdote from the colonial records:

...a medicine man ... had been to Fannah and Accra to treat some of the Cases; he died on June 6th, his sister died on June 12, an aunt died on June 19th. Botiano, also a village immediately on the West bank of the Sakum river, was infected by a man from Fannah ill with the disease coming to the village to be attended by the medicine man, his half-brother. He died of the disease and the medicine man was next attacked and died, after which several others more or less related were attacked and died...all suffered from pneumonic plague.”²¹¹

A similar pattern occurred along the coastline near Accra, from Tema to the Fante territory near Cape Coast, where travelling fishermen spread the disease until it eventually burned out

²⁰⁹ Simpson, *Treatise on Plague*, 15.

²¹⁰ PRAAD ADM 11/1/1747. “Meeting of the Committee of Public Health,” July 30, 1908, 203. At least three other priests or healers were known to have died, but no accurate statistics were taken. See PRAAD ADM 11/1/1747. “Report on the Fourth Outbreak of Plague in Accra,” September 4, 1908, 228.

²¹¹ Simpson, *Report on Plague*, 10-11.

due to rapid deaths of its victims.²¹² Despite the dangers of the plague, the healers who followed African traditions continued to use personalized treatments that brought them in close contact with infected bodies, increasing the death rate amongst healers who dared attempt to cure for the disease.

In December of 1908, Simpson declared the city free of plague.²¹³ When the numbers were compiled in 1909, the British counted a total of 302 cases of plague in the colony, 85% of which proved fatal (an unusually high death rate caused by the virility of the pneumonic strain).²¹⁴ No Europeans were infected. Before Simpson left he once again tried to impress his ideas about healthy living spaces upon the authorities of the Gold Coast, urging them to increase the amount of light penetrating between houses and air flowing through the laneways. He suggested that the Colonial Government survey broad boulevards through Ussher Town and James Town and urged them to replace all clay and straw huts with rat-proof brick buildings. In 1909, the Colonial Government dutifully attempted to follow Simpson's suggestions by increasing the Public Works budget for sanitary improvements, laying new streets, building some new rat-proof housing at Korle Gonno and Adabraka,²¹⁵ funding a clinic exclusively for African patients in James Town, and expanding the Accra Laboratory.²¹⁶ They also developed a long-term plan for the construction of a reservoir to supply drinking water to the city, at the projected expense of £140,000. But their plans to dramatically rebuild the city proved unattainable because the budget of the Public Works Department was required to provide houses at Korle Gonno as compensation

²¹² PRAAD ADM 11/1/1747. "Acting Governor to the Secretary of State," March 7, 1900, 70-71; Simpson, *Report on Plague*, 12.

²¹³ Simpson, *Statement on the Outbreak of Plague*, 191.

²¹⁴ Simpson, *Statement on the Outbreak of Plague*, 191.

²¹⁵ Kilson, *African Urban Kinsmen*, 8.

²¹⁶ *Gold Coast Colony Blue Book* (Accra: Government Printer, 1909), K3; Ashitey, *Epidemiology of Disease Control in Ghana*, 7.

to people who had been dislocated Ussher Town during the epidemic. And in 1909, Simpson's dream of sanitizing the capital city faded away when the governor began to focus his energies on the construction of a railroad to Kumasi.²¹⁷

The dominant narrative of the 1908 bubonic plague epidemic in Accra privileges the epidemic as an event that spurred the development of European medical ideas, techniques and material culture in the city, but Simpson's victory over bubonic plague in Accra should be understood largely as a triumph of imported colonial medicine over an imported colonial disease. Bubonic plague was new to Accra, and the African healers living there had no cure for it, but the epidemic only lasted for a year, and afterwards, simply disappeared. Though the inoculation campaign was deemed a success, it is difficult to see it as a seminal event because of its continuity with African practices of inoculation. The vast majority of people who took the needle from colonial officials would not have understood the science behind it but they would have reckoned that it had something to do with cleansing the blood or protecting against sickness caused by external agents. Moreover, Simpson's attempts to reconstruct the core of the city were resisted by the inhabitants of Accra, particularly people living in Ussher Town, even though the prized middle-figure of Dr. Quartey-Papafio was a Ga from an Usher Town family. Though the Public Works Department were able to build some homes were rebuilt according to sanitary regulations in Korle Gonno, and though there was a strong presence of European medical and sanitation practices on the periphery of the city in the European reservations of Victoriaborg and the Ridge, the Gold Coast Medical Department was unable to medically colonize the residents of Accra. As we shall see, the forces of biopower were compelled to recede until the progressive era of the 1920s.

²¹⁷ Gold Coast Government. "Minutes of Legislative Council, June 6, 1908," in *Government Gazette* (June 6, 1908), 515.

Meanwhile, the network of African healers continued to proliferate and serve the majority of residents in Accra

Conclusion

The current historiography of medicine in Africa celebrates the early colonial period as the starting point of the evolution of modern medicine in Ghana. According to this metanarrative, a transition had been made, from a time when surgeons occupied a marginal role within the healing culture of the city of Accra, to a time when colonial medical officials could finally use advances in public health and medical science to ameliorate the health of both the colonizers and the colonized. Read another way (with a Foucauldian analysis that has never been brought to bear on the medical activities of the Gold Coast government), this was the dawning of an era of biopower, a time when the power of the colonial state became intertwined with medical knowledge and practice. Indeed, if judged solely by the accounts of physicians and the records of the Medical Department of the Gold Coast, one might be led to believe that the emergence of colonial medicine was the most significant change to the healing culture of Accra in the late 19th and early 20th century.

Without question, European-derived therapies had begun to play a larger role in Accra. The move to Accra was predicated on rebuilding a capital city according to the dictates of sanitary science, and the attempts to intervene into Ussher Town were a logical outcome of the desire to sanitize the city. Under the umbrella of the Gold Coast Medical Department physicians, medical officers, and sanitary inspectors were now able to intervene directly into the lives of the residents of Accra. And the new institution of the colonial hospital offered a new therapeutic avenue for African residents in the city. However, it would be anachronistic to argue that the foundations of modern medicine, as a set of

universal healing ideas and practices, were built during the early colonial period. Rather, the activities of colonial medical officials were always predicated upon safeguarding the health of European officials and merchants (whether from malaria, plague, or yellow fever), a fact that was well understood by the African population of Accra. And it would be a major overstatement to say that the bodies of the residents of Accra were colonized -- biopower could only express itself in Accra in a fragmentary manner due to budget limitations, disinterest on the part of colonial governors, and resistance by the inhabitants of Accra. While British medical professionals did hold power within colonial circles (in particular in the courtroom and the colonial hospital, and during emergencies like epidemics), they played only a minor role as healers within the broader therapeutic networks of Accra.

Moreover, privileging the story of colonial medicine does not do justice to the lived experiences of patients and healers in the city of Accra during the early colonial era. What must be unequivocally stated about this period is that Ga, and other West African-derived, therapies continued to dominate the provision of health care in the city. Evidence from court documents demonstrates that African healers were responsible for making herbal concoctions, fabricating consecrated healing devices, preventing barrenness, administering trials-by-ordeal, and many other aspects of healing. Patients moved easily between African healers in their quests for health, employing the help of friends and family members in the process. Even a major crisis like the bubonic plague epidemic, with its evacuations and mass inoculations, did not result in any sort of medical hegemony in the city.

It also must be emphasized that the healing culture of Accra was changing rapidly, as three new healing cultures emerged in the late 19th century. Islamic healing, brought by Brazilian and Hausa immigrants, included knowledge about the Quran (using incantations, prayer, and written passages with the purpose of healing), as well as new types of herbalism.

Christian faith-healing was not yet part of the healing culture of the city, but the European missionaries and African catechists at the Basel Mission translated the Bible into Ga and established a Ga-speaking Christian community that would later draw on the power of the Holy Trinity to cleanse sins and generate health. Patent medicines also began to filter into the city, in the traveling kits of colonial officials, travelers and merchants, and via mail, as residents of the city read about the medicines in newspapers and ordered them from England and the USA. These mobile healing tools added to an already established culture of kitchen physic, increasing the possibilities for patients to self-medicate beyond the purview of professional healers. These new therapeutic avenues were largely practiced within small enclaves in the city, or by particular classes or occupational groups, but together they formed a plurality of healing options for patients, all of which would flourish in the 20th century.

Chapter 4. Pluralistic Healing During the Cocoa Boom, 1908-1930s.

During the first third of the 20th century, European demand for cocoa boomed, transforming the Gold Coast into the wealthiest colony in tropical Africa.¹ Exports of cocoa beans grew exponentially, from a modest 5,000 tons in 1900 to an annual average of 243,000 tons by the 1930s.² Accra became the headquarters for cocoa exports, and the primary port for offloading imported goods to the Gold Coast Colony.³ The port city of Accra, which European merchants had previously characterized as an “old-fashioned hap-hazard sort-of-place,” suddenly became a bustling transshipment point.⁴ After stagnating for several decades, the population of the city started to grow exponentially, from around 20,000 in the 1910s, to 40,000 in the 1920s, and 60,000 by the 1930s.⁵ Shipping and marketing companies brought in hundreds of employees to work in the city from around West Africa and from Europe, making it an increasingly polyglot and multiethnic colonial capital.⁶ Though the Ga population of the city still made up the majority of residents in Accra, Ga practitioners

¹ J. D. Fage, *An Introduction to the History of West Africa*, 2nd ed. (Cambridge: Cambridge University Press, 1959), 194; Peter N. Stearns and William Leonard Langer, *The Encyclopedia of World History: Ancient, Medieval, and Modern* (New York: Houghton Mifflin Harcourt, 2001), 795.

² *Gold Coast Colony Blue Books*, 1908-1939; Peter C. Sederberg, “The Gold Coast under Colonial Rule: An Expenditure Analysis,” *African Studies Review* 14, no. 2 (September, 1971), 183-84.

³ Poly Hill, *The Migrant Cocoa-farmers of Southern Ghana* (Cambridge: Cambridge University Press, 1963), 217. See also Victor K. Nyantang, “Cocoa Trade between Ghana and The Netherlands: Past, Present and Future,” in *Merchants, Missionaries & Migrants: 300 years of Dutch-Ghanaian Relations*, ed. I. van Kessel (Amsterdam: KIT Publishers, 2002), 62-63.

⁴ Allister Macmillan, ed., *The Red Book of West Africa: Historical and Descriptive Commercial and Industrial Facts, Figures, & Resources* (London: Frank Cass and Company Limited, 1968 (1920)), 173.

⁵ Acquah, *Accra Survey*, 31.

⁶ Dickson, “Evolution of Seaports in Ghana,” 109; Wilfrid Dyson Hambly, “Review of M.J. Field. Religion and Medicine of the Gã People,” *American Anthropologist*, New Series, 40, no. 2 (April - June, 1938), 312; Field, *Religion and Medicine*, 2.

increasingly shared the pool of patients with healers from other traditions, as other African, religious, and colonial communities

The historiography of medicine on the Gold Coast recognizes the cocoa boom as a decade when budget surpluses in the Gold Coast Colony allowed for advances in colonial medicine. Historian Stephen Addae provides statistics to show that, between 1919 and 1930, the number of physicians living in the Gold Coast doubled, the budget of the Medical Department tripled, and the number of hospital beds increased ten-fold.⁷ David Scott noted that “the period 1918-1932 was particularly fruitful for the enthusiastic public health worker,” demonstrated by the fact that sanitary measures and inoculation campaigns radically diminished instances of yellow fever, smallpox and relapsing fever.⁸ Additionally, K. David Patterson noted that it was in the 1920s that the Medical Department of the Gold Coast finally acknowledged the “necessity of engaging Africans at all levels” in order to meet the health needs of the colony.⁹ And finally, Adell Patton Jr. has located the 1920s as an era when physicians in West Africa were finally able to break through the colonial colour bar.¹⁰ In sum, the interwar years on the Gold Coast have been understood by historians as a progressive era, a time when the benefits of medical science could finally be provided to the colonized populations.

The historiography of medicine on the Gold Coast portrays the increasing power of the Medical Department as a benefit to the subject populations of Gold Coast, but one might also argue that European-derived medical practices were imposed on the subject population of the colony by the power of the state. In many respects, the 1920s was a decade when biopower, which had been so long confined to the rhetoric and reports of

⁷ Addae, *Evolution of Modern Medicine*, 67.

⁸ Scott, *Epidemic Disease in Ghana*, 201, 63, 81-82, 130.

⁹ Patterson, *Health in Colonial Ghana*, 16.

medical officers, was physically asserted over the inhabitants of the British colonies. This was an era when, as McLeod and Lewis noted, a time when “European medicine and its handmaiden, public health” began to serve the British as a tool of colonization.¹¹ But unlike the historiography of East and Southern Africa, where historians have used biopower to frame the history of medical services, the associations between medicine knowledge and colonial power in the Gold Coast colony have never been investigated. Indeed, if there is a period in the history of the Gold Coast that requires some degree of Foucauldian analysis of the discourses and practices of Medical Department, it is the era of the cocoa boom, when the colonial state became increasingly involved in the lives of the inhabitants of the capital city of Accra.

This chapter will show how the expansion of the colonial medical system during the interwar period reflected both a degree of efficacy (demonstrated by some measurable health benefits of colonial medicine) as well as a degree of coercion (demonstrated by the control that Medical Department asserted control over the residents of the city), that increasingly put the residents of Accra in contact with European-derived healing practices. But it will also show that, though prominent in the work of Scott, Patterson and Addae, the significance of the medical interventions of the colonial state have been overstated. It is important to note that the actions of the Medical Department were consistently challenged by African residents of the city. On the one hand, Ga priests, chiefs and spirit mediums resented government incursions into the traditionally Ga neighborhoods of the city and refused to participate in sanitation initiatives. On the other hand, educated African elites, most prominently political

¹⁰ Patton *Physicians, Colonial Racism*, 156-57.

¹¹ Roy M, MacLeod and Milton J. Lewis, *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988), x.

activist Dr. F.V. Nanka-Bruce, pointed out the failure of colonial medical initiatives to improve the health of the residents of Accra.

Even more importantly, the historiographical emphasis on the expansion of colonial medicine has unduly obscured the activities of non-European practitioners in Accra. Rather than thinking about the 1920s as a time when medical practices expanded at the expense of an ethnically circumscribed “Ga superstitions,” we must instead imagine an urban landscape of pluralistic healing, where patients could choose between African healers (priests, spirit mediums, herbalists, from not only the Ga community but from a diversity ethnic backgrounds), European-trained physicians (at hospitals or clinics), healing derived from the major religions of Christianity and Islam (in the form of prayer or apotropaics), and self-healing via a new set of medical commodities (in the form of over-the-counter patent medicines). The multiple healing cultures of the city are represented in four sections of this chapter. The first is an analysis of the work of anthropologist Margaret Field, who demonstrated how, even after centuries of upheaval and change, Ga society continued to support a class of healers with the skills needed to both maintain the health of individual bodies and to heal social and spiritual illnesses. Field’s work is read in two ways: firstly as a continuity of the diverse aspects of Ga healing culture, and secondly as evidence of how non-Ga African therapies became available to patients in the city. The second section covers the growth of the Gold Coast Medical Department during the tenure of the Governor Gordon Guggisberg, who believed that the efficacy of colonial medicine could win over the residents of the city and encourage them to participate in sanitary reforms. Guggisberg tried to break the impasse between the colonial government and the Ga *mantsemei* by offering representation on an Accra Town Council, but his efforts brought only limited success. The inhabitants of James Town and Ussher Town continued to resent the incursions of sanitary

inspectors. More influential were efforts to channel patients suffering trauma towards clinics and hospitals, by using the police forces and the courts, and by requiring a paper trail to record injuries and medical treatment. The third section covers the story of British-trained, West African, physicians who were able to make a living in private practice supplying medical services to the merchant classes of the city. The steady growth in the number of African physicians demonstrated the way that European-derived medical practices had been appropriated as a means of upward mobility by the sons of African elites. Their work in the city localized European-derived medical practices for the first time, bringing practices like surgery to all classes of residents in the city, but this new generation of doctors still had to compete, and sometimes even share their patients, with other types of healers. The fourth section discusses the rapid expansion of a market for patent medicines, or what became known in Ga as *blofo tsofa* (white man's medicine). The patent medicine market initiated an era of self-medication whereby patients could define their role in colonial Accra via the consumption of imported goods. The residents of the city also appropriated these medicines and imbued them with their own meanings, utilizing them for local needs. This section will also briefly discuss Christian and Islamic healing, but due to a lack of sources, the narrative threads of these therapeutic options will be picked up again in chapter 7, during the 1950s, when sources show that these major religions became major factors in determining the pluralistic healing culture of the city. The goal of this chapter is to show that the, despite the growing power of European-derived medical practitioners, the residents of Accra continued to seek out multiple forms of healing, sometimes combining incompatible disease aetiologies and healing practices together at the same time.

Section 1. Pluralism Past and Pluralism Present in Margaret Field's *Religion and Medicine of the Gã People*.

Sir William John Ritchie Simpson's official report on the bubonic plague epidemic of 1908 depicted an indigenous healing system in decline, decimated by a new disease that they did not understand and could not hope to cure. But as chapter 3 demonstrated, the plague epidemic was only a brief episode in the long history of healing in the city, and it did little to displace centuries of African domination of the healing practices in Accra. As this section will show, West African healing methods did not decline after the plague campaign -- rather, African healers, as part of a robust urban African culture, continued to minister to most of the needs of the sick in the city. The strongest evidence to show this comes from a comprehensive study of Ga religion and healing by English ethnographer, Margaret Field, which showed that, even after centuries of contact with Europeans, Ga priests, spirit mediums, and herbalists of Accra offered a wide variety of religious and health services to the residents of the city. At the same time, her work showed the dynamism of the healing culture in the city, which allowed for the adoption of new ideas and practices from other parts of West Africa and Europe.

Margaret Field moved to the Gold Coast in the late 1920s to take a position as an instructor at Achimota College and during her time in Accra, she took an interest in Ga culture and language. In the early 1930s, she began to attend and record religious ceremonies along the Ga-speaking coast, from Tema to Accra, and, after several years of participating in the cultural life of Ga priests and healers, she returned to England to work on a dissertation at the London School of Economics. The result was her first monograph, *Religion and Medicine of the Ga People*, published in 1937. With her doctoral credentials in hand, she was promoted to the role of Government Anthropologist, succeeding R.S. Rattray, an anthropologist of the Asante who had trained at the LSE before her. Field followed her first

publication with a more structuralist account of Ga society (*Social Organization of the Ga People*, published in 1940) and, after the Second World War, wrote several articles and books about the Akan peoples to the north of the city, but she is best known for the rich description of the lives of the priests and healers in *Religion and Medicine of the Ga People*.

Field's ethnography of Ga religion and healing represents a distinct historiographical break from Carl Christian Reindorf's *History of the Gold Coast and Asante* because it offers a synchronic perspective of Ga culture, one that did not assume that the Ga state was evolving into a modern, colonial, Christian society. Although today it might be misunderstood as rendering Ga society within the trope of the ethnographic present, at the time it was a progressive work, part of a new British school of anthropology (spearheaded by Bronislaw Malinowski) that sought to describe non-Western cultures on their own terms.¹² Field saw herself as searching for deep understanding of the Ga mind, which she understood through the lens of the burgeoning discipline of psychology. Field wanted to know how Ga institutions of religion and healing were understood by the Ga themselves,¹³ and the work provides a sense of how being Ga was directly related to health and healing.

Margaret Field wrote her dissertation as a junior scholar surrounded by esteemed anthropologists of the period, including Bronislaw Malinowski (who founded the field of anthropology at the LSE), R.S. Rattray (who had written ethnographies of the Asante) and E.E. Evans-Pritchard (who had pioneered work on the idea of witchcraft within the Zande ethnic group of Central Africa). However, as a woman in a male-dominated field, she was subject to overt sexism. When Field published *Religion and Medicine of the Ga People* in 1937, Meyer Fortes and E.E. Evans-Pritchard largely dismissed the book as "amateur science,"

¹² Fredrik Barth, et al., *One Discipline, Four Ways: British, German, French, and American Anthropology* (Chicago: University of Chicago Press, 2005), 22.

¹³ Field, *Religion and Medicine*, v.

referring to Field as “Miss Field” rather than using the title of Doctor, and suggesting that she had been too “independent” because she had not consulted enough with the major scholars in her discipline.¹⁴ This type of criticism limited Field’s chances of continuing an academic career in the metropole.

However, it is now apparent that Margaret Field’s understandings of the dynamism of Ga culture offers tremendous insight into the historical changes that took place within in the healing culture of the city of Accra. Unlike R.S. Rattray, who had claimed that Asante healing knowledge came largely from dwarven forest spirits, or E.E. Evans-Pritchard, who essentialized the Azande through the concept of witchcraft, Field did not set out to find a single Ga idiom of religion and healing. Rather, she was quite aware that Accra was the product of ethnic and linguistic mixing, especially between Ga and Akan understandings of health and illness, and she did not essentialize Ga culture as timeless. To her credit, Field understood the complexity of Ga culture: as a composite of disease aetiologies (including the hybrid Ga/Akan concepts of the *kela*, *susuma*, *ghomotso*, and *aye*)¹⁵, practices (including the rise and fall of the power of priests and spirit mediums, as well as the arrival of healers from distant regions)¹⁶ material cultures (including local and imported herbs, as well as composite consecrated healing devices).¹⁷

Field’s account of Ga healing culture shows substantial continuity with 17th and 18th century travelogues (found in chapter 1) and 19th century court records (found in chapter 2). This, of course, was part of her goal, because she needed to demonstrate the “fundamental

¹⁴ Meyer Fortes. “Religion and Medicine of the Ga People, by Margaret Field,” *Bulletin of the School of Oriental Studies, University of London* 9, no. 2 (1938), 479-81; E. E. Evans-Pritchard, “Review of Religion and Medicine of the Ga People, by Margaret Field,” *Geographical Journal* 91, no. 2 (February 1938), 177-78.

¹⁵ Field, *Religion and Medicine of the Gã People*, 92-96, 137.

¹⁶ Field, *Religion and Medicine of the Gã People*, 77-78, 123-30.

¹⁷ Field, *Religion and Medicine of the Gã People*, 37, 114, 120, 123-24, 131, 140.

realities of the human constitution” and the “invisible roots of life” in order to circumscribe the Ga as an anthropological subject.¹⁸ But Field’s demonstration of historical continuity in Ga practices was not a contrivance based on a reinterpretation of 19th century sources or Carl Christian Reindorf’s history of the Ga. Many of the practices she described correlate with fragments related to healing in the court records of the first few decades of the 20th century, including: the movement of patients between healers, use of therapy management groups, spirit possession, animal sacrifice, libations of alcohol, scarification and inoculation with *ti*, oaths and trials-by-ordeal, and consecrated devices used to control land, reinforcing the fact that indigenous West African healing practices were alive and well in Accra, and that many of them remained tied to deeply historical conceptions of the Ga identity.¹⁹ Whereas in chapter 2 we were forced to rely exclusively on the bits and pieces related to healing found

¹⁸ Field, *Religion and Medicine of the Gã People*, 134.

¹⁹ Field, *Religion and Medicine of the Gã People*. Page numbers in brackets: patient movement between healers (127), therapy management groups (95), spirit possession (101), animal sacrifice (90), libations of alcohol (72), scarification and inoculation (131), with *ti*, and trials-by-ordeal (138); Evidence from a court case in 1914 also offers an example of a therapy management group. See PRAAD SCT 2/4/57, “Lutterodt vrs Amartefio,” 16th February 1912 - 19th September 1914, 115-16; In an example from court records, a woman who was desperate to have more children put herself “into fetish” because she had had so many miscarriages and children who had died as infants. In order to protect the one small child she did have, and to procreate again, she swore an oath a lesser deity, and agreed to live and work at the shrine, and worship the god. See PRAAD SCT 2/4/53, “Kojo Ababio IV versus T.R. Quartey,” 31st August 1912 - 13th February 1913. October 1, 1912, 238; Court records indicated that land exchange was still brokered via the *wulomei* and the *wontsemei/woyei* during the early 20th century. In 1912, the ownership of a piece of land was disputed, and witnesses were called to declare their knowledge of the estate by naming specific landmarks on the property (like the hills, the rocks, and the forests of the landscape), the *otutui* present on the property, the deities associated with natural and man-made landmarks, and the names of the living priests who were expert in making connecting supernatural ownership to human ownership (PRAAD SCT 2/4/51, 16th February 1912 - 19th Sept, 1914, May 13, 1912, 180). Other cases showed the importance of consecrated objects, like stools and drums, as mobile titles to land that could be transferred from owner to owner (PRAAD SCT 2/4/50. 21st September 1911 - 12th Apr, 1912, “Kobina Jasi versus Kofi Tchum,” November 16, 1911, 268) As brokers of knowledge about ancestral ownership, Ga healers and religious experts continued to regulate property rights in the city, maintaining a grid of nodes that connected them to the world of the supernatural.

in the court records in order to sketch out the culture of local healing, in the 1920s, Field's field work on the religion and medicine of the Ga offers rich description that can be supplemented and supported by court records.

Because Field conducted her initial research without the support of a major institution in England, she struggled to justify her fascination with African healing practices to her British colleagues on the Gold Coast. We are given a glimpse of the resistance she received in a passage where she voices a common opinion held by colonial officials about "Native" healing:

The average European will say, 'Native medicine no doubt contains a few good herbal remedies; after all, quinine was a South American native remedy. By all means rescue these good remedies if you like, and put them in the British Pharmacopoeia, but let all the superstition die out'²⁰

These comments are ironic considering how few attempts had been made in the past to "rescue" West African herbal reagents and incorporate them into the British pharmacopoeia, but Field included this comment for another reason. Field asserted that it was a misunderstanding to believe that Ga healing could be distilled down to a universal scientific meaning, arguing that the Ga could not conceptually divorce the pharmaceutical virtues of a herb from the power of its *woji*, and that European medical thought took "no cognizance of the fundamental set of supernatural concepts on which these treatments are based."²¹ According to Field, it was folly to believe that Ga healing could be quantified according to scientific principles, and she strongly believed that the material cultural of healing could not be separated from the spiritual powers that imbued medicines with health-giving powers.

Field's ethnography of the Ga demonstrates that a network of African therapists was alive and well in the city, but in her diligent quest to enumerate the essential components of

²⁰ Field, *Religion and Medicine of the Ga People*, 134.

²¹ Field, *Religion and Medicine of the Ga People*, 134.

Ga religion and medicine, Field understated many of the changes occurring in the city in the 1920s. Field wanted to show how Ga religion and healing, or as she termed it, the “true *Ga* life,” ran “amazingly strong and deep” within the residents of Accra, but in doing so she attempted to silence the plurality of healing options that had developed within the city. As Rosalind Shaw has argued, many early anthropological studies were conducted with the hope of recording the core elements of a non-Western society but ended up reflecting the changes that occurred during the colonial period.²² If this is true, we can read Field’s work in two ways: firstly, as evidence of the continuity of Ga healing, and secondly, as evidence of the continuity of a pluralistic healing culture in Accra.

Margaret Field offered only a few sparse references to the other therapeutic options available to the residents of Accra in the 1920s and 1930s, but she did characterize Accra as an “intricate tangle of fragments of tribes and families” that demonstrated a remarkable “toleration and consideration for other people’s gods.”²³ This toleration, according to Field, was correspondingly “extended to other people’s medicines” both by professional Ga healers and the average patient, making the city open to new types of spirits and practices. One Ga healer who was particularly close to Field, a *wontse* named Boi Bi Boi, informed the anthropologist that he had collected his healing powers from as far afield as Liberia, the Ivory Coast and Dahomey.²⁴ Field also met many non-Ga healers, including people with water spirits, invisible dwarves, and conjuring tricksters.²⁵ Of particular note amongst this group is the appearance of Nana Tongo, a witchfinding deity from the Tongo Hills, in the

²² Shaw, *Memories of the Slave Trade*, 9; Nicholas B. Dirks, Geoff Eley, Sherry B. Ortner, eds. *Culture/power/history: a reader in contemporary social theory* (Princeton, NJ: Princeton University Press, 1994), 3; Eric Hobsbawm and Terence Ranger, eds. *The Invention of Tradition* (New York: Cambridge University Press, 1992), 211.

²³ Field, *Religion and Medicine of the Gã People*, 3.

²⁴ Margaret Joyce Field, *Social Organization of the Gã people* (London: Crown Agents for the Colonies, 1940), 104.

Northern Territories of the Gold Coast Colony. Pilgrims to the Tongo Hills could purchase the power of the deity for a hefty fee, and relocate Nana Tongo as a witchfinding god in their own community. In a biography of the deity, John Parker and Jean Allman demonstrated that, by the 1930s, Nana Tongo, had been woven into the “ritual landscapes of the Akan, Ewe and Ga peoples,”²⁶ and was clearly playing a role as a witchfinding god in Accra.²⁷ And Nana Tongo was only one of many foreign deities resident in the city. In fact, Field felt compelled to create an entire category of “medicine-men” -- practitioners who dealt in spirits from distant places such as the Northern Territories, the Krobo District to the northeast of Accra, or the French colony of Dahomey (famous for its *Vodun* pantheon of deities).²⁸ Ironically, by delineating the fundamental components of Ga religion, Field indirectly described a plurality of non-Ga deities and practitioners who were active in the city.

In order to sustain her argument that the inhabitants of the city were imbued with a robust Ga identity, Field also felt the need to play down any syncretism with Christian and Islamic ideas and practices. Field silenced Islam entirely, not once mentioning the presence of a mallam, a mosque, or the *ẓoŋo* in her work -- a surprising omission considering the Muslim population numbered in the hundreds during her tenure on the Gold Coast and a substantial minority of those Muslims were Ga. She also argued that the “Christian insistence on complete segregation” at the Basel Mission at Osu “left the heathen habits less damaged than one might have feared.” But in other parts of the book she leaked out evidence that Ga Christians, despite attempting to segregate themselves with healing cultures associated with fetish, were still very much involved in Ga healing practices. Field argued

²⁵ Field, *Religion and Medicine of the Gã People*, 129-30, 138-41.

²⁶ Allman and Parker, *Tongnaab*, 19.

²⁷ Field, *Religion and Medicine of the Gã People*, 138.

that the Christians of Accra were still polytheistic, tolerating the existence of other deities and spirits. “A Ga Christian,” according to Field, “may believe that the ways of the heathen gods are bad, but he does not believe that there are no heathen gods.”²⁹ She also mentioned the case of a “church-goer” who had an attack of hysteria and was later diagnosed by a Ga spirit medium as being possessed by a local god.³⁰ Field’s attitude is here is patronizing, as she denies Ga Christians the possibility of a Pauline conversion, but the implication is that a pluralistic attitude toward healing remained, even amongst members of Christian congregations. It also allows us to suggest that, even in the Osu salem, Christians likely sought out help from Ga and other healers, rather cutting themselves off completely from the so-called heathen community.

Field intended to silence European influences on the healing culture as much as possible because she believed that the Ga did not take European medicine seriously. However, in the process of delineating what she believed to be the true character of the Ga, she could not help but reveal the changes wrought by colonial sanitary and medical reforms in the city. The activities of the Gold Coast Sanitation, Medical and Health Departments (covered in the next section) were actually quite extensive, reaching into the lives of almost all of the inhabitants of the city. According to Field, the principles of sanitation were incomprehensible to the Ga, and the actions of Medical Officers and sanitary inspectors were misunderstood by the Ga as the actions of a new god known as ‘*Gov’ment*’:

Among the great invisible gods who hold Ga prosperity in their hands has come a new, great, invisible god of less calculable and less tolerant quality, namely ‘*Gov’ment*’. From his fabulously wealthy, heavenly home across the water he sends his gifts and his emissaries... He is not tolerant: he quite deliberately destroys the holy places and hinders the vital rites of older gods. He is illogical: he does not build the new town latrine in place of the old

²⁸ Field, *Religion and Medicine of the Gã People*, 124.

²⁹ Field, *Religion and Medicine of the Gã People*, 132.

³⁰ Field, *Religion and Medicine of the Gã People*, 101.

latrine, but in place of the sacred grove. He has little idea of right and wrong, and cannot tell the difference between good people and bad...A “scholar” who can talk oily English in the right quarter can undermine the authority of a chief and smash up the peace of a town.³¹

The disputes between this new god of ‘*Gov’ment*’ and the older deities of the town are not covered in detail by Field, but she claimed that even the sanitary inspectors who searched for mosquito larvae in the compounds of urban residents were understood as the emissaries of this new god. Though she did hint that the changes wrought by colonial rule loosened the “unified structure” of Ga religion, she claimed that the “general attitude of the people towards the fundamental needs of life” were unchanged by colonial interventions.³² Once again, Field’s tone is patronizing, suggesting that the residents of the city could only understand the colonial government as a spiritual entity, and not as the workings of a broader imperial system. This is hard to believe, considering Accra had been the capital of the Gold Coast for almost 50 years before the publication of her book. But within Field’s notion of ‘*Gov’ment*’ we do find the people of Accra reckoning with the sanitary initiatives taken by the Gold Coast Ministry of Health.

At the time Field was writing, hundreds of Africans were already working in the various branches of the Medical Department, but she dismissed the possibility that this might alter the Ga religious or healing culture of the city. In one vignette she described “An experienced and highly trusted dresser in a European-run hospital,” who, in the morning, would “conscientiously and intelligently carry out the European treatment of an out-patient,” and then in the evening, meet the patient outside the hospital to “recommend to him a medicine-man of a village ten miles away.”³³ Her purpose here was to portray the shallowness of colonial medicine and the depth of Ga healing culture; according to Field,

³¹ Field, *Religion and Medicine of the Gã People*, 132.

³² Field, *Religion and Medicine of the Gã People*, 132.

European healing methods (as actions of the “*Gov’ment*” simply could not be reconciled with Ga notions about the “fundamental realities of the human constitution” and “the invisible roots of life”).³⁴ But this passage also reveals coexistence of different aetiologies of disease in a city where the residents could move back and forth between European-derived and African-derived therapeutic networks.

Field also offered glimpses into changes in the way lay-remedies were produced in the homes of people in Accra. In her section on “Herbs in the Home,” which was intended as a description of the many local herbs used to heal, she briefly mentioned that “enemas are in great favour and give much pleasure -- in fact no single imported article can have given more joy than the enema syringe.”³⁵ Though the mention of the syringe in this passage was likely added simply to get a chuckle out of her readers, it hints at how imported medical tools were being used in conjunction with traditional herbal remedies. Unfortunately, Field’s concerns with the essential practices of the Ga obviate any further discussions of syncretism within the material culture of healing. Were more imported items incorporated into Ga healing practices? Perhaps, but the *Religion and Medicine of the Gã People*, only offers fragments of such evidence. And sadly, Field’s field notes were never archived, precluding the chance of finding points of syncretism that Field might have felt imprudent to include in her ethnography of the Ga.

One change to the medical landscape of Accra that Field openly admitted to was the growing market for patent medicines. However, rather than deal with the obvious challenges that imported medicines would have posed to Ga medicine, she dismissed them

³³ Field, *Religion and Medicine of the Gã People*, 134.

³⁴ Field, *Religion and Medicine of the Gã People*, 134.

³⁵ Field, *Religion and Medicine of the Gã People*, 130.

in a footnote, claiming that only gullible “literate Africans” could fall victim to the quackery of patent medicine vendors:³⁶

They believe every word of the patent medicine advertisements that they read and freely spend their money on such things as ‘Brain and Memory Pills’ and subscriptions to correspondence ‘colleges’ selling courses of instruction in Ancient Egyptian mysteries of the Soul.³⁷

If we put Field’s deprecating tone aside, this short passage reveals the presence of a new class of Ga-speakers with primary school education or more, who were employed by merchants or the colonial government, and who were experimenting with medicines and healing ideas beyond the purview of Ga healers. This group of consumers may have been a minority in the city, but they were a growing one, and they represented a new generation of urbanites who were also comfortable using a new material culture of imported medicines. Field even mentioned an interest in “Egyptian mysteries of the Soul,” which might have been a reference to theosophic or anthroposophic ideas of a global spirituality that emerged at the start of the twentieth century, some of which included the use of homeopathic medicines.³⁸ These little hints offer a window into a world of open-minded patients who were willing to seek new avenues to health.

Field’s *Religion and Medicine of the Ga People* is a touchstone for scholars interested in Ga culture and history. It has been a foundational work for anthropologists studying Ghana, many of them women who have followed in Field’s footsteps as ethnographers of the Ga.³⁹ As such, it has accomplished what Field intended it to do -- reifying the subject of the Ga as

³⁶ Field, *Religion and Medicine of the Gã People*, 133, fn 1.

³⁷ Field, *Religion and Medicine of the Gã People*, 133, fn 1.

³⁸ Rudolf Steiner, *Fundamentals of Anthroposophical Medicine: Four Lectures Given to Doctors* (Stuttgart, 1922), published online through the Mercury Press, accessed May 22, 2014, http://wn.rsarchive.org/Lectures/GA314/English/MP1986/FunAnt_index.html.

³⁹ Kilson, *African Urban Kinsmen*; Kilson, *Kpele Lala*; Claire C. Robertson, *Sharing the Same Bowl: A Socioeconomic History of Women and Class in Accra, Ghana* (Bloomington: University of Indiana Press, 1984).

a people, and enumerating the elements of Ga institutions from the perspective of the Ga. But, perhaps unwittingly, Field also exposed the hybrid and changing nature of Ga healing, by offering insight into the hybrid forms of African-derived healing concepts within the disease aetiology of Ga-speakers. And, for the purposes of this dissertation, the most interesting part of the book is what it reveals about the ongoing pluralistic culture of healing in Accra. In her efforts to circumscribe Ga healing as a set of definable and comprehensible practices, Field involuntarily offered a window into a world beyond Ga ethnomedicine. To Field, her brief references to non-Ga therapies would have constituted extraneous data but for the purposes of this dissertation they offer a glimpse into a world of pluralistic therapies coexisting with a vibrant, changing, locally-generated healing culture.

Section 2. Colonial Medicine as Biopower: Sanitary Reforms in the 1920s.

As Margaret Field hinted, the so-called “*Gov’ment*” was intolerant of other cultures, and as such was perceived by African residents in the city as a challenge to their conceptions of health and healing. In the 19th century, the Gold Coast Medical Department had operated on a small budget without the overt support of colonial governors, but in the 20th century funding for medical and public health reforms increased dramatically, and a new, medicalized version of colonialism began to emerge on the Gold Coast. In the early 20s, the activities of the Medical Department were divided into three distinct branches with their own budgets: the medical branch (responsible for clinics and hospitals), the health branch (responsible for sanitation, vaccinations, and preventative measures), and the laboratory branch (responsible for scientific investigations, clinical and pathological tests, and post-mortem examinations).⁴⁰ The work of the medical branch, responsible for the establishment of Korle Bu Hospital, and a number of clinics in the city, will be covered in chapter 4. The work of the laboratory

branch, though relevant to the expansion of colonial medicine in Accra, will only be briefly touched upon, and will be reintroduced in chapter 5. This section will focus largely on the activities of the health branch, which brought pipe borne water to Ussher Town, funded the construction of new markets, imposed fees and licenses on daily activities in the city, and dispatched “mosquito brigades” in the most intimate spaces of the residences of Accra. Backed by the police, the courts, laboratory scientists, some influential Ga chiefs, and many African lawyers and doctors, these reforms posed a challenge to the pluralistic network of healing in the city, cutting off patients from therapy management groups and guiding into European-derived therapeutic networks. However, there were real limits to how far colonial medical officials of the health branch could alter the lived experiences of people in Accra. As Field showed, the indigenous healing networks of Accra remained intact, and new types of healers continued to enter the city. Moreover, the urban quarters of the city remained largely unchanged -- there was almost no rebuilding of the old neighborhoods, no sewer construction, little investment in drains, and no attempt to suppress local shrines or challenge African healers. In sum, though colonial medicine was increasingly prominent in the city, the pluralistic healing culture of the city was quite able to survive the challenges of the intolerant ‘*Gov’ment*’.

The increasing interest in medical and sanitary reforms by British officials of the Gold Coast government has a direct correlation to the effective standardization of quinine. Around 1900, the Colonial Office regularized the daily intake of quinine for colonial officials at four to five grains, and suggested that it be taken as a tonic in water with a citric or carbonic acid (to activate the alkaloids in the quinine).⁴¹ Very quickly, the high death rates

⁴⁰ Patterson, *Health in Colonial Ghana*, 11.

⁴¹ “Quinine,” *Encyclopaedia Britannica*, 11th ed. (1911), 758. The suggested cure, taken all at once, was 10 to 30 grains (15 grains = 1 gram) at one time.

for Europeans began to decline and it became much less risky for European officials and merchants to work in West Africa than it had been in the past. By 1920, the European population of Accra rose to an all-time high of over 1000 persons, mostly men involved in the import of European goods and the export of cocoa.⁴² By the 1930s, the Medical Department made quinine pills available at colonial post offices for a moderate price of 6d for 16 doses (a course sufficient to cure malaria infection), and malaria was no longer considered to be a significant threat to the health of whites in the colony.⁴³

Yet despite increasing economic growth and better health in the city, the Europeans living in Accra continued to regard the city as unhealthy. In particular, they feared the mosquito. Though a cure for malaria had been found, and quinine was available in pill or injection form to all residents of Accra for a reasonable fee, yellow fever was a continuing source of anxiety for the white population of the city. A small epidemic in 1910 that killed nine Europeans in Takoradi had terrified the white population because there was no vaccination for the disease at the time (despite advances in virology, a vaccination for the disease was not mass produced until the 1930s).⁴⁴ The African population of the city, which the British considered to be a reservoir for the disease, was still believed to be a threat to the

⁴² Macmillan, *Red Book of West Africa*, 165. Macmillan estimated the expatriate population (of government officials, merchants, miners and missionaries) in the Gold Coast at 2,000, of which probably half lived in Accra. The African population of the city also grew exponentially in the first few decades of the 20th century, but this cannot be exclusively attributed to the introduction of synthesized quinine. Non-European residents of Accra could only access quinine pills through dispensaries at hospitals and clinics until 1935, when it was sold directly to the public through the Accra post office. They may have been able to buy the pills as curatives at shops and markets, but there is no evidence to show that Africans were investing in the purchase of quinine as a prophylactic. What more likely led to an increase in the African population was an in-migration of workers from around West Africa combined with increased economic prosperity (which would have led to corresponding rises in nutrition, baby weights, and other demographic metrics related to fertility). Patterson, *Health in Colonial Ghana*, 36.

⁴³ Patterson, *Health in Colonial Ghana*, 36.

⁴⁴ Addae, *Evolution of Modern Medicine*, 370-1.

health of the European population, as was the Korle Lagoon, which was deemed a spawning ground for malaria larvae.

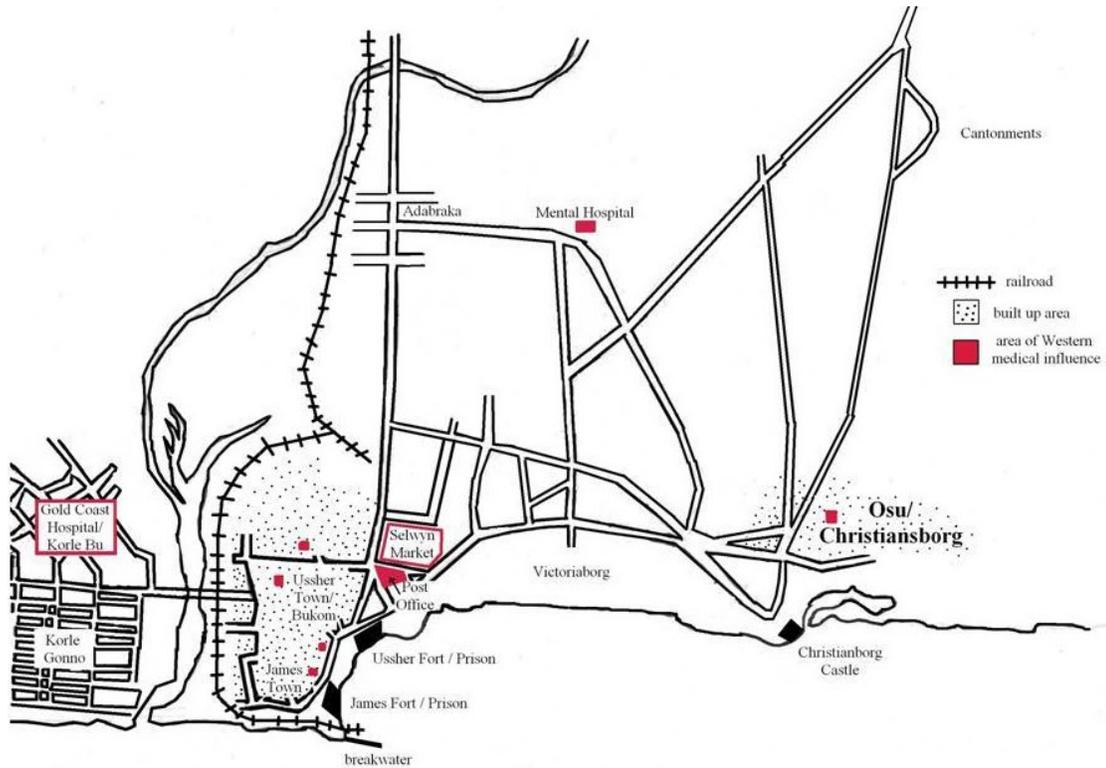
In the first two decades of the century, the technocrats of the Gold Coast Medical Department had been unable to alter the urban geography of Accra according to the precepts of sanitation, mostly due to meagre colonial revenues.⁴⁵ For instance, in 1912, the newly appointed Governor Clifford began planning further segregation measures (including the demolition and segregation of parts of Ussher Town), but abandoned them for financial reasons. Clifford also expressed the opinion that “dispossessing large numbers of Africans of their homes” to maintain the health of a white minority was not justified because British officials were quite aware of the dangers of residing in tropical Africa.⁴⁶ Clifford was also aware that the African elites of the city considered segregation due to the fear of yellow fever to be “white man’s humbug,” because Africans did not suffer from the disease (due to immunity developed if a person contracted the disease during childhood and survived).⁴⁷

Aspirations to demolish and rebuild the city were further delayed by the First World War, when a priority was placed on marshalling resources for the war effort rather than on sanitation and health. Another delay was incurred by the influenza epidemic of 1919, which, unlike the successful inoculation campaign led by Sir William Jeffrey Simpson in 1908, demonstrated of the impotence of colonial medicine in the face of a global pandemic. The story of influenza is aptly covered in an article by K. David Patterson, but it merits a brief mention here because the futility of the influenza campaign serves as a contrast to the sense of accomplishment found in Simpson’s report on the plague campaign. Despite a shocking death toll of 655 deaths in the city, twice as many as the plague, no colonial medical expert

⁴⁵ Dumett, “The Campaign against Malaria,” 170-72.

⁴⁶ Addae, *Evolution of Modern Medicine*, 43.

⁴⁷ *Gold Coast Leader*, 12-26 (August, 1911), 3.



Accra 1935

Figure 4.1. Map of Accra, circa 1935. By the interwar period, institutions of colonial medical practice had been established at Korle Bu and at small clinics within Ussher Town, James Town and Osu. The post office sold quinine tablets, which were also available along with patent medicines, at the newly constructed (according to British sanitary regulations) Selwyn Market. The first permanent structure for an asylum also appears here. However, the core Ga neighborhoods of the city remained largely untouched by sanitary and medical reforms. *Source:* map by author.

arrived with a plan to halt the epidemic -- there were no forced removals, no demolitions, no inoculations, and barely enough resources to bury the dead. In the words of Patterson, the “government's reaction to the epidemic was basically fatalistic”; though the Gold Coast Medical Department imposed quarantines and established some preventative measures, they did little to halt the epidemic. Though there was no comprehensive response to the epidemic by Ga chiefs, African healers in the city did not shy away from attempting to fight the illness. A local newspaper recorded several new forms of herbal remedies that became available in the city during the epidemic, including a herb-pepper mixture used as a purgative and a type of powder (probably a *tɔ*) taken internally in a tincture of alcohol.⁴⁸ It is unlikely that African remedies did anything but mollify the symptoms of the flu, but their availability during the epidemic proved that African healers had not wilted away but rather continued to adapt their healing traditions to new illnesses.

As security and prosperity returned after 1919, government plans for a healthy capital began to take shape again, this time under the leadership of a governor who saw medicine as a keystone to future development of the Gold Coast. The Guggisberg years were a time of increased prosperity, a period that saw the construction of the railroad to Kumasi, the deep water harbour at Takoradi,⁴⁹ and the Prince of Wales College at Achimota. Guggisberg also spent prodigiously on health care because he equated a healthy workforce with a healthy colonial economy, and because he believed that medicine was a gift that the colonizer could bestow on the colonized. In the years prior to his arrival, the governors of the colony had been obliged to limit their expenditures on health because of the modesty of

⁴⁸ K. David Patterson, “The Influenza Epidemic of 1918-19 in the Gold Coast,” *Journal of African History* 24, no. 4 (1983); *Gold Coast Leader*, 30 November, 1918, 1.

export revenues and because of resistance from the residents of Accra, but in the 1920s, the exponential growth in export tariff revenue enabled Guggisberg to initiate an expansion of clinics, hospitals, and the training of nurses and dispensers.⁵⁰ With the immense financial support offered by Guggisberg, it was conceivable that discourses of biopower might finally align with the capacities to expand the three branches of the Medical Department in Accra.

One of Guggisberg's first actions as governor was an attempt to break the impasse between local African elites and the colonial government over sanitary reforms in the city. In 1919, he appointed a committee of local lawyers to review the performance of the Accra Town Council, which at the time was a minor coordinating body made up of government officials, and asked them to recommend how residents might be able to participate more fully in rebuilding the dilapidated quarters of Accra.⁵¹ Two years later they produced a report that stated that the only way to get the residents of James Town and Ussher Town interested in sanitation would be to give the vote to all landowners of 21 years and older, and to allow ratepayers to elect a majority of members to the Council. Guggisberg expressed no intention of following the recommendations for enfranchisement, but in 1924 he did concede to allowing a minority of men drawn from the professional classes to sit on the Council, with a majority of the seats reserved for government officials. The paramount chiefs of James Town and Ussher Town and some African physicians in Accra supported the new Town Council, but the imposition of a new level of government in the city was opposed by the influential Nai and Korle priests who repudiated any new justification for

⁴⁹ A.W. Cardinall, *The Gold Coast, 1931 (Chief Census Officer)* (Government Printer, Accra, Gold Coast), 46.

⁵⁰ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 14; the Gold Coast spent significantly more on sanitation than other colonies, such as Nigeria and Kenya, who averaged around seven percent during the 1920s. Arthur E. Horn, "The Control of Disease in Tropical Africa: Part I," *Journal of the Royal African Society*, 32, no. 126 (January, 1933), 24.

⁵¹ Akyeampong, "Boxing in Accra," 44.

taxes. Though the bill was passed by the colonial government it was not wholly supported by the residents of Accra, who considered it a further attempt to extend colonial rule over the city.⁵²

Despite a lack of support by the residents of James Town and Ussher Town, the new Town Council did establish a modest base of revenues through government grants for the cleaning of government buildings and bungalows, and by imposing fees on the daily activities of the cities inhabitants, including market rents, slaughter-house fees, building fees, alcohol licences, dog licences, hawkers' licences and the sanitary fines for harbouring mosquito larvae.⁵³ This piecemeal funding was enough to enable the Town Council to build concrete stalls at the Salaga and Selwyn Markets in the 1920s, two key points of distribution for foodstuffs in the city.⁵⁴ The government also extended a fresh water pipeline from the Densu River, and offered free water at pipe stands around the city. This gesture was boycotted by the some of the *nulomei*, who, according to their taboos of office, refused to drink water that did not fall from the sky,⁵⁵ and by others who claimed that the water would cause barrenness in women,⁵⁶ but it was patronized by the general population who struggled to find clean water supplies during the dry season. A major health benefit to the introduction of pipe borne water was a dramatic reduction in incidences of Guinea worm, a disease which had so long been a source of pain and suffering in the city.⁵⁷

⁵² *Accra Town Council Minutes*, September 13, 1926; *Gold Coast Independent*, October 30, 1926, 1316. For more information about resistance to the Towns Ordinance Act see Roger Gocking, *The History of Ghana* (Westport, Conn: Greenwood Press, 2005), 52-54.

⁵³ Acquah, *Accra Survey*, 26.

⁵⁴ Gold Coast Colony, *Report on the Medical Department by the Government of the Gold Coast* (Accra: Government Press, April 1924 to March 1925), 21.

⁵⁵ Field, *Religion and Medicine of the Gã People*, 131-32.

⁵⁶ Patterson, "Health in Urban Ghana," 253.

⁵⁷ Patterson, "Health in Urban Ghana," 263; J.W.S. Macfie, "Intravenous injection of tartar emetic in Guinea-worm infections," *Lancet* 195, no. 5038 (March 20, 1920), 654-655.

The Department of Health supported the efforts of the Town Council by funding parallel sanitation work by the Public Works Department, which included employing scavengers to collect rubbish, clean the drains, and dump night soil in the surf to the west of Korle Lagoon.⁵⁸ And as efforts to sanitize the city began to take shape, segregation was abandoned.⁵⁹ Though whites continued to choose to live in Victoriaborg and the Ridge, the restrictions on the movement of Africans across the 400 yard “neutral zone” between the European Reservation and the old quarters of Accra were officially removed (though still monitored by police who monitored the road between the two parts of the city).⁶⁰

The most controversial action taken by the colonial government to sanitize the city of Accra was the creation of the so-called “mosquito brigades,” a new generation of sanitary inspectors hired by the Town Council in the 1920s.⁶¹ The position of inspector offered a salary that was competitive with the private sector, starting at £72 and rising in increments of £4 per annum, and that offered the opportunity to advance through the ranks of the colonial service.⁶² Once they had graduated from training school, the inspectors were formed into teams and dispatched around the city to monitor the sanitary habits of the residents.⁶³ Though many of them were born in Accra, and spoke Ga and Twi, the inspectors were disliked by the residents of the city because could enter compounds without the permission

⁵⁸ Patterson, “Health in Urban Ghana,” 253.

⁵⁹ Addae, *Evolution of Modern Medicine*, 43.

⁶⁰ Patterson, “Health in Urban Ghana,” 255. As Mable Dove notes in her 1934 play, *A Woman in Jade*, the residential area was open to African subjects of the Gold Coast, but the police patrolled the road to Accra to prevent African prostitutes (what Dove called “Black Cargo”) from entering the European residential area. Stephanie Newell, and Audrey Gadzekpo. *Selected Writings of a Pioneer West African Feminist*. Nottingham: Trent Editions, 2004, 90.

⁶¹ Addae, *Evolution of Modern Medicine*, 129.

⁶² This salary was approximately equivalent to that of senior nursing sisters at the colonial hospital. See Gold Coast Government. *Civil Service List* (Accra: Government Press, 1917), 173; or to a junior clerk in the Sanitary Department in 1930. See PRAAD Accra Town Council, *Estimates of Revenue and Expenditure* (1931-2), 6.

of the owner, and fine people for violations like the improper disposal of rubbish or for harbouring mosquito larvae in water pots. Sanitary inspectors were the closest point of contact with colonial authority for most inhabitants of the city, and they were reviled for the way that they intruded into the washing and cooking areas of compounds in the city, which were gendered as women's spaces, led to public complaints.⁶⁴ Newspaper editors in both Accra and Cape Coast decried the rude and overzealous behaviour of the young African men trained as inspectors, who often dumped out precious water supplies without compensation and sometimes disturbed women taking their baths.⁶⁵

Although Scott, Patterson and Addae recognized that the actions of the mosquito brigades were deeply resented by urbanites around the colony, they have argued that destroying the breeding grounds for mosquitoes resulted in lower rates of malaria in the cities (based on a decreasing number of sites where larvae could breed, not by number of cases treated)⁶⁶. The African residents of the cities of the Gold Coast saw things differently. In Cape Coast, the editor of the *Observer* argued that mosquito larvae control measures were a “yellow fever bogey” invented to create jobs for white sanitary inspectors.⁶⁷ There were so many cases of larvae violations brought before the Accra Police Court in the 1920s that, as John Parker has pointed out, it became known to Ga-speakers as the “Loloi [larva] Court.”⁶⁸ The inspections were characterized by Margaret Field as tantamount to “religious persecution,”⁶⁹ and publicly criticized by Dr. Nanka-Bruce, who declared them that they

⁶³ *Gold Coast Independent*, February 5, 1927, 173.

⁶⁴ Parker, *Making the Town*, 199.

⁶⁵ Patterson, *Health in Colonial Ghana*, 40.

⁶⁶ Patterson, *Health in Colonial Ghana*, 40; Scott, *Epidemic Disease in Ghana*, 42; Addae, *Evolution of Medicine*, 128;

⁶⁷ Patterson, *Health in Colonial Ghana*, 40.

⁶⁸ *Gold Coast Independent*, November 24, 1928, 1106; Parker, *Making the Town*, 199.

⁶⁹ Field, *Religion and Medicine of the Gã People*, 132 fn 1.

terrified the “ignorant people” of Accra, but the government did not relent.⁷⁰ Though the inspections did not culminate in riots, the actions of sanitary inspectors in the compounds of the city were perceived of as an encroachment into intimate spaces of the African inhabitants of the city, and they did little to encourage the residents of the city to cooperate with broader goals of sanitary reform.⁷¹ Dr. Selwyn-Clarke, the Principle Medical Officer during the 1920s and early 1930s, was not well liked by the African residents of Accra, and though the new market built to the north of Ussher Town in 1922 was named in his honour,⁷² it was popularly referred to as “Makola Market” rather than “Selwyn Market.”⁷³

Sanitary inspections in the heart of the city of Accra reflected colonial spatial understandings about healthy and unhealthy spaces in the city. Though the physical segregation of the black and white populations of the city had been eliminated, African residents of the city felt that the sanitary inspectors harassed the residents of James Town and Ussher Town unduly, while neglecting to enforce their regulations in the European Reservation. Dr. Nanka-Bruce, the editor of the *Gold Coast Independent* and member of the Aboriginal Rights Protection Society, declared that the sanitary inspectors were racially biased, and claimed that they neglected to punish Europeans harbouring mosquito larvae in “flower pots and ice chests.”⁷⁴ Initially, Europeans were not liable to prosecution, but in the 1930, the law was changed to make the white residents of the segregated reservation responsible for eliminating locations for mosquitoes to breed.⁷⁵ Inspectors did search the homes of some Europeans, as demonstrated by an instance when a sanitary inspector fined

⁷⁰ *Gold Coast Independent*, May 20, 1939, 471.

⁷¹ Addae, *Evolution of Modern Medicine*, 129.

⁷² *Gold Coast Independent*, November 11, 1922, 525.

⁷³ Claire Robertson, “The Death of Makola and Other Tragedies,” *Canadian Journal of African Studies*, 17, no. 3 (1983), 470.

⁷⁴ *Gold Coast Independent*, July 24, 1926, 899.

⁷⁵ Patterson, *Health in Colonial Ghana*, 41.

Doctor Cicely Williams, a physician at Korle Bu Hospital, when he found mosquito larvae in a vase at her bungalow.⁷⁶ But Dr. Nanka-Bruce, the only African physician on the Accra Town Council, made a strong point about the nature of sanitary inspections, which were expressly created to protect the white inhabitants of the European Reservation from a so-called native reservoir of disease in the old quarters of the city. The hegemony of colonial medicine was difficult to establish when the inhabitants of all classes in Accra saw themselves as victims of harsh and unevenly enforced sanitary regulations.

The efforts made by the Department of Health and the Accra Town Council to sanitize Accra were simply not enough to meet European standards of urban sanitation in the 1920s. Dr. Nanka-Bruce, who himself advocated sanitary reforms, was consistently critical of the piecemeal measures taken by the government. In a series of editorials and commentaries, he noted that, despite its new construction, the Selwyn Market was surrounded by rubbish and in a poor sanitary state, and he called on the sanitary inspectors to monitor public spaces as closely as they monitored the domestic ones.⁷⁷ Of particular nuisance to Nanka-Bruce were the public latrines erected by the government, which he claimed were poorly built, foul smelling, and lacking in privacy.⁷⁸ He also pointed out that the drains of the city were completely dysfunctional -- during the rainy season, the streets of the city flooded because the gutters were clogged with human excrement and refuse, and during the dry season, they contained fetid pools of water that harboured mosquitoes.⁷⁹ Intermittent inspections, according to Nanka-Bruce, were simply not enough to keep the city

⁷⁶ Ann Dally, *Cicely: The Story of a Doctor* (London: Victor Gollancz, 1968), 23.

⁷⁷ *Gold Coast Independent*, September 4, 1926, 1060-63; *Gold Coast Independent*, January 26, 1929, 113.

⁷⁸ *Gold Coast Independent*, December 15, 1934, 1190; *Gold Coast Independent*, July 24, 1926, 802.

⁷⁹ *Gold Coast Independent*, September 4, 1926, 1063; *Gold Coast Independent*, July 23, 1926, 805; *Gold Coast Independent*, July 24, 1926, 802; *Gold Coast Independent*, September 25, 1926, 1156; Patterson, "Health in Urban Ghana," 256.

in a healthy state. In a forceful editorial in 1929, he described the dilapidated condition of some dwellings in Ussher Town and called upon the Colonial Government to “seriously consider breaking down and reconstructing the several congested areas in Accra and other large towns...”⁸⁰ But despite years of criticism, the public health reforms of the Guggisberg era progressed only in a piecemeal fashion. The Town Council did hire inspectors to enforce the building code, but they were only required to regulate the construction of new dwellings.⁸¹ In some cases, the Town Council did take advantage of their connections to local chiefs to change the built environment of the city. For example, in 1929 they passed a motion to demolish a market in Korle Gonno that was deemed unsanitary, and accomplished the task by paying James Town Manche Kojo Ababio IV a one-time fee of £10 to take care of the job himself.⁸² But this case was an exception to the rule because it had the support of a prominent Ga chief. For the most part, the residents of the old quarters of the city saw fines for public health violations as a new type of taxation and were unwilling to accede to government demands to rebuild their cities.

Public health reforms were only marginally successful in Accra, but they were only one part of a broader attempt to regulate and control the movements and activities of the subjects of the Gold Coast. During the 1920s and 1930s, the colonial police force, the prison system, and the courts all contributed to a process that began to monitor the health of the bodies and guided or coerced the sick and injured subjects into colonial institutions. This was particularly evident in the case of accidents that involved physical trauma and required surgical intervention.⁸³ Residents of Accra who suffered injuries, like cuts or

⁸⁰ *Gold Coast Independent*, January 26, 1929, 114.

⁸¹ *Gold Coast Independent*, March 26, 1927, 407; *Gold Coast Civil Service List* (Accra, Government Printer, 1917), 236.

⁸² *Gold Coast Independent*, February 9, 1929, 183.

⁸³ Patterson, *Health in Colonial Ghana*, 82 & table 28.

broken bones, were often rushed to physicians, and by the 1920s, the clinics and hospitals were widely patronized by people needing emergency care for traumatic injury. In 1926, when a building inspector employed by the Town Council fell off the scaffolding of a mosque, he was treated by Dr. Macauley, a surgeon employed by the government.⁸⁴

Residents of Accra who were not in the employ of the government also took their wounded to surgeons. When a boy fell off a cocoa nut tree at Faanaa in 1926, a fishing village near the mouth of the Sakumo Lagoon, he sustained a fracture in his leg and was taken to Dr. Nanka-Bruce's clinic to reset the bone.⁸⁵ When the Gold Coast Hospital was built at Korle Bu in 1924 (covered in detail in chapter 5), trauma patients were still taken to the closest surgeon, but since there was always a physician on staff at the hospital, some of the wounded found themselves rushed to the emergency room at Korle Bu.

An even larger category of injuries developed with the arrival of automobiles in the city. In the 19th century, there may have been many road accidents involving horses, but there is only one recorded carriage accident in the extant court records. It happened on High Street between Accra and Christiansborg when two carriages collided and a resident of the city named A.F. Lokko was dragged by his horse. After the accident, Lokko went home, was tended to by a local healer, and took the case to court when he was feeling better. Neither the police nor any surgeons were involved.⁸⁶ The situation changed when cars and trucks began to arrive in large numbers in the 1920s,⁸⁷ and when a municipal bus service was

⁸⁴ *Gold Coast Independent*, October 2, 1926, 1185.

⁸⁵ *Gold Coast Independent*, December 25, 1926, 1639. "Accident at a Faanaa Village"; for another example see PRAAD SCT 2/4/57. 16th February 1912 - 19th September 1940, 191-20.

⁸⁶ PRAAD SCT 2/4/25, "A.F. Lokko versus Connell," 25th March 1897 - 30th August 1897, April 27, 1897, 130-33.

⁸⁷ Jack Arn, "Third World Urbanization and the Creation of a Relative Surplus Population: A History of Accra, Ghana to 1980," *Review: Fernand Braudel Center* 19, no. 4 (Fall, 1996), 430.

inaugurated in 1927.⁸⁸ As road traffic started to increase so did the number of car accidents. The high speeds of automobile collisions produced more fatalities and dramatic cases of physical trauma than ever before.⁸⁹ However, African healers were excluded from caring for the victims of severe accidents because the police were responsible for dealing with these crisis situations. When an accident occurred, the police requisitioned nearby vehicles to send injured passengers or dead bodies to the hospital and then filed reports on the accidents, taking statements from the drivers and passengers.⁹⁰ These reports, which included the registration numbers of the automobiles, were used in court if any of the parties in the accident wanted to sue for damages.⁹¹ A legal paper trail developed through police investigation of accidents, connecting the colonial medical system to the courts, and obliging people who suffered injuries to participate in the colonial medical system. Even more than the interventions of sanitary inspectors, police control over accidents can be seen direct expression of biopower -- the assertion of state control over the bodies of the subject population of the Gold Coast.⁹²

Like many other medical systems around the world in the early 20th century, the diagnosis and control of medical subjects required written statements about the diagnosis, the causes, and the prognosis of an illness. Official recognition of a sickness required a

⁸⁸ Dickson, *Historical Geography of Ghana*, 298-99.

⁸⁹ Automobile imports to colony grew from 283 in 1921 to over 2000 in 1929, Cardinall, *Gold Coast*, 107.

⁹⁰ For accounts of car accidents in the newspapers see *Gold Coast Independent*, December 18, 1926, 1606; *Gold Coast Independent*, March 2, 1929, 271; *Gold Coast Independent*, January 8, 1927; for cases from court records in the 1930s and 40s see PRAAD RG 16/2/23 "J.O. Tettey for Adjaye Quarcoo v Cobblah, 26/10/36, 498-505; PRAAD RG16.2.31, "Tettey vs Osamfo Adorkor," 12/20/49, 192; PRAAD RG 16.2.18, "Wazil Hausa versus Belenyah," 12/4/45, 303-04.

⁹¹ For an example of a civil case involving a car accident see PRAAD ADM 23/9/36, "J.B. Blankson v. J.W. Quarshie," 317-18.

⁹² Michel Foucault, *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*, ed. C. Gordon (Brighton: Harvester Press, 1980), 96.

certificate to be signed by a physician, and causes of death required documentation from an autopsy.⁹³ Additionally, to make a claim for compensation for injury, a plaintiff required medical documentation as evidence. The demand for medical documents in the city was strong enough to create a black market for doctors' notes. Dr. Cicely Williams, a British physician who worked at the hospital in Accra in the 1920s, recalled being offered a bribe of 10 guineas to provide a false a medical certificate needed to make a case in a colonial court.⁹⁴ Williams refused to provide any certificate for work she had not done, but the request speaks to the increasing importance of medical documentation. This paper trail was reinforced by documentation produced by British scientists at the Accra Laboratory (renamed the Gold Coast Medical Research Institute in 1920), who wrote reports on insect vectors, parasitology and who tabulated the malaria indices using data collected by sanitary inspectors.⁹⁵ Unlike African practitioners, who diagnosed their patients orally and did not offer any written documentation after their visit, the medical system of the colonial state was text-bound.

As in the case of Commey in 1877, people who suffered traumatic injuries from violent crimes were directed to British-trained surgeons so that there would be a deposition available for court records after the crime occurred. In reported cases of suspected rape, the police took female victims to British-trained doctors for medical examination to verify the assault in case of trial.⁹⁶ And in cases of violence by people with mental illness, the accused could be judged insane and sent to the asylum, as in the 1929 case of Ahudor, a customs clerk who was assaulted in the streets of Accra while walking with his wife. After a quarrel in the street, a man named Akwei struck Ahudor over the head with a stick and knocked him unconscious. Ahudor's wife took her husband to a local surgeon, who examined him and

⁹³ PRAAD SCT 2/4/69, 17th May 1918 - 14th November 1919, 584-88.

⁹⁴ Craddock, *Retired Except on Demand*, 56.

⁹⁵ Patterson, *Health in Colonial Ghana*, 22.

ordered that he be sent to the hospital, where he died later in the evening.⁹⁷ The police held Akwei but when he was brought before the magistrate, he was judged to be insane and was sent to the mental hospital at Adabraka for a medical assessment.⁹⁸ In another case in the same year, a fight broke out at Selwyn Market between two Hausa-speakers. In an insane rage, a woman named Masalachi struck the head of Mama Yadu, another vendor, against the wall of the Market. The quarrel attracted the attention of the police, who arrived on the scene, arrested Masalachi, and sent her to the asylum to be “placed under medical observation.”⁹⁹ Though the mental hospital offered little in the way of therapy, and operated mostly as a place of confinement for patients considered dangerous to the public, it fitted into a system within which colonial subjects involved in crimes could be isolated and observed by medical technocrats.¹⁰⁰ Victims of violence and people who were deemed mental patients became wards of the colonial medical system, thereby losing access to the African therapy management groups that would normally arrange health care for them in the compounds of African healers.¹⁰¹

The police and the courts also intervened in the normally sacrosanct activities of the Ga priests if there was any sort of public disturbance at the major shrines. For example, when police were called out to the mouth of the Sakumo Lagoon, to stop a riot between two rival fishing villages, they were usurping the power of the Sakumo *wulomo*, who told the police that the two factions were supposed to report to him for mediation.¹⁰² The police disregarded his request. The police also arrested any religious leaders who forced people,

⁹⁶ *Gold Coast Independent*, January 15, 1927, 79, 83.

⁹⁷ *Gold Coast Independent*, January 12, 1929, 79.

⁹⁸ *Gold Coast Independent*, January 12, 1929, 79.

⁹⁹ *Gold Coast Independent*, January 12, 1929, 82.

¹⁰⁰ E.B. Forster, "A Short Psychiatric Review of Ghana," *American Journal of Psychotherapy* 16 (1962), 28.

¹⁰¹ Field, *Social Organization of the Gã People*, 105.

under threat of spiritual reprisal, to work at their shrines. In the sensational “Oyamia Case” of 1926, a trial that was followed closely by the public in Accra, a *woyoo* was accused of coercing a person to stay at her shrine for ritual purposes. During the trial, the woman became possessed by a spirit and became so animated that the bailiffs had to hold her down to control the spasms in her body. She was later convicted of “holding a person in pawn,” and sent to prison in James Fort, and afterwards to a jail in Sekondi.¹⁰³

These examples demonstrate the growing involvement of the police in matters of public order that would normally be presided over by the Ga religious authorities, evidence of elements of biopower within the colonial government that posed a potential threat to non-European healers.¹⁰⁴ Officially, the Gold Coast Native Jurisdiction Ordinance of 1885 had prohibited any sort of “fetish” activity involving charms or medicines,¹⁰⁵ and as John Parker has shown, district officers in the Ashanti and Northern Regions vigorously suppressed shrines that were deemed detrimental to the colonial order.¹⁰⁶ British desires to circumscribe the activities of healers on the Gold Coast were stated more explicitly within a bill introduced by the Secretary for Native Affairs in 1927, which disallowed the use of medicines deemed “noxious,” the act of putting people into “fetish,” and any sort of curse that fell under the category of defamation or slander.¹⁰⁷ This bill demonstrated that the government planned to restrict the work of indigenous religious and healing experts who were considered a threat to colonial rule, and it contained strict punishments, including fines

¹⁰² *Gold Coast Independent*, March 26, 1927, 399.

¹⁰³ *Gold Coast Independent*, October 16, 1926, 1254.

¹⁰⁴ *Gold Coast Independent*, March 26, 1927, 399.

¹⁰⁵ William B. Griffith, *Ordinances of the Settlements on the Gold Coast and of the Gold Coast Colony in Force April 7th, 1887* (London: Stevens & Sons, 1887), 722-23.

¹⁰⁶ John Parker, “Witchcraft, Anti-Witchcraft and Trans-Regional Ritual Innovation in Early Colonial Ghana: Sakrabundi and Aberewa, 1889-1910,” *Journal of African History* 45, 3 (2004), 419.

¹⁰⁷ *Gold Coast Independent*, January 15, 1926, 75.

of £25 and up to three months in prison. But despite the threat that this bill might have posed to healers in Accra, there was no record of mass arrests or demolitions of shrines in Accra. In fact, only one shrine in Accra, the home of a goddess of fertility, Naa Ede Oyeadu, was suppressed by the British during the entire colonial period (the story of this shrine and its relationship to maternity in the city is covered in chapter 4). In order to maintain a peaceable relationship with inhabitants of the capital city, the British largely left African religious leaders and healers alone. But the threat of reprisals remained, and if a healer ran afoul of colonial laws, he or she had no indigenous authorities to appeal to.

The medical and sanitary interventions of the 1920s, when combined with the expansion of the powers of the police, the courts, and the Accra laboratory, amounted to a serious bid for colonial medical hegemony. It can be argued that the provision of pipe-borne water and the destruction of larval breeding grounds did reduce instances of guinea worm and malaria in the city, increasing the aggregate health of the population of Accra. For the first time, the public health measures provided by the colonial government did offer tangible benefits to the population of the city. And more than ever before, the medical appendages of government were finding ways to determine the states of health of the bodies of colonial subjects, and the healthiness of the places where colonial subjects lived. When patients were brought into the colonial fold, their condition was tracked through medical reports, police reports, and court documents, within an increasingly text-bound system that rendered the sick of the city as medical subjects. This was colonial biopower -- a form of medical control that now had the potential to cut the residents of Accra off from their therapy management groups and guide down healing channels of exclusively European-derived therapies, making it a significant challenge to conventions of pluralistic healing in the city. But, to borrow a metaphor from Fred Cooper, the flow of colonial medical power in Accra can be

understood more as arterial than capillary.¹⁰⁸ State directed, European-derived, healing practices did become a legitimate force in determining states of health in Accra, but only along official channels and only according to specific legal parameters. Beyond the purview of the “*Gov’ment*,” healers from other traditions continued to define health according to their own criteria and continued to serve the diverse needs of patients in the city.

Section 3. African-Born Physicians in the Early 20th Century.

According to K. David Patterson, the colonial physician was a “puzzling figure for Africans”:

He was usually a white male, a stranger who had to use an interpreter. He often asked impolite questions; demanded, for unknown reasons, samples of blood, urine, and feces; and sometimes cut open the bodies of the dead...some were so disagreeable that people avoided them.¹⁰⁹

The cultural divide between Africans and white physicians was exacerbated by the fact that the Gold Coast simply did not seem to attract the best quality British physicians. But in the 1920s, a new cadre of African physicians began to change the way the African residents of Accra perceived European medicine. Like the white doctors before them, African physicians were imbued with a strong belief in the efficacy of European-medical techniques, and they regarded African healing traditions as an impediment to the improvement of health in the colony, but they were able to create a rapport with patients in a way that their predecessors had not. Firstly, they could speak the local languages, which helped in translating the purposes and goals of their therapies. Secondly, they drew their clients from a growing class of wealthy merchant families of the city, who were able to afford their services and who wanted to associate themselves with the elite status of European medicine.

¹⁰⁸ Frederick Cooper, “Conflict and Connection: Rethinking Colonial African History,” *American Historical Review*, 99, no. 5 (December, 1994), 1533.

Finally, after centuries of using tools and practices that were of little use in ameliorating the health of Africans, they were able to offer a type of sterile surgery that gained popularity amongst Africans in cases of trauma. After centuries on the margins, European medical practices had finally been appropriated by Africans and had finally carved a substantial niche for themselves within the pluralistic healing culture of Accra. But though physicians were now better established in the city, they still had to compete with other types of healers. As this section will show, the strides taken by British-trained African doctors to establish themselves as a legitimate therapeutic option did not necessarily diminish the influence of therapeutic pluralism in Accra.

In the 19th century and early 20th century, black doctors had to struggle for professional recognition and they faced a colour bar that prohibited them from the highest ranks of the colonial medical service. But in the 1920s, as part of Guggisberg's initiative to Africanize the colonial government service, a new category of Junior African Medical Officer was created with a salary starting at £400 per year, a very large salary for a colonial subject of the Gold Coast.¹¹⁰ Though African physicians continued to rail at the limited African opportunities at the higher ranks and the lower pay for African officials overall, the junior and middle ranks of the colonial government were being rapidly filled with educated Africans. With the construction of a new model colonial hospital at Korle Bu (covered in chapter 4), the opportunities for clinical work expanded too. And as the city grew, the possibilities for making a good living in private practice began to grow. Not only did being a doctor pay well, it was also a high status profession within colonial circles. A physician on the Gold Coast, whether white or black, had access to the elite society that gathered at the

¹⁰⁹ Patterson, *Health in Colonial Ghana*, 15.

¹¹⁰ David Kimble, *A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1928* (Oxford: Clarendon Press, 1963), 109.

prestigious Rodger and Accra Clubs¹¹¹ and was also welcome at many official government functions.¹¹² By the 1920s, the profession of medicine was befitting of the sons of wealthy elites in Accra.

The first physician to follow in the footsteps of Quartey-Papafio was Dr. Frederick Victor Nanka-Bruce.¹¹³ He left Accra for Edinburgh in 1901, where he trained as a surgeon, and returned to Accra in 1907 taking occasional employment with the Colonial Government (as part of a committee to investigate infant mortality in the city).¹¹⁴ But Dr. Nanka-Bruce also maintained his independence from the West African Medical Service, staying active politically as a member of the Gold Coast Aborigines' Rights Protection Society and as (as mentioned in the section above) an editor of the *Gold Coast Independent*.¹¹⁵ Other doctors who practiced in the city during the early 20th century included Dr. Van Hien, member of a merchant family from Osu, Drs. W.F. Renner Dove and Horace Dove, two sons of a prominent Sierra Leonean merchant who practiced in Ussher Town, and C.E. Reindorf, the son of Carl Christian Reindorf.¹¹⁶ By 1923, there were six clinics run by African-born physicians in the city, and they did not have to emblazon "*Domi Abra*" on their signs because there were more than enough clients to sustain their practices.

However, as Adell Patton has noted, despite growing demand for medical services by the elite families of Accra, black doctors still had to compete with practitioners who

¹¹¹ Clifford, *Our Days on the Gold Coast*, 56.

¹¹² Jinny Kathleen Prais, *Imperial Travelers: The Formation of West African Urban Culture, Identity, and Citizenship in London and Accra, 1925-1935*, Ph.D. Dissertation University of Michigan, 2008, 22.

¹¹³ Sampson, *Gold Coast Men of Affairs*, 179.

¹¹⁴ Addae, *Evolution of Modern Medicine*, 227.

¹¹⁵ Sampson, *Gold Coast Men of Affairs*, 178-80.

¹¹⁶ Gold Coast Colony, *Gold Coast Handbook* (Accra: Government Press, 1923), 596-97.

There were also three European doctors in the city in this year: Jessie Hawksworth Beveridge, Alexander Cowie Paterson, and Francis Matthew Simmons. Cardinall, *Gold Coast*, 173.

followed African healing traditions.¹¹⁷ As a class of healers imbued in the universalism of science and medicine, physicians in Accra assumed that local beliefs would wither away as an increasingly literate population became aware of the capabilities of medicine, but even during the cocoa boom they had to compete to find patients willing to pay for their services. They were able to offer surgical interventions, which were sought after in a society where internal medicine was largely unknown and where there were few techniques for adequately dealing with traumatic injuries. And in the late 1920s and 1930s, quinine and arsenic injections were available to treat yaws and syphilis, but British-trained doctors did not yet have the capacity to fight bacterial or viral infections, leaving them with rather limited skills with which to distinguish themselves from the healing tools offered by African healers. This raises an inevitable question: if physicians did not have adequate healing techniques to be able to supersede established indigenous healing practices, how did they manage to compete, coexist and tolerate other healers? There are few sources available to answer this question, but one intriguing court case gives an instance of how the two worlds of healing managed to coexist in mutual tolerance.

In 1918, a teenaged girl named Olivia, the daughter of a wealthy African merchant, fell sick at her home in Accra. Over the course of her illness she was treated by two different practitioners. The first was a Dr. Dove, a Sierra Leonean born, British-trained physician who had moved to the Gold Coast to practice medicine in Accra.¹¹⁸ Dr. Dove diagnosed Olivia with tuberculosis. The second was Merry Brew, a herbalist and spiritualist

¹¹⁷ Patton, *Physicians, Colonial Racism*, 18.

¹¹⁸ Patton, *Physicians, Colonial Racism*, 156-7; *The Marcus Garvey and Universal Negro Improvement Association Papers*, 4 (Berkeley: University of California Press, 1985), 53, fn.1; The Dr. Dove mentioned in the trial was likely one of two brothers from Sierra Leone, Dr. Arthur Farrell Renner-Dove or Dr. Hollis Dove, who had moved to Accra sometime at the start of the century. Dr. Arthur Farrell Renner-Dove was appointed to the Gold Coast Medical Services in 1923.

who had married into the prominent Brew merchant family from Cape Coast.¹¹⁹ Merry Brew believed that Olivia was suffering from a witch's curse. When Olivia died one year later, the cause of death was officially registered as tuberculosis, but her story did not end there. The late Olivia became the center of a trial that forms a useful a case study for observing how physicians, healers, patients, and therapy management groups interacted in the city.

According to the testimony of Olivia's mother, Dodaye, Olivia died from a spiritual attack by Merry Brew. When she realized that her daughter had been cursed, Dodaye took Brew before the tribunal of the Ga *mantsemei* to accuse her of malpractice. There are no records from the Ga traditional court, but we do know that Brew counter-charged Dodaye with defamation through the colonial legal system. At the start of the proceedings, Dodaye was called before the magistrate to prove how Brew was responsible for Olivia's death. According to Dodaye, the family had first called Dr. Dove to their house to cure Olivia, but while the physician was attending to the patient, Merry Brew arrived at the house to inquire about Olivia's illness. When Dr. Dove left the room, Brew told Dodaye that Olivia's womb was being "eaten by witches,"¹²⁰ and that she had a remedy that could fight off the illness. Brew then left the house and the family discussed whether they should employ her. Though she was very sick, Olivia made it clear to her family that she wanted the services of Merry Brew, so Dodaye requested that Brew prepare a special consecrated healing draught comprised of pieces of Olivia's red menstrual cloth mixed with some other personal items,

¹¹⁹ The Brew family was prominent in the history of Anamaboe and Cape Coast. See Randy J. Sparks, *Where the Negroes Are Masters: An African Port in the Era of the Slave Trade* (Cambridge, Massachusetts: Harvard University Press, 2014).

¹²⁰ PRAAD SCT 2/4/69, "Merry Brew versus Doday," 17th May 1918 - 14th November 1919, October 10, 1919, 546.

burnt into a *ti*, and mixed with rum.¹²¹ The potion was supposed to cleanse Olivia's reproductive system, but when Olivia drank the concoction she became sicker than before.¹²² The treatment for witchcraft continued for a few more days but Olivia's health still did not improve. Then suddenly, Merry Brew left for Cape Coast, seemingly evading the consequences of the failing health of her patient. In a fit of anger, Olivia's mother cursed the name of Merry Brew around the neighbourhood.

When Brew returned to Accra, she found that Dodaye had challenged her reputation as a healer, and decided to take Dodaye to court for defamation. On the witness stand in the colonial court, Merry Brew told the court that she had a good reputation in Accra as a healer, and that she made her living on the substantial fees that she charged for her services (an average of £4 per day -- an excellent rate of pay for that time).¹²³ Her specialty was healing women's fertility problems, and she told the magistrate that before Olivia had been attended by Dr. Dove, she had treated the girl for a venereal disease, and then later helped her try to get pregnant. As the case progressed, it became clear that Olivia's family had followed a double healing strategy as a therapy management group. They brought in Dr. Dove to directly treat Olivia's illness, which was either a lung infection or venereal disease. But that they also believed that their daughter had been cursed by a "fetish" object that had been found in their house, which they believed had been planted there by an enemy of the

¹²¹ A 'shame cloth' is known as *bue* in Ga, and is traditionally worn during menstruation, a time when women who follow the taboos of the local shrines must observe taboos regarding their movement through religious sites and their contact with religious officials. This composite medicine is similar to forms of *ti* found in Accra today.

¹²² PRAAD SCT 2/4/69, "Merry Brew versus Doday," 17th May 1918 - 14th November 1919, October 10, 1919, 546.

¹²³ PRAAD SCT 2/4/69, "Merry Brew versus Doday," 17th May 1918 - 14th November 1919, October 10, 1919, 548.

family.¹²⁴ Olivia's parents sent the fetish to Merry Brew, who neutralised it with a concoction of *ti*, which she gave to Olivia. Brew claimed that her medicines had healed Olivia already, and that the girl's most recent illness was simply a cold that she had caught while travelling north of the city. On the strength of her defense, Merry Brew won her case of defamation against Dodoye.

The competing versions of this story indicate that dual scales for assessing the health of the patient operated simultaneously during the course of Olivia's illness. Dr. Dove had been treating Olivia's lung infection independently of the therapies of Merry Brew, but since the illness that killed Olivia was probably tuberculosis, Dr. Dove's treatments would have had little effect because there was no cure for the disease in 1919. For her part, Brew also seems to have avoided any direct contact with Dr. Dove. At one point during her healing sessions with Olivia, Brew actually told the girl to stop taking her concoction until she had completed Dr. Dove's treatment, possibly because she thought the two therapies would not mix well, or possibly because she wanted to avoid a conflict with a physician. As for Dr. Dove, we do not have any indication that he was aware of the alternative treatments, though he did meet Merry Brew at Olivia's house and might have suspected that she was treating the girl.¹²⁵ Even if he was aware that Olivia was being treated by an African healer, it would have been impolite to protest, as he would have wanted to keep Olivia's family as clients.

After the First World War, African physicians began to play a larger role as the bearers of European-derived healing techniques within the pluralistic healing culture of Accra. They found more opportunities in the colonial service and in private practice, had begun to build up a client base amongst African elites, and were sought after in particular for

¹²⁴ PRAAD SCT 2/4/69, "Merry Brew versus Dodoye," 17th May 1918 - 14th November 1919, October 10, 1919, 549.

their ability to deal with traumatic injuries and surgical needs. According to the current historiography of colonial medicine, it was at this point that European-derived medicine won the confidence of the African population. For instance, while Adell Patton notes that physicians had to compete with African healers in the 19th century, he does not continue this argument when discussing the 20th century, perpetuating an assumption that residents in the cities of West Africa began to patronize physicians exclusively.¹²⁶ But the case of Olivia demonstrates that, despite their increasing status, physicians could still end up competing with African healers. In a city where there was no regulatory body to oversee healers, physicians had to accept the fact that their patients might take advice from two or more healers, and that the therapies that the physician offered might not take priority over an African form of therapy. While African physicians might have expected that the practical benefits of medicine would supplant African healing methods, they were still few in number by comparison to the diversity of African healers, and they did not yet have cures for the major diseases that people in Accra continued to suffer from. As such, they simply could not claim exclusive rights to determine the health of their patients within the pluralistic healing culture of Accra.

Section 4. Christian Healing, Islamic Healing, and Patent Medicines (*blofa tsofa*).

The documentary record contains a wealth of material about therapies from Europe and indigenous medicinal practices, largely because those sources reflect the concerns of the colonizers. The documentation of colonial medical initiatives was essential in order to track their efficacy, but also was an important way of creating a body of knowledge about tropical

¹²⁵ PRAAD SCT 2/4/69, “Merry Brew versus Doday,” 17th May 1918 - 14th November 1919, October 10, 1919, 546.

¹²⁶ Patton, *Physicians, Colonial Racism*, 145.

diseases and African patients.¹²⁷ African therapies were documented by colonial officials too, either to preserve knowledge of the primitive origins of civilization, or to better understand how to establish systems of indirect rule that offered the least amount of disruption to African cultures.¹²⁸ A historian must dig through a much wider variety of sources to tell the story of other therapeutic options. For instance, there is almost no extant material to account for healing practices amongst Islamic communities in the city, though the Muslim population was a rapidly growing subsection of the urban population of Accra. The data is less sparse when it comes to Christian communities and faith-healing in West Africa, but there is little direct evidence to show the influence of these new churches in Accra. Much more information is available about the growth in the patent medicine market (which became known as “white man’s medicines,” or *blofa tsofa*) during the 1920s and 1930s but it comes from unconventional sources like print advertising and oral history. This section will continue the narrative of the growth of these three new therapeutic alternatives in Accra, as evidence of the dynamism of the pluralistic healing culture of the city.

By 1920, the Christian community of Accra was comprised almost exclusively of four major denominations: Roman Catholic, Methodist, Anglican and Presbyterian.¹²⁹ The largest of these was the Presbyterian Church, which had been granted the right to take over the Basel Mission from German authorities during the First World War, and had begun to expand out of Osu to build churches around the city. The Christian community was

¹²⁷ As Joel Howell has noted, meticulous record keeping at hospitals, especially of laboratory testing, increased dramatically in the first three decades of the 20th century. Joel Howard, *Technology in the Hospital: Transforming Patient Care in the 20th century* (Baltimore: Johns Hopkins University Press, 1995), 2, 225.

¹²⁸ Anna Grimshaw, “Visual Anthropology,” in Henrika Kuklick, ed. *A New History of Anthropology* (Oxford, UK: Blackwell, 2008), 298; Thomas Hylland Eriksen, Finn Sivert Nielsen, *A History of Anthropology: anthropology, culture, and society*, (London: Pluto Press, 2001), 56.

¹²⁹ Smith, *Presbyterian Church of Ghana*, 140-41.

growing gradually, but as far as we know, none of these churches incorporated faith-healing into their services. The conservative nature of the churches of Accra is surprising in contrast to revivalist movements happening in other parts of West Africa. In the colony of Nigeria, the Aladura (“praying people” in Yoruba) revivalist movement began in 1918, during the influenza epidemic when a group of Christian converts claimed to use the power of the Holy Spirit to protect people from the disease, and repudiated the use of European-derived medicines. Aladura churches did appear in Accra, but not until much later. The earliest Aladura church to arrive on the Gold Coast was the Faith Tabernacle of Nigeria, which appeared sometime in the early 1930s. The apostles of the Faith Tabernacle branch firmly believed in divine healing and their followers were divided when a group of congregants took quinine pills, in violation of the church’s prohibition against taking European medicines.¹³⁰ By 1938, the church had become the Christ’s Apostolic Church in Accra. Little is known about the activities of the parishioners this early anti-syncretic church, but ideas about health and healing were central to the understanding they had of their relationship with God. Other revivalist movements in the 1920s included William Wade Harris’s Twelve Apostolic Church, in the western part of the Gold Coast. The ideas of Harris did belatedly spread to Accra, but not until 1953 when a splinter group from the Methodist Church established a small branch of the Twelve Apostolic Church in the city.¹³¹ To the north, the prophet Samson Opong, who claimed to be able to read the bible from a stone that he carried with him, converted 10,000 people in the villages and towns of the

¹³⁰ Allan Anderson, *An Introduction to Pentecostalism: Global Charismatic Christianity* (Cambridge: Cambridge University Press, 2004), 117.

¹³¹ Acquah, *Accra Survey*, 148; Baeta, *Prophetism in Ghana*, 21; Gordon Haliburton, *The Prophet Harris: a Study of an African Prophet and his Mass-Movement in the Ivory Coast and the Gold Coast 1913-1915* (London, Longman, 1971), plate after page 202.

Ashanti region, but this movement also seems to have little impact in Accra.¹³² Though the idea that a Christian might abandon African healing practices for a religious community that healed through faith in the Holy Spirit was in the air amongst Christian congregations in Accra by the 1930s, there is little evidence to show that churches were attracting members with promises of faith-healing.

The amount of information about Islamic healing during the interwar period is also frustratingly thin. The majority of Muslims in Accra were labeled as so-called “Hausa” migrants,¹³³ but by the end of the 1930s, there were emerging Muslim enclaves in suburbs of Accra, including Adabraka, Tudu, Sabon Zongo, Fadama, Lagos Town, Nima, Kanda, Maamobi, Kotobabi, and other small communities leading all the way up the Odaw River to the market town of Madina.¹³⁴ Some of these communities were populated by new immigrant groups, such as the Sisala migrants from the Northern regions of the Gold Coast in Maamobi, or the Zabarima migrants from Niger living in Tudu.¹³⁵ Unfortunately, we know little about the healing practices in these enclaves because no ethnographic work has been done on the subject of healing and no extant documents remain. However, there is some colonial medical documentation relating to the diseases that these Muslim migrants suffered from because researchers brought them into the Accra Laboratory in order to extract samples from them for the creation of vaccines for Yellow Fever and Relapsing Fever. For instance, a Muslim man who suffered from Yellow Fever, known only as “Asibi” to British medical researchers, had his name given to a particular strain of the disease

¹³² Kofi Asare Opuku, “A Brief History of Independent Church Movements in Ghana since 1862,” in *The Rise of Independent Churches in Ghana* (Accra: Asempa Publishers, 1990), 17; Gerald H. Anderson, *Biographical Dictionary of Christian Missions* (Grand Rapids, MI: W.B. Eerdmans, 1999.), 506-7.

¹³³ Percy Selwyn-Clarke, G.E.H Le Fanu, and A. Ingram, “Relapsing Fever in the Gold Coast,” *Annals of Tropical Medicine and Parasitology*, 17, no. 3 (1923), 390.

¹³⁴ Mumuni, “Islamic Non-Governmental Organizations,” 139.

isolated by Hideyo Noguchi in 1927,¹³⁶ and in 1931, a strain of Relapsing Fever spirochetes was taken from a patient at Korle Bu Hospital named only as “Aliferi.”¹³⁷ But the medical literature treats them only as research subjects, leaving us with only their first names and almost no details about their Islamic healing cultures. There is only one mention of Islamic devices used to protect against illness -- while delousing patients infected with relapsing fever Drs. Selwyn-Clarke, Le Fanu, and Ingram noted that amulets were “carried in great numbers by Hausas and Northern Territory tribesmen.”¹³⁸ Though we can assume that the Hausa *wanzamai*, Yoruba *alufa*, and other Islamic healers were practicing in these communities, there is simply not enough data to describe the emerging and changing Muslim healing cultures of the city, which is much better documented in the 1950s (covered in chapter 7).

By contrast, patent medicines are prominent in the historical record because they were globally-branded commodities with bold print advertising campaigns that made up a majority of the advertising images in Gold Coast newspapers. They were also distinctly new category of imported goods that helped generate a consumer society in the Gold Coast Colony. In the 1920s, firms like the United Africa Company imported bicycles, cars, cloth, gin, toiletries, margarine, and many other goods into the city,¹³⁹ and increasingly, Accra became a zone of display for foreign goods.¹⁴⁰ Patent medicines, which took on the Ga name of *blofo tsofa*,

¹³⁵ Scott, *Epidemic Disease in Ghana*, 128.

¹³⁶ Scott, *Epidemic Disease in Ghana*, 32-33.

¹³⁷ Helen Russell, “Experimental Relapsing Fever, Accra, 1931,” *West African Medical Journal* 6 (1933), 36.

¹³⁸ Selwyn-Clarke et. al., “Relapsing Fever,” 425.

¹³⁹ Prais, *Imperial Travelers*, 141-43; van den Bersselaar, *King of Drinks*, 215.

¹⁴⁰ Timothy Dwight deWaal Malefyt and Brian Moeran, *Advertising Cultures* (Berg Publishers, 2003), 41; Richards comments that the discourse of colonization produced by explorers like Henry Morton Stanley conceived of Africans in terms of their relationships to exports and imports. Thomas Richards, *The Commodity Culture of Victorian England: Advertising and Spectacle, 1851-1914* (Stanford: Stanford University Press, 1990), 123.

were also a popular import.¹⁴¹ The value of drugs and medicines imported into the Gold Coast Colony grew exponentially, from £3,083 in 1891, to £142,115 in 1920, an increase over 600% in just 30 years.¹⁴² On the supply side, the number of manufactured goods in the city was increasing due to increased contact with the markets of the United States (a side effect of the First World War)¹⁴³ and the mass production of goods in Europe and America. As a result, patent medicines were no longer rare items brought to the city in the medicine chests of European travelers -- by the 1920s, they were sold in major European-owned department stores, like Swanzy's, Kingsway, Ollivants and the United African Company stores,¹⁴⁴ in dozens of small chemist shops along the Horse Road and High Street,¹⁴⁵ and by women in Selwyn Market.¹⁴⁶ Moreover, there were no restrictions on the importation of proprietary medicines, likely because they offered a source of tariff revenue for the colonial government.

On the demand side, it is a little more difficult to pinpoint why patent medicines became so ubiquitous in Accra. In the United Kingdom, the popularity of patent medicines had begun to wane after British Medical Association launched their "secret remedies" campaign in the 1910s, which questioned the medicinal value of proprietary medicines and revealed that they contained highly addictive compounds.¹⁴⁷ On the Gold Coast, medical authorities

¹⁴¹ Senah, *Money Be Man*, 120.

¹⁴² *Gold Coast Colony Blue Books* (Accra, Ghana: Government Printer, 1891, 1920).

¹⁴³ Sir Charles Lucas, *The Gold Coast and the War* (London: Oxford University Press, 1920), 28.

¹⁴⁴ Macmillan, *Red Book of West Africa*, 173. These shops, as sites of fashion and social distinction, are mentioned in Mabel Dove's column "Women's Corner" of the *Times of West Africa* newspaper. Newell & Gadzekpo *Pioneer West African Feminist*, 20 & fn 16.

¹⁴⁵ In the 1931 census, for example, there were a recorded 83 "druggists" in the Eastern Province, (which included Accra), Cardinall, *Gold Coast*, 173.

¹⁴⁶ van den Bersselaar, *King of Drinks*, 215.

¹⁴⁷ British Medical Association, *Secret Remedies, What They Cost and What They Contain* (London, 1910); British Medical Association, *More Secret Remedies: What They Cost & What They Contain* (London, 1912); Arthur J. Cramp, *Nostrums and Quackery: Articles on the Nostrum Evil and Quackery*, 2nd ed. (American Medical Association Press, 1921); Lori Loeb, "Doctors and

also expressed concern about the consumption of patent medicines, which they saw as an impediment to inculcating the population of the city with the virtues of sanitation. This official attitude was expressed by Dr. Nanka-Bruce, who publicly derided the “pernicious custom of buying patent medicines,” claiming that self-medicating with proprietary medicines distracted from the larger efforts to sanitize the city.¹⁴⁸ Margaret Field also commented on the presence of patent medicines in the city, claiming that gullible Africans were falling prey to patent medicine vendors, who violated the “ancient ethics” of authentic Ga healing.¹⁴⁹ But despite an official air of contempt for patent medicines, *blofo tsofa* were still emerging as a distinct therapeutic option outside of colonial and African circles of healing power.

It is difficult to trace consumption patterns of patent medicines precisely, but the visibility of specific medicinal products in newspapers and recollections of specific brands in the memories of people living in Accra today indicate that patent medicines were widely consumed. As imported products, they arrived with their own unique healing properties and medicinal meanings, which were presented to the reading public via advertisements in newspapers and by their labels. The emergence of what Karin Barber has called a “stratum of literates” (a new class of literate government and commercial employees that developed in Accra in the first half of the 20th century) meant that there were hundreds, perhaps thousands, of residents in the city would have been able to read the advertising copy and labels of patent medicines and understand their purported medicinal properties¹⁵⁰ However,

Patent Medicines in Modern Britain: Professionalism and Consumerism,” *Albion: A Quarterly Journal Concerned with British Studies*, 33, no. 3 (Autumn, 2001), 411.

¹⁴⁸ *Gold Coast Independent*, November 6, 1926, 1357.

¹⁴⁹ Field, *Religion and Medicine of the Gã People*, 133.

¹⁵⁰ Barber, *Africa's Hidden Histories*, 8. For more information on literacy rates, see T. David Williams, “Sir Gordon Guggisberg and Educational Reform in the Gold Coast, 1919-1927,”

as the oral histories of some of these products will demonstrate, patterns of literacy did not directly correlate with patterns of consumption, as some of these medicines were inscribed with new meanings as they were localized and worked into the healing culture of Accra. As Arjun Appadurai has argued, commodities have a “social life,” that allows them to move between “regimes of value.”¹⁵¹ This suggests that goods like patent medicines, though created for the purpose of healing specific ailments, were able to change their meanings as they moved from one cultural milieu to another. In the case of Accra, the meanings of patent medicines changed as they traveled from the colonial metropole (where they were understood as dubious popular nostrums to be consumed outside of the purview of physicians) to the urban quarters of Accra (where their healing virtues were reconfigured according to Ga concepts of disease aetiology). As their properties were discussed and debated in the markets and neighborhoods of Accra, patent medicines took on new significances as cures for ailments considered important to the residents of the city. To better understand how patent medicines filled this unique therapeutic role, we will look at print ads and oral histories of three of the most popular medicines in Accra during the cocoa boom: Atwood Bitters, Sloan’s Liniment and Woodward’s Gripe Water.

Atwood’s Vegetable Physical Laxative Bitters, a combination of herbs and roots in a tincture of alcohol, was invented by Moses Atwood in Georgetown, Massachusetts in 1840. It was originally formulated as a cure-all for intestinal disorders under the name Atwood’s Quinine Tonic Bitters, but the product was so successful that Atwood patented the formula and began to sell it in the USA. In 1877, the license was transferred to the Manhattan Medicine Company, which sold the product under the name of Atwood’s Physical Jaundice

Comparative Education Review 8, no. 3 (December, 1964), 305; Fred Agyemang, *Century With Boys: The Story of Middle Boarding Schools in Ghana, 1867-1967* (Accra: Waterville, 1967), 92

Bitters until well into the 20th century.¹⁵² Today the license is held by JRB Enterprises Limited, a British company that wholesales patent medicines to Africa and India, where Atwood's Bitters is still popular. It is still a widely recognised brand name and label in Accra, and remains available in many of the city's chemist shops and pharmacies. Though expensive (triple the price of locally produced herbal laxatives), it continues to sell well because it has a local reputation as both a strong laxative and as a fertility medicine.

Memories of the past use of Atwood's Bitters continue to linger in the minds of the 21st century inhabitants of Accra. Interview evidence shows that Atwood's had a reputation of having medicinal powers beyond its advertised effects. Though it is still used as a laxative (and is considered stronger medicine than remedies made with herbs like *nyanyara*, a herb

¹⁵¹ Arjun Appadurai, *Social Life of Things* (Cambridge: Cambridge University Press, 1986) 21, 50.

¹⁵² *U.S. Supreme Court*, "Manhattan Medicine co. versus Wood," US. 218 (1883), 108.

Is Constipation making you Weak & Ill?

For clear head new life

Take

ATWOOD'S
Jaundice Bitters
for Stomach, Liver
and Bowels

Obtainable at all Chemists and Stores.
Sole Proprietors:
THE MANHATTAN MEDICINE COMPANY,
NEW YORK.

CAUTION: Beware of fraudulent Bitters. See that this picture of John F. Henry covers the cork of the bottle and that the Manhattan Medicine Company's name is on the label.

Figure 4.2. Atwood's Bitters. The face of a constipated man (with features Africanized to appeal to the colonial market) dominates this advertisement. This was the first ad to appear in Gold Coast newspapers that targeted an African audience, though it is unknown which artist or advertising company devised the images. Also evident in this advertisement is the proliferation of copycat purgatives taking advantage of the brand recognition that Atwood's had around the English-speaking world. *Source: Gold Coast Times, June 8th, 1929.*

traditionally used for constipation),¹⁵³ many people in the city today know of Atwood's as a fertility nostrum that helps women become pregnant.¹⁵⁴ This may (indirectly) have something to do with the alcohol content of the product (which ranges from 15 to 16 percent), but it is more likely because of its similarity to locally manufactured medicines. In Accra there were many strong herbal drinks (usually prepared with rum or gin) known to heal the womb after pregnancy and to generally increase fecundity. The contents of Atwood's fit squarely into this category, and its link to fertility is an example of an early form of 'glocalization', a situation where a patent medicine, invented in the USA, licensed in the UK, and sold around the world, was imbued with new meanings within the locale of Accra.¹⁵⁵

Sloan's Liniment is a similar example. In the 1920s, there were a number of patented emollients available in the shops of Accra, but the most widely advertised product was Sloan's Liniment. Invented by Earl Sawyer Sloan of Missouri, the liniment was originally a salve used to help horses recover from injuries, but it became popular in the USA and Europe for the aches and pains of arthritis and rheumatism.¹⁵⁶ James Michael Davidson has noted that Sloan's Liniment appeared in an American context as an object left on burial mounds by African-Americans in Texas – the reasons why are unknown, but as a global medicine, the liniment seems to have taken on different forms of significance in differing

¹⁵³ Locally produced laxatives can be made from *nyanyara* and other herbs for less than a dollar (depending on the availability of the herbs). Interview, Ankroh Ansa, June 21, 2007.

¹⁵⁴ Interview, Hannah Ofusu, June 20, 2006; Interview, Ama Wiafe, June 20, 2006.

¹⁵⁵ Glocalization is a term derived from business jargon of the 1990s, and was later popularized by sociologists Roland Robertson, Keith Hampton, and Barry Wellman. Barry Wellman, "Little Boxes, Glocalization, and Networked Individualism," in *Digital Cities II*, ed. Makoto Tanabe, Peter van den Besselaar and Toru Ishida (Berlin: Springer-Verlag, 2002), 11-25; Barry Wellman and Keith Hampton, "Living Networked On and Offline," *Contemporary Sociology* 28, 6, (November, 1999), 648-54.

Make sure you ask for Sloan's
Liniment-apply it to the part
affected by rheumatism-
then - pains and

ACHES ended!

You cannot get anything better
for your muscular pains than Sloan's
Liniment. Simply apply it lightly
—don't rub—and relief is quick
and certain.

Distributors for West Africa:
Fossett & Johnson Ltd., 86 Clerkenwell Road,
London, E.C.1.

**SLOAN'S
LINIMENT**

Look for the picture of
Dr. Sloan on the packet

Figure 4.3. Sloan's Liniment. Sloan's was intended for use to relieve muscle pain, but it was used in a variety of other ways in Accra. The bold image of the face of the inventor distinguished the product from other liniments, making it recognizable to illiterate consumers. The advertisement also makes explicit reference to West Africa, though it may have been adapted from an advertisement used for other markets. *Source: Gold Coast Observer, September 12, 1947, 238.*

¹⁵⁶ James Michael Davidson, *Mediating Race and Class through the Death Experience: Power Relations and Resistance Strategies of an African-American Community, Dallas, Texas (1869-1907)*. Doctoral dissertation, University of Texas at Austin, 2004.

locales. On the Gold Coast, Sloan's was the most widely advertised liniment and had a ready market in a place where skin creams were commonly used to prevent chapping during the dry season. Sloan's garnered the nickname "old man" (said in Ga as *numo* or Twi as *akwakoraa*) because of the image of the moustachioed Dr. Sloan on the label, and the liniment was known for its ability to penetrate the skin to quicken the setting of broken bones.¹⁵⁷ But it was not only used externally. Sloan's was also diluted in water, mixed with herbs and taken internally as a "blood tonic."¹⁵⁸ It could be used for people with broken bones, but it was also used to help mothers to "heal the sores in the womb" after childbirth.¹⁵⁹ In other cases it was diluted in warm water for use as a vaginal douche or an enema.¹⁶⁰ Like Atwood Bitters, many people in Accra disconnected Sloan's Liniment from its European meanings and gave it a new use in dealing with the health concerns of people living in Accra.¹⁶¹

Another medicine that sold well in the city in the early 20th century was Woodward's Gripe Water, a tonic for babies with colic. Formulated by William Woodward of Stamford, Lincolnshire in 1851, Woodward's Gripe Water was a tincture of four to nine percent alcohol combined with sucrose, dill seed oil, and bicarbonate included to sooth a baby's stomach.¹⁶² Woodward sold his medicine to the public in small quantities and to the

¹⁵⁷ Interview, Sister Mary, June 13, 2006; Dmitri van den Bersselaar has shown how gin brands became indigenised with truncated names that represented images on the labels, like "bird" and "money" gin. European marketers were aware of these local namings, and flooded the market with similar looking products to take advantage of prior brand recognitions, van den Bersselaar, *King of Drinks*, 11-53.

¹⁵⁸ Interview, Hannah Ofusu, June 11, 2006.

¹⁵⁹ Interview, Felicia Lamptey, June 10, 2006.

¹⁶⁰ Interview, Augustina Quaye, June 20, 2006; Interview, Ama Wiafe, June 20, 2006.

¹⁶¹ Kojo Senah records Sloan's Liniment as one of the commonly used medical antiseptics in Bortianor in the 1990s. Senah, *Money Be Man*, 120, 124.

¹⁶² Ivan Blumenthal, "The Gripe Water Story," *Journal of the Royal Society of Medicine* 93 (April 1-2, 2000), 172-73; Thomas Hawkes Tanner, *An Index of Diseases and Their Treatment*, 3rd ed



Figure 4.4. Woodward's Gripe Water. Woodward's was branded as a protector of the children of the British Empire, and this advertisement claims that it was available not only at chemists, but also in "Bazars", indicating that the producers envisioned the product to be available in marketplaces in cities like Accra. The image of baby Hercules strangling two serpents is taken from a 1786 oil painting by Joshua Reynolds and is reminiscent of the icon of the medical profession, the staff of Aesculapius, an image that alludes to the story of two snakes, one bringing poison and another bearing the remedy for poison. The intentions of the advertisers are not known, but it is possible that the image was used to associate Woodward's Gripe Water with ancient curative powers. Though the advertising for Woodward's Gripe Water was never localized for the African Market, the brand is still sold in stores in Accra today. *Source: Gold Coast Times*, November 9th, 1929.

(London: Henry Renshaw, 1883), 155; J. Dobson, "Malaria in England: a Geographical and Historical Perspective," *Parassitologia* 36, no. 1-2 (August, 1994), 35-60.

children's wards of hospitals by the gallon, and registered his trademark in 1876. In the late 19th century, the medicine started to travel around the world in the luggage of the wives of British servicemen in the colonies, and Woodward advertised his product as a medicine for all children of the British Empire. One advertisement showed images of cavalry and battleships, branding the gripe water as a "protector" of infants around the Empire¹⁶³ Though Woodward probably envisioned his Gripe Water as a protector of English babies, it was widely accepted by mothers in Accra as a purgative for babies and a pacifier for colic. Moreover, it was an expression of conspicuous consumption, and a way of participating in a newly developing commodity culture associated with mothering. But unlike Atwood's and Sloan's, its meaning never changed, indicating that its use did not need to be localized to have meaning in Accra as a device of healing. Woodward's worked in Accra as it did around the rest of the British Empire: as a medicine to soothe colic.

Advertisements for Atwood's Bitters, Sloan's Liniment, and Woodward's Gripe Water were published again and again throughout the first half of the 20th century, with little alteration. As oral evidence shows, these products gained traction in the West African market, meriting continued advertising, but these advertisements, with the exception of one ad for Atwood's Bitters, were actually crafted for the intended target of white colonial officials, miners, merchants and missionaries living around the empire. For the most part, the newspapers simply ran the same advertisements that were used in the UK or the USA, without any attempt to appeal directly to the West African market. Considering the growth of the African market for patent medicines and other consumer goods, it is odd that no advertising campaigns were developed to directly target African consumers. There are two

¹⁶³ Blumenthal, "The Gripe Water Story," 173.

reasons we can suggest to explain this. The first is that patent medicine companies advertised to distinguish their products from copycat medicines produced in Europe and the USA, not from West African products. During the same time period in India, locally manufactured bottled nostrums did challenge the dominance of patent medicines, so importers were obliged to use local languages and imagery to indigenize their products.¹⁶⁴ For example, in order to compete with Indian products like Babuline Gripe Water, advertisers of Woodward's Gripe Water used Hindu images of gods like Krishna to embed their commodities within a local network of symbols. But in Accra there were no local manufacturers of patented medicines, and therefore no justification to increase advertising budgets. The second reason is that the two major spoken languages in Accra, Ga and Twi, were not significant written languages at the time. The literature in Ga and Twi was miniscule by comparison to English, which was the language of instruction in schools. While in Uganda, some advertisements contained copy translated into Luganda, (as in the case of Zam Buk ointment and Dr. Ross's Vermifuge) in order to market directly to Ugandan consumers,¹⁶⁵ advertising in a local language in Accra would not have been the best way to connect to the target market in Accra.

Even though advertisers did not substantially alter their print campaigns to target West Africans, the residents of Accra still learned about, distributed, and consumed these products. We can suggest several reasons for their adoption. The first would be that, despite their dubious reputation in the UK, some patent medicines did have genuine value as palliative treatments for things like stomach problems, baby colic, or sore limbs, conditions

¹⁶⁴ Kajri Jain, "New Visual Technologies in the Bazaar: Reterritorialisation of the Sacred in Popular Print Culture," in *Sarai Reader (2003): Shaping Technologies*, ed. Jeebesh Bagchi, Monica Narula, Shuddhabrata Sengupta, Geert Lovink, Marleen Stikker (Sarai Media Lab, Autonomedia), 49.

suffered by people everywhere around the world.¹⁶⁶ Secondly, they were relatively affordable. While some patent medicines may have been more expensive than local herbal remedies, they were more affordable than complicated rituals offered by African healers, and much cheaper than the fees for visiting a local physician.¹⁶⁷ A third reason why the residents of Accra bought patent medicines was because it offered them the chance to self-medicate privately, an option that would have been invaluable to sufferers of venereal disease, for example. This assertion is congruent with the late 20th century work of anthropologists van der Geest and Whyte, who found that patent medicines allowed patients to disengage with their “social entanglements” and discretely deal with personal medical problems.¹⁶⁸ A fourth reason might be that, for less-private ailments, a patient could make it clear to their friends, family and associates that they were taking patent medicines, thereby publicly associating themselves with aspirational consumption patterns of Europeans and African colonial elites. As Raymond Dumett has shown, the cocoa boom resulted in an “ever-increasing” amount of luxury goods pouring into the city, including “tobacco, perfumes, silks, patent medicines, and jewelry.”¹⁶⁹ It is clear that by the 1920s, patent medicines had become more than just

¹⁶⁵ *Matalisi* (The Messenger) (December 14, 1924), 10; *Ebifa Mu Uganda* (News from Uganda) (September, 1937), frontispiece.

¹⁶⁶ Wilbert M. Gesler, “Illness and Health Practitioner Use in Calabar, Nigeria,” *Social Science and Medicine* 13D, no. 1 (1979), 27.

¹⁶⁷ Gesler, “Illness and Health Practitioner Use,” 29; Senah, *Money Be Man*, 160. Senah also notes that store-bought medicines usually have longer shelf lives than the average local herbal remedy.

¹⁶⁸ Sjaak van der Geest & Susan Reynolds Whyte, “The Charm of Medicines: Metaphors and Metonyms,” *Medical Anthropology Quarterly* 3, no. 4 (December, 1989), 345.

¹⁶⁹ Raymond E. Dumett, “The Social Impact of the European Liquor Trade on the Akan of Ghana (Gold Coast and Asante), 1875-1910,” *Journal of Interdisciplinary History*, 5, no. 1 (Summer, 1974), 94.

devices of healing – they were also markers of distinction that allowed for the fashioning and refashioning of a medical self.¹⁷⁰

All of these factors contributed to the growth of the patent medicine market in Accra, but the most compelling reason why patent medicines were popular is that they fitted easily into the pluralistic healing culture of the city. Because they were detached from a professional administrator, the meanings of patent medicines were easily amenable to local needs and could be taken while a patient also sought out therapies from healers from African or European traditions. These findings contrast some recent literature that has tended to emphasize how imported goods foisted consumer identities upon colonial subjects in the colonies. According to Meghan Vaughn, the language of medical advertising recreated colonial subjects as consumers with “modern bodies” that suffered from incurable illnesses (such as overwork, exhaustion, neuralgia, and general debility).¹⁷¹ In order to cope with such maladies, colonial subjects were obliged to use imported medicines, the only medicine that could cure them.¹⁷² Similarly, Thomas Richards has claimed that patent medicines were “radically transitive remedies”¹⁷³ that generated an archetype of the colonial patient as self-healer,¹⁷⁴ which in turn created an addiction to identity-generating capacity of advertising.¹⁷⁵ While advertising did shape notions of health in the colonies for some people, the messages promulgated by advertisers did not always determine how the medicines were used. As the oral histories of these patent medicines show, consumers in Accra sometimes used imported

¹⁷⁰ Benjamin Orlove and Arnold J. Bauer, “Giving Importance to Imports,” in Benjamin Orlove, ed., *The Allure of the Foreign: Imported Goods in Postcolonial Latin America* (Ann Arbor: University of Michigan Press, 1997), 18.

¹⁷¹ These terms are taken from an advertisement for Hall’s Tonic Wine. *Gold Coast Independent*, Saturday, July 1st, 1922.

¹⁷² Vaughn, *Curing Their Ills*;, 11.

¹⁷³ Richards, *Commodity Culture of Victorian England*, 195.

¹⁷⁴ Richards, *Commodity Culture of Victorian England*, 195.

¹⁷⁵ Richards, *Commodity Culture of Victorian England*, 202-03.

goods according to their specific cultural needs, in ways never intended by their producers.¹⁷⁶ This was not misplaced credulity, but part of a pattern of localization that prioritized concerns like reproductive and spiritual health, and that sustained pluralism in the city rather than allowing for imported medicines to displace local systems of healing knowledge.

Conclusion

The era of the cocoa boom has been understood by historians of medicine in the Gold Coast as a time of medical progress that benefitted both colonizers and the colonized. This chapter has shown that European-derived healing practices did, in fact, offer some health advantages to the urban population in the city, in the form of surgery, arsenic injections for yaws and other illness, and via a number of sanitary reforms. The provision of clean water from the Densu River, for instance, brought people fresh water that eliminated the scourge of Guinea worm from the city. But the imperial mantra of public health also allowed colonial officials to intrude in the daily lives of the residents of the city. Sanitary inspectors, especially the infamous “mosquito brigades,” brought the colonial medical regime in contact with men, women and children in homes previously off limits to colonial officials. And many patients in the city found themselves drawn into a text-based colonial medical system through their contact with physicians, doctors, police, judges, and sanitary inspectors, and at major institutions like the colonial hospital.

However, the power of the colonial medical state, though enhanced in the 1920s, was still relatively limited in its reach. While discourses about the differences between white and black bodies justified the segregation and control of African populations in Southern

¹⁷⁶ As William O’Barr has noted, the consumer of an advertised product may “miss the point,” but they will usually draw something out of advertising that assists them in

and East Africa, the Gold Coast Medical Department abandoned efforts to segregate the city along racial lines, and their efforts at sanitation were largely conducted on the periphery of the old quarters of the city. Most of the African residents of Accra continued to see colonial medicine as an expression of colonial power, and as such expressed their resentment at the incursions of the mosquito brigades, resisted the overtures of the Town Council, and criticized efforts of the Public Health Branch as insensitive and unfair.

The British-trained African doctors of Accra, on the other hand, were more influential in establishing European-derived healing methods as a therapeutic option in the city. The physicians who (following the lead of the trailblazer Dr. Quartey-Papafio) set up private practices in the city were especially important for the elite families in the city, who patronized African physicians as a way of situating themselves within the elite circles of colonial society. Even though physicians still had little to offer in the way of therapies for the major illnesses of the city except for surgery and arsenic injections, they were able to develop an affinity with their patients that racist, transient, and often incompetent white doctors had failed to do. But like the activities of the sanitary inspectors, the impact of African physicians also had its limits. They were few in number, and even when they began to build a client base in the city, they still faced competition from African healers. A good example of this is the case of Olivia, who was attended by both a physician and an African healer.

But the most important point to be made is that the expansion of medicine during the interwar period is only one strand of a larger, plural storyline. Other therapeutic alternatives continued to serve the expanding population of the city irrespective of the growth of the Medical Department, and even with the presence of British-trained African

understanding and practically applying a product (William M. O'Barr, *Culture and the Ad:*

physicians. Margaret Field argued that the residents of Accra continued to follow African healing traditions that she labelled as Ga, but the subtext of her work indicates that the Ga tradition of healing had already incorporated ideas from other ethnic groups. Though we have little data on the use of faith-healing within Christian churches, or the use of Islamic medicines, we can conjecture that these avenues of therapy were also available to a minority of patients in the city who were part of these religious communities. And perhaps even more significant than colonial medicine during the 1920s was of the expansion of the patent medicines market, which patients used as medicaments for bodily illnesses without necessarily seeking the healing advice of physicians or African practitioners. Though they were derived from European sources, the meanings and uses of patent medicines sometimes changed within the competitive healing marketplace of Accra, a place where people continued to tolerate the coexistence of different ideas about health, continued to hope from one practitioner to the other, and mix and match herbal remedies and medicines.

Chapter 5. Colonial Medical Culture in the Suburb of Korle Bu: the Gold Coast Hospital, 1923-1945.

While the Gold Coast Medical Department struggled to restructure the sanitary infrastructure of Accra, facing resistance from the residents of the African quarters of town and criticism from African elites, a distinct medical culture began to emerge on the west side of the city. In 1923, the colonial government selected an open piece of land on a hill sloping towards the Korle Lagoon as the site for a new, modern, medical institution. The construction of the Gold Coast Hospital (which became known locally simply as “Korle Bu”) decentred medical practice in the city by operating outside of circles of African political and religious power and away from white preserve of Victoriaborg. The Gold Coast Hospital was built specifically to treat the illnesses suffered by the African subjects of the Gold Coast, with the stated goal of ameliorating the health of the colonial subjects and increasing the population of the colony. However, it soon became the site of a burgeoning medical subculture, funded and supported by progressive governors and medical officers, but propagated largely by African physicians, nurses and technicians who acquired medical skills and went further to immerse themselves the culture of the medical professions.

Historians of medicine in Ghana deem the construction of the Gold Coast Hospital a major turning point for colonial medicine. Stephen Addae positions it as the manifestation of decades of planning to build a “great African Hospital” to combat the diseases of the tropics.¹ Patterson notes that the Gold Coast Hospital became a linchpin for a colony-wide hospital network, allowing for the training of doctors, nurses and dispensers who would later

¹ Addae, *Evolution of Modern Medicine*, 68. Governor Clifford, in collaboration with Dr. C.V. Le Fanu, commissioned a set of blueprints for the institution in 1917, but Governor Guggisberg finally turned the blueprints for the into bricks and mortar in 1924 and his name has been associated with the institution ever since.

be dispatched around West Africa.² Scott adds to the story by showing how the expansion of the laboratory at new hospital facilitated research on epidemic disease, including Hideyo Noguchi's use of patients at the hospital to isolate the Asibi yellow fever strain in 1927.³ Writing their histories of medicine based on colonial records, these authors show how the Gold Coast Hospital became "the focal point of medical activity in the country."⁴ What these historians have assumed is that the efficacy of European-derived medical practices drew patients to the hospital, as part of a natural *telos* of medical progress.

Positioning the Gold Coast Hospital, or Korle Bu, as the culmination of years of colonial medical progress is understandable considering that the historiography of the institution is dominated by former physicians and due to the fact that colonial medical documents show strong evidence of the diversification of colonial medical practices at the Gold Coast Hospital. Without question, Korle Bu figures prominently in the history of medicine in the Gold Coast and Ghana, but this chapter will challenge the received story of the birth of a great African institution by delinking the hospital from a narrative of medical evolution and by focussing instead on how a colonial medical subculture developed on the hospital campus. What it will argue is that the success of Korle Bu must be understood as the outcome of a variety of complex factors, including new therapies that drew patients to the hospital with the promise of health, manifestations of biopower that coerced patients through colonial channels toward the hospital campus, and the appropriation of medical professions by the aspirant classes of Accra. In fact, the story of the early years at Korle Bu, in many respects, is a story unto itself -- the development of an urban medical enclave on the

² Patterson, *Health in Colonial Ghana*, 16-17.

³ Scott, *Epidemic Disease in Ghana*, 32-63.

⁴ Addae, *Evolution of Modern Medicine*, 68.

periphery of Accra, distanced from the realities of pluralistic healing that continued in the city centre.

This chapter has four sections. The first section will offer some qualifications to claims that the success of Korle Bu was due to its ability to deliver efficacious European-derived healing practices to the colonial subjects of the Gold Coast by looking at how patient demand was generated at the hospital. While the new Gold Coast Hospital, guided by the vision of Governor Guggisberg, did offer distinct curative value in its remedies for maladies such as yaws, venereal diseases, and malaria, patients were more reluctant to submit to surgery and other procedures. Moreover, demand for its services were the same as the demand for equivalent services around the Gold Coast and West Africa. Additionally, its success as a centre for research and training must also be qualified, as the laboratory faced major budget limitations and the dream of transforming the facility into a medical school did not come to fruition during the colonial era. It concludes by stating that the achievements of physicians at Korle Bu during the interwar period were more modest than the historiography of the period will admit.

The second section argues that Korle Bu represented the continuing expansion of biopower, which, on the hospital campus, transformed colonial subjects into medical subjects. Based on recorded memories of former employees at Korle Bu found in *Golden Jubilee Souvenir (1973)*, a booklet published to mark the 50th anniversary of the institution, this section will show how Korle Bu reflected modernist ambitions to homogenize human bodies in a way that would allow experts to monitor diseases as they moved through aggregations of in-patients.⁵ The built environment of the hospital campus was designed to assert control over patients: separating them from their therapy management groups,

⁵ Foucault, *Birth of the Clinic*, 111.

controlling their movement through the building, aggregating them together with other patients, and placing them under the gaze of physicians, nurses and technicians.

The third section will use the same oral histories found in the *Golden Jubilee Souvenir* to show how, for the sons and daughters of the elite and educated classes of the city, the new institution of the Gold Coast Hospital, provided a means of achieving professional expertise and upward mobility. To a new cadre of African workers at Korle Bu, the hospital campus was a space where they could mingle with colonial elites in a way that they could never do outside the hospital. Korle Bu opened up new avenues of distinction with which one could define individual and social status in Accra, and despite a well-established colour bar to advancement in the institution. Conversely, the hospital campus became a location where the indignities of racism and exclusion were experienced, resented, and remembered as a rite of passage for people joining the medical professions.

The fourth section focuses on the most successful aspect of European-derived medical practices at Korle Bu, maternity services. Due to the conjunction of two historical circumstances, the first being the suppression of the shrine associated with fertility and childbirth and the second being the rise of the maternal sciences within European-derived healing practices, mothers in Accra began to adopt a new form of parenting known as “mothercraft.”⁶ The practices of mothercraft employed literate forms of knowledge about child rearing and included the consumption of commodities deemed to be healthy by colonial medical officials. This component of colonial medicine changed the way that women determined states of health in the city, in particular, the states of health of children. One notable agent in the cultural transformation of maternal and infant care was Cicely Williams, a doctor best known for giving the name *kwashiorkor* to a prominent nutritional

⁶ Ana Davin, “Imperialism and Motherhood,” *History Workshop*, 5 (1978), 38-39.

deficiency in the city. During her term at Korle Bu she practiced a form of medical transculturation that allowed her to understand the cultural roots of malnutrition and bridge the linguistic gaps between the patients and doctors at Korle Bu. However, her tenure was cut short when she rebelled against the patriarchal system established at Korle Bu. Nonetheless, mothercraft had found a niche within the healing culture of the city of Accra, demonstrating the strength of colonial medicine in particular circumstances.

Section 1. Korle Bu and Governor Guggisberg's Vision of Paternal Biomedicine

“Awole Gorgi, Gorgi No. 1 Hossey”
“All Hail Georgie, Georgie, Number One Horsey!”⁷

On October 9th, 1923, Governor Gordon Guggisberg took the podium at the inauguration ceremony of the new Gold Coast Hospital. In the background a brass band played “*Awole Gorgi*” - a popular lyrical tribute to the paternalistic charisma of the governor. He stood before the newly constructed in-patient ward, and gave a speech to white colonial officials, British-trained African doctors, the Ga chiefs, and other chiefs from around the colony.⁸ On that day in October, the Gold Coast had a population estimated at 2.3 million, and Accra was a city of around 44,000, including about 3,000 Europeans.⁹ The population was growing, but the colony still had a statistically high infant mortality rate¹⁰ and the British feared that the labour force was not growing fast enough to keep up with the booming

⁷ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 97.

⁸ ADM 11/1/850, “Letter from the Acting Secretary for Native Affairs to the Colonial Secretary,” S.N.A. 36/1923 Special Warrant for £448.9.6. 30th January, 1924; ADM 11/1/850, “Memorandum from the Secretary of Native Affairs to the District Commissioner, Accra,” S.N.A. 36/23 6th October, 1923.

⁹ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 97; Addae, *Evolution of Modern Medicine*, 28.

¹⁰ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 36, 141-44. Guggisberg calculated the infant mortality rate at around 200-300 per 1000, compared to 77 per 1000 in England.



Figure 5.1. Photo of Governor Guggisberg, circa 1921. Guggisberg, governor of the Gold Coast from 1919-1927, asserted that economic progress on the Gold Coast was dependent of the health of its population. His health reforms attempted to expand sanitary services and colonial medical care within Accra, and were epitomized by the construction of the Gold Coast Hospital at Korle Bu. His name has been given to the major thoroughfare that runs from Accra, across the lagoon, to the hospital, and his statue stands in front of the historic out-patient ward, the first building built on the Korle Bu campus. *Source:* Korle Bu Neuroscience Website, www.korle-buneuro.org/about/guggisberg.html, (accessed July 23, 2006).

economy.¹¹ In his speech to the assembled dignitaries, Guggisberg declared that the colony was underpopulated; it needed workers, and healthy families to support those workers.¹²

According to the new governor, this need could only be met by providing the subjects of the Gold Coast with “methods of modern medicine,”¹³ and Korle Bu was to be the state of the art hospital that filled that need. Guggisberg regarded it as an institution built “to show the people at home how Britain provides for the care of the native peoples who have entrusted themselves to her charge,”¹⁴ a way of uniting the colonizers and the colonized in a collective project of curative and preventative care that he envisioned growing into a vast network of clinics and dispensaries stretching into every district of the colony.¹⁵ For the first time in the history of the Gold Coast, a governor was able to articulate a coherent vision for medical care in the colony.

The rhetorical strategies that Guggisberg mobilized here were borrowed from the “dual mandate” of colonialism established by Frederick Lugard in Nigeria.¹⁶ According to Lugard, the British could only justify the expansion of British economic interests in Africa if they

¹¹ For more on colonial anxieties about see: Ana Davin, “Imperialism and Motherhood,” 34; Crawford Young, *The African Colonial State in Comparative Perspective* (New Haven: Yale University Press, 1994), 169.

¹² *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 15, 38.

¹³ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 36.

¹⁴ Taken from a quote from the back of a postcard entitled “A ward in the hospital for Africans, Accra, Gold Coast,” in the Smyly Gold Coast [i.e. Ghana] Collection, 1911-1929. Cambridge University Library: Royal Commonwealth Society Library. GBR/0115/Y30448L. Selected postcards of the Gold Coast [i.e. Ghana], West Africa 1924: series II. PC Gold Coast/7-11. 1924.

¹⁵ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 36.

¹⁶ For examples of Lugard’s reliance on the triumph of medicine in Africa see Lord Frederick J.D. Lugard, *The Dual Mandate in British Tropical Africa*, 5th ed. (London: Frank Cass & co. Ltd, 1965), 144, 151-54.

were predicated on the spread of civilization¹⁷, and by extension, the provision of medical care. As Lugard stated in 1919:

The white man was at first engaged in consolidating his own position, and making the tropics more healthy for Europeans engaged in their development. He has now accepted the principle that they must be made more healthy for the native population. (Lord Lugard, 1919)¹⁸

Guggisberg also believed that medical progress was essential to colonial rule because it promised to generate healthy, productive subjects who could build a robust colonial economy.

When it opened in 1923, Korle Bu was the largest hospital in West Africa, with over 200 beds for in-patients¹⁹ and a large out-patient ward to serve patients from around the colony. It also became a training centre for nurses, dispensers, sanitary inspectors, laboratory technicians, and physicians who had recently graduated from medical schools in Britain. The emphasis on training African medical workers was an initiative that can be attributed to governor Guggisberg because, after investigating the French colonial model of training, which placed technical and surgical duties in the hands of white doctors, leaving a large quantity of undereducated “native dressers” to do the menial medical labour.²⁰ Instead of a two-tiered, racially based system, he advocated a Fabian vision of combining the proficiency of the Voluntary Hospitals of the middle classes with the universality of the infirmaries that

¹⁷ Gaurav Desai, *Subject to Colonialism: African Self-fashioning and the Colonial Library* (Durham: Duke University Press, 2001), 2, from Lugard, *Dual Mandate*, 94-95.

¹⁸ Lugard, *Dual Mandate*, 92-93. Lugard footnotes this passage as the words of Colonel Amery of the Colonial Office in 1919.

¹⁹ Speech Delivered by Major A.H. Selormey Commissioner for Health, on the Occasion of the Unveiling of the Golden Anniversary Plaque of Korle Bu Hospital. *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 141-44.

²⁰ R. E. Wraith, *Guggisberg* (London: Oxford University Press, 1967), 240.

served the working classes.²¹ Guggisberg hoped that Korle Bu would be a hospital for everyone in the colony, regardless of colour, and that eventually it would be operated by the subjects of the Gold Coast. The Guggisberg vision also happened to be politically sound, because his aspirations were shared with the British-trained African doctors of the city (such as newspaper editor, Dr. Nanka-Bruce), who were also enthusiastic about the new institution.²²

If judged solely by patient demand, the hospital was, indeed, an immediate success. In 1924, the doctors and nurses of the new hospital treated a total of 1,500 in-patients; by 1938 this had more than doubled to almost 4,000. The out-patient demand grew too, reaching 11,283 in 1926-27, and 17,903 by 1938.²³ By the 1930s, the hospital was crowded to the point of overcapacity.²⁴ Korle Bu was a full service medical institution, offering therapies from everything from basic coughs and colds to thoracic surgery, and the patient registers are replete with hundreds of different ailments that sufferers brought to the hospital in the hope of a cure. Korle Bu far surpassed the old colonial hospital on High Street, and became known throughout the colony and the region as a centre for colonial medical care.

However, it is necessary to qualify the statistical success of Korle Bu in order to put it in the context of the expansion of colonial services around the colony and around the region. When the out-patient numbers are compared with dispensary attendance in other parts of the colony, they do not seem so dramatic. For example, in 1927-28 Korle Bu saw

²¹ For a brief history of the creation of the Ministry of Health and the growing coordination of class-based hospital systems in London see Geoffrey Rivett, *The Development of the London Hospital System. 1823-1982* (Oxford: Oxford University Press, 1986), 184.

²² Wraith, *Guggisberg*, 240; Patterson, *Health in Colonial Ghana*, 18.

²³ Statistics compiled from *Reports on The Medical Department by the Government of the Gold Coast* (Government Press, Accra). Prior to 1926, dispensary visits were only provided as a total for the colony. For example, in 1923-24, there were 77,492 dispensary visits (*Reports on The Medical Department, 1923-24*, 17); Patterson, "Health in Urban Ghana," 257.

13,786 out-patients, a very large number in comparison to the old hospital, but representing only 11% of the 120,642 patients seen at government facilities in the entire colony.²⁵

Notably, smaller dispensaries in remote regions of the colony attracted more patients than Korle Bu, exemplified by the Upper West Region, where a single Catholic mission saw more than 30,000 out-patients annually for the treatment of for yaws, malaria, trypanosomiasis and other illnesses during the 1930s.²⁶ Nor were the numbers at Korle Bu dramatic when compared with attendance at hospitals in Nigeria and Uganda, which also rose significantly during the 1920s.²⁷ Historians Patterson and Addae have charted attendance rates at hospitals after the construction of Korle Bu, marking them as a major achievement when compared to the low attendance rates at the old colonial hospital, but its success must be put in the context of an exponentially expanding urban population of over 40,000 people, and within a rapidly growing colonial population.

Moreover, the popularity of Korle Bu must be qualified by the fact that, while the doctors at the hospital had treatments available for almost any illness presented to them, the efficacy of most medical therapies was still quite limited. The Gold Coast Hospital was born in an era when the miracle cures offered by sulpha drugs and penicillin were still unavailable, leaving only a handful of very specific remedies to draw African patients to the hospital. What really brought patients to the dispensary at Korle Bu were curative “quick fixes” -- in

²⁴ Statistics compiled from *Reports on the Medical Department by the Government of the Gold Coast* (Government Press, Accra).

²⁵ *Reports on the Medical Department, 1927-28.*

²⁶ Hawkins, *Writing and Colonialism*, 200-01; campaigns to treat endemic diseases in other parts of Africa also created high participation rates. For example, in Nigeria, British medical brigades treated 10,000 cases of trypanosomiasis in 1931. Arthur E. Horn, “The Control of Disease in Tropical Africa: Part III,” *Journal of the Royal African Society* 32, no. 128 (July, 1933), 254.

²⁷ Horn, “Control of Disease in Tropical Africa: Part I,” 24-25.

particular neoarsenobillon for yaws and neosalvarsan for syphilis and gonorrhoea.²⁸ There were local cures for the ulcerations on the skin caused by these diseases (known locally as *ajito*), which included herbal infusions and baths, and dressing the lesions with pepper, copper sulfate dust, and palm oil.²⁹ With continuous treatment, these local therapies may have been effective, but they would have involved months of expensive and tedious therapy. Patients came to prefer injections of arsenical compounds into the gluteus maximus (which British Medical Officers referred to as “bum-punching”) because their effects were observable within a matter of days.³⁰ Patients also sought out injections of quinine sulfate for malaria, making it the third most common illness treated at the Gold Coast Hospital. Therapies for injuries, bronchitis, conjunctivitis, and constipation, also appear as common in the hospital records, but to a far lesser degree.³¹ After that, the number of people treated are small in number and divided amongst dozens of different ailments. And, as we shall see, patients continued to show reluctance to submit to surgical options, especially those involving anaesthesia.

The main reason for the demand for so-called “bum punching” must have been the desire on behalf of patients to rid themselves of disfiguring diseases like yaws, free themselves of the stigma of venereal disease, or get rid of a malarial fever that they were unable to treat with local herbal bitters. It is possible that the presence of African doctors at the hospital increased attendance. For example, it is said that when C.E. Reindorf (son of

²⁸ Patterson, *Health in Colonial Ghana*, 26; C.E. Reindorf, “The Problem of Venereal Disease on the Gold Coast and the Possibilities of Control,” *West African Medical Journal* (1927), 8-9; Deborah Pellow, “Research Article:” STDs and AIDS in Ghana,” *Genitourinary Medicine* 70 (1994), 420.

²⁹ C.E. Reindorf, “Influence of fifty years of scientific medicine on beliefs and customs in the Gold Coast,” *West African Medical Journal*, 3, no. 3 (September, 1955), 118.

³⁰ C.J. Hackett, “Private medical practice and anti-yaws campaigns in South Eastern Nigeria, 1925-1950,” *Tropical Doctor* 10 (1980), 129-32.

³¹ *Reports on the Medical Department, 1924-1938*.

C.C. Reindorf) became the director of the Venereal Disease Clinic the number of patients increased, but the rise in attendance has more to do with a general acceptance of cures by injection, a trend that had started with the anti-plague campaign of 1908.³² It should also be noted that there is also a link between the provision of these particular therapies and the goals of Governor Guggisberg, who sought to increase the working population of the colony. Venereal disease, in particular, was understood by British doctors as a threat to population growth in the colonies, and as Meghan Vaughn has shown in her study of yaws and syphilis in Uganda, medical officers saw the high incidence of yaws as the result of the reckless sexual activity within African populations that was causing disease and sterility.³³ Guggisberg too was influenced by anxieties about infertility amongst colonial populations, so much so that he advocated for the creation of a special venereal diseases clinic at the hospital. It is said that Guggisberg was so enthusiastic about the clinic that he actually tracked down C.E. Reindorf while they were both on a steamer to Liverpool, offering him a position at the Venereal Diseases Centre (which had yet to be built) if he agreed to specialize in the treatment of syphilis during his medical training at Edinburgh.³⁴ Though the statistics do show that African patients “flocked” to the hospital for injections,³⁵ the very provision of such injections was part of a larger government plan to halt venereal diseases in order to increase the birth rate in the colony.

The in-patient wards at the Gold Coast Hospital were not as popular as the dispensary. By the 1920s, patients in Britain had come to accept that suffering from an acute

³² Addae, *Evolution of Modern Medicine*, 98-99, fn. 20.

³³ Vaughn, *Curing Their Ills*, 138.

³⁴ Interview, Dr. Barnor, August 29, 2003; *Gold Coast Independent*, January 22, 1927, 111.

³⁵ Addae, *Evolution of Modern Medicine*, 365.

illness might require a stay at a hospital,³⁶ but this was not necessarily the case in Accra. Principal Medical Officer Dr. Selwyn Clarke noted that the Africans in the city did not “take kindly to hospital treatment” adding that they only submitted to treatment after pressured to do so, and that they were eager to be discharged as soon as possible.³⁷ The reluctance of patients to enter hospital wards is confirmed by oral histories of the hospital (covered in Section 3). While in-patient numbers did rise, reaching over 200 bed stays per day, it is difficult to argue that they were filled entirely by demand, considering how hard it was for doctors to convince their patients to go under the knife.

Korle Bu’s role as a centre for medical research has also been celebrated in the medical historiography of the Gold Coast, and it was home to some key research activities in the 1920s. However, its role in contributing to the development of medical research on the Gold Coast deserves some qualification. After the construction of Korle Bu, the Accra Laboratory, renamed as the Accra Medical Research Institute, was moved to the Korle Bu campus, where it was expanded to include a pathology lab, an incubator room, cages for animals used as test-subjects, and a mosquito proof house for research on insect-borne illnesses. In its first few years, it suffered with staffing problems, but afterwards researchers at the Institute published dozens of scientific papers on the transmission of disease via insect vectors, with a special focus on malaria, trypanosomiasis, and relapsing fever.³⁸ The laboratory was also the setting for the race in the late 1920s to discover the virus that caused yellow fever, attracting eminent scientists from around the world such as William Alexander Young and Hideyo Noguchi. Sadly, it was also the setting of a disaster in 1928, when both

³⁶ Gwendoline M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board, 1867-1930* (Berkeley: University of California Press, 1971), 61.

³⁷ Selwyn-Clarke et. al., “Relapsing Fever,” 414; Patterson noted that not all people who were diagnosed with an illness that could be treated by surgery were willing to stay at the hospital, see Patterson, *Health in Colonial Ghana*, 17.

Young and Noguchi became infected with the disease and died.³⁹ After their deaths, the Medical Department cut back the budget for the Institute, and it did not produce any more original research until after the Second World War.⁴⁰ Moreover, it should be pointed out that it was not a research centre in the sense that basic medical research was conducted on a broad spectrum of maladies. Rather, the Accra Laboratory had one purpose -- to find cures for the tropical diseases that were hindering labour productivity and the growth of the labour force. African physicians, like C.E. Reindorf, were conscripted to work at Korle Bu for this purpose as well.

From its inception, the governors of the Gold Coast had imagined the Gold Coast Hospital as medical school for physicians, but this dream was thwarted in the early years of the instruction due to the jealousy of the other governors in British West Africa, who reserved the right to operate their own training programs. Plans to turn Korle Bu into a teaching hospital were cancelled by the colonial office in 1931 and replaced with a small scholarship program for Africans who wanted to train as physicians in the UK.⁴¹ An apprenticing program for nurses was initiated in 1927, but a similar program for dispensers at Korle Bu was delayed until Governor Slater managed to allocate funding to it in 1931. As we will see in Section 2, Korle Bu did become an important training ground for medical professionals trained in the UK, but it was not until 1964, long after Ghanaian independence that Korle Bu would take on the suffix of "Teaching Hospital."⁴²

³⁸ Addae, *Evolution of Modern Medicine*, 184; Patterson, *Health in Colonial Ghana*, 22.

³⁹ Patterson, *Health in Colonial Ghana*, 22. See also Gustav Eckstein, *Noguchi* (London: Harper and Brothers, 1931); Dan D'Amelio, *Taller than Bandai Mountain: The Story of Hideyo Noguchi* (New York: Viking Press, 1968).

⁴⁰ Patterson, *Health in Colonial Ghana*, 22.

⁴¹ Patterson, *Health in Colonial Ghana*, 16.

⁴² Senah, *Money Be Man*, 54.

The inauguration of Korle Bu was a watershed in the provision of European-derived therapeutics in Accra. By comparison to the old bungalow in Victoriaborg, the Gold Coast Hospital was a state of the art facility. And to the credit of Governor Guggisberg, the hospital did break down barriers between medical practitioners and the subjects of the Gold Coast, but it must be remembered that his vision of medical progress in the Gold Coast was not selfless. The stated intent of his medical policy was to increase the population of the colony, and improved health care, specifically campaigns against venereal disease, were part of Guggisberg's larger strategy to increase the labour force of the colony. To say that the therapies available at the Gold Coast Hospital led to the, as Patterson states, an "increasing public acceptance of an alien medical system,"⁴³ or as Addae asserts, "embracement of modern medicine"⁴⁴ may be incorrectly associating the part with the whole. Patients attended the hospital in large numbers, but they came for specific cures for specific ailments, and showed trepidation when offered other forms of therapy. The hospital established colonial medicine as a powerful therapeutic alternative but only within the context of the established patterns of patient choice within the pluralistic healing network of Accra.

⁴³ Patterson, *Health in Colonial Ghana*, 11.

⁴⁴ Addae, *Evolution of Modern Medicine*, 364.



Figure 5.2. Inauguration of statue of Governor Guggisberg in front of the old out-patient ward at Korle Bu, 1974. Saka Acquaye's bronze statue of Guggisberg is still mounted outside the original in-patient ward at Korle-Bu Teaching Hospital today. This photo was taken during one of the Jubilee ceremonies in 1974, when dozens of dignitaries and hundreds of employees gathered to see the unveiling of the new statue. (Source: by permission of the estate of Brig.-Gen. Frederick Gordon Guggisberg).



Figure 5.3. Rear view of the out-patients department, which included the X-ray, eye and dental sections, of the Gold Coast Hospital, circa 1940. Evident here are the power lines, which brought electricity from a generator on the campus to provide power for the machinery and lights in the hospital. *Source:* Basel Mission Archive Photo, ref #: QD-30.102.0001.

Section 2. Biopower at the Gold Coast Hospital.

The previous section called into question assumptions of medical efficacy present in the current medical historiography of Ghana by arguing it was specific therapies, like injections, that drew patients to Korle Bu for treatment. In other words, though there were pull factors that attracted patients to the institution of the hospital, they amounted to a handful of particular treatments. But there were also push factors that drove patient demand at the new hospital. If patients were admitted to Korle Bu, it usually happened through a process of persuasion and pressure by colonial authorities. It is not surprising to think that patients were reluctant to go to a hospital considering that they were required to leave behind their loved ones, and abandon their ethnic and spiritual identities in order to take on a new identity as a patient with a specific number in a specific ward. At the Gold Coast Hospital, colonial subjects became medical subjects in the clinical sense when they placed themselves under the control of physicians, nurses and technicians providing them with treatments. Though patients at the old colonial hospital had also submitted their bodies to colonial medical authority, the scale of operations at Korle Bu made the Gold Coast Hospital a unique institution that contributed to the rapid growth of European-derived therapies in Accra.

There is no 'patients history' of Korle Bu, but there is an excellent compilation of memories about the early days of the hospital contained in the *Golden Jubilee Souvenir* booklet, published in 1973, on the 50th anniversary of the founding of the Gold Coast Hospital.⁴⁵ As a historical source, the *Golden Jubilee Souvenir* has a dual meaning for the historian. Firstly, it is an example of a state-directed commemoration (in this case by the junta of the National

Redemption Council) of a national institution, conducted with the aim of associating an oppressive military regime with modernity and progress. The *Golden Jubilee Souvenir* attempted to demonstrate that Korle Bu remained the vanguard of medical care in Ghana in the 1970s, despite the fact that a drop in cocoa export revenues had led to a decline in funding for the hospital, and despite the fact that newly trained medical doctors were seeking better paying opportunities outside the country.⁴⁶ But though the *Golden Jubilee Souvenir* bears the mark of state manipulation, it is much more than propaganda. The publication is also useful for the purposes of writing the history of the early years of the hospital because it contains an oral history of the institution, compiled by Mr. J.M. Akita, the Chief Archivist at Korle Bu, and Robert Addo-Fening, of the Department of History at the University of Ghana. The memories contained within the *Golden Jubilee Souvenir* offer insights into the experiences of patients as they submitted to the authority of medical care, sought to escape medical care, or combined therapies from other healing cultures with therapies at Korle Bu.

The Gold Coast Hospital concretely represented a transition from the individuated patient care (provided by African healers or private physicians) to collective care of abstracted bodies and diseases (within a medical institution). If they chose to patronize an African healer, a patient and their therapy management group might visit their home compound for a short or a long period of time, conducting rituals that they believed would result, whether in the short term or long term, in bodily and spiritual health. Visiting the clinic of an African physician was similar because a patient and their therapy management group could choose to see them or request that the physician visit their home. Korle Bu was different. When a patient entered the wards of Korle Bu, they had to leave their therapy

⁴⁵ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir.*

management groups outside the doors and submit completely to the authority of European medicine, allowing themselves to be cleansed, dressed, and placed in beds, row on row, sleeping with strangers, in the long wards of the new hospital. Rather than choosing to “healer-hop” they found themselves in a position where the healers did the hopping, as doctors, nurses and technicians moved from patient to patient.

The physical structure of the Korle Bu was the embodiment of a new type of medical architecture, with sweeping multi-story edifices supported by neoclassical columns, filled with medical equipment and pharmaceuticals that had never been used in the colony before.⁴⁷ The practical application of medical notions of space and the body were evident as the sick person arrived at the hospital and made the transition through the building to become a patient. Anyone admitted to the hospital for surgery had to pass through an ablution block of water taps and washbasins, where they were bathed and disinfected before entering the in-patient wards. In some areas, such as the surgery wards, were completely aseptic; medical staff had to wash and change their attire before entering them. Patients too were stripped of all clothing except for their hospital gowns -- and under no circumstances were patients allowed to bring amulets or any other apotropaics into the surgical wards.⁴⁸ The in-patient wards were laid out in an H-shape design, an inherited legacy of medical architecture that emphasized long hallways and open wings, designed to allow salubrious

⁴⁶ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, ix; Addae, *Evolution of Modern Medicine*, 457.

⁴⁷ For references to the design of hospitals in the colonies see Harold Cook, “From the Scientific Revolution to the Germ Theory,” in *Western Medicine: An Illustrated History*, ed. Irvine Loudon (Oxford: Oxford University Press, 1997), 81, 161; Thomas R. Metcalf, “Architecture and the Representation of Empire: India, 1860-1910,” *Representations*, no. 6 (Spring, 1984), 37-39.

⁴⁸ Williams notes that she came across a wide variety of consecrated devices, including amulets or talismans. Cicely Williams, “Witchdoctors,” *Pediatrics*, 46, no. 3 (September, 1970), 450; Interview, Nurse Faustina Arthur, May 11, 2004; Interview, Nurse Evelyn Rose Naa Ahima Gilbertson, April 16, 2004.

breezes to flow in and out of the building, connected by narrow walkways.⁴⁹ These were typical “Nightingale wards” that allowed for the hierarchical surveillance of sick bodies,⁵⁰ adequate spacing between patients, and maximum airflow across corridors. The design of the wards allowed for isolation when necessary, as each patient was divided up according to their degree of infectiousness, and completely isolated if they suffered from tuberculosis. Unwittingly, patients at Korle Bu found themselves (literally) embedded within buildings of the Gold Coast Hospital reflected the aseptic design principles of Joseph Lister, the patterns of patient spacing advocated by Florence Nightingale, and obsessions of Sir William John Ritchie Simpson with light and ventilation.⁵¹

The hospital was also designed in such a way as to effectively separate human bodies from soiled clothing, bodily fluids and cadavers. Hospital staff washed sheets and bedclothes with electric laundry machines rather than by hand, and disinfected linens in a steam boiler room. Human waste was disposed of in a novel way too; it was flushed down the drain and into pipes that led out of the campus and emptied into the Korle Lagoon. The former colonial hospital had rudimentary outdoor latrines and baths, and the doctors who worked there complained about its dangerous sanitary conditions,⁵² but Korle Bu had

⁴⁹ Jeanne Kisacky, “Restructuring Isolation: Hospital Architecture, Medicine, and Disease Prevention,” *Bulletin of the History of Medicine* 79, no. 1 (2005), 7; John D. Thompson and Grace Goldin, *The Hospital: a Social and Architectural History* (New Haven: Yale University Press, 1975), 154-69; Rivett, *London Hospital System*, 79.

⁵⁰ Butchart, *Anatomy of Power*, 28.

⁵¹ Geunter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999), 339-98.

⁵² PRAAD ADM 1/2/144, “Le Fanu and O’Brien to Principle Medical Officer,” January 23, 1922.



Figure 5.4. A ward of the Gold Coast Hospital, with a nursing station in the middle of the hall and a portrait of King George on the back wall. Constructed according to the Nightingale model, the wards of Korle Bu were built to facilitate the flow of air. Also evident is a hierarchical medical gaze; patients were monitored from the nurses' station in the centre of the ward, and were under constant surveillance by the eyes of King George. The therapy management groups that usually accompanied patients were restricted to visiting hours only. *Source:* Basel Mission Archive Photo, ref #: QD-30.102.0002.

running water and toilets inside the building. Many of the employees were initially unaccustomed to using the flush toilets of the indoor latrine, recalling that the water closets reduced privacy because they did not allow a person to leave a building to relieve themselves. Eventually, the employees adapted to the convenience of toilets and they soon recognised that the flushing water was intimidating to newcomers to the hospital. As a joke, they could discipline the younger patients at the hospital by telling them they would flush them down

the toilet if they misbehaved.⁵³ All of the new equipment at the hospital was new to the colony and had never been seen by new in-patients before.

The handling of cadavers also differed at Korle Bu. The typical mortuary practices of African residents in the city in the 1920s followed a pattern of dressing the body for presentation in the home and then transporting it outside the city for burial in government approved graveyards, all within one or two days.⁵⁴ At Korle Bu, dead bodies were separated from the living as soon as possible and removed by motor hearse to be refrigerated at the mortuary.⁵⁵ The science of medicine required rigorous pathology work, and bodies were held at the hospital for post-mortem inspection if they were thought to have any value for research at the laboratory. A coffin store was also built conveniently close to the mortuary, so family members could transport their deceased relatives back to their homes in a casket.⁵⁶ Korle Bu was designed to control the movement of human bodies, whether in life or in death, in a way that made it the institution unique to the healing culture of Accra.

According to the memories found in the *Golden Jubilee Souvenir*, patients at Korle Bu were often intimidated by the machinery and the equipment it contained. For instance, there was a great deal of trepidation associated with the use of gases as anaesthetics. D.H. Reindorf, a member of a prominent local family of British-trained physicians, who had trained as a dispenser and later as an anaesthetist, recalled that he was both honoured and feared as a member of the surgical team in the early years of the hospital:

⁵³ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 76.

⁵⁴ Parker, John. "The Cultural Politics of Death & Burial in Early Colonial Accra," in *Africa's Urban Past*, David Anderson & Richard Rathbone, eds. (Oxford: James Currey, 2000), 208-09.

⁵⁵ Joel Noret has investigated the way that refrigeration of the corpse extended the liminal mourning period between death and burial and a time lag that allows for capital to be pooled for grand funerals. Joel Noret, "Morgues et prise en charge de la mort au Sud-Benin," *Cahiers d'études africaines* 44, no. 4 (2004), 745-67.

⁵⁶ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 55.

I was for a considerable period the sole Anaesthetist and when going from the Dispensary to the Theatre with pomp and parade, all my admirers and patients, ready for the operation, cheered me by saying “OKUM NIPA” was coming: meaning I put people to sleep or literally killed them temporarily.⁵⁷

In this instance, the nickname given to the anaesthetist demonstrates both a trepidation and reverence for someone given the authority to temporarily “kill” in order to heal. This is not surprising coming from patients who might have had similar relationships with African healers who were sometimes also feared as sorcerers. Although the technology at the hospital may have served to empower employees by granting them healing power over their fellow subjects, the patients at Korle Bu were understandably unnerved by the power that technicians had to control states of consciousness.⁵⁸

Patients were also anxious about the intrusive forms of surgery practiced at the new hospital. Though the African healers of Accra had some painful therapies, including slicing the skin to rub in dry powders, radically intrusive surgical acts like opening the chest cavity were not part of African healing practices. If they wanted to convince patients to allow them to put them to sleep and cut open their bodies, physicians working at Korle Bu had to build up their reputation as reliable surgeons and cultivate a good bedside manner. When Dr. Nanka-Bruce reminisced about his first few years at Korle Bu, he recalled that persuading a patient to submit to an operation was a time-consuming process:

I remember when I returned from Edinburgh as a qualified doctor how it took us many hours, and even days, to beg and coax a would-be patient to submit to an operation for his own benefit. In fact, we spent more time coaxing the patient than in performing the operation.⁵⁹

⁵⁷ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 82. The phrase “*okum nipa*” translates literally as ‘killer of human beings’.

⁵⁸ Perceptions of anaesthesia differed in other parts of the continent. For rumours about the use of chloroform in Uganda, see White, *Speaking with Vampires*, 104-20.

⁵⁹ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 88. (extract from “West Africa Review” Vol. XXII no. 286 of July, 1951.)

Even though surgical procedures for “indigents” (as African subjects of the Gold Coast were known in hospital records) were conducted free of charge, not all attempts to convince patients to go under the knife were successful.⁶⁰ As one nurse recalled, patients often “disappeared from the hospital on the eve of their operations.”⁶¹ Surgeons at Korle Bu always had a steady supply of trauma victims that were brought to the hospital after accidents,⁶² but voluntary surgery was a hard sell. In a setting like Accra, where internal surgery was a new practice, it is understandable that some patients would forgo surgery if the terror of treatment outweighed the promise of a cure.

Perhaps the greatest expression of biopower was in the way the staff of the hospital raised and named abandoned infants. During the interwar period, many children ended up at the hospital after being abandoned on land owned by the colonial government, like the railway station in Accra, or the golf course on the grounds of Korle Bu. Others were simply left at the hospital and never picked up by their parents.⁶³ These children were technically wards of the Gold Coast Government, but they lived in hospital residences and were nursed, cared for, and raised by hospital nurses. Two examples loom large in the memories of the nurses who worked at Korle Bu. The first is Grace Ward, a baby born to an immigrant from the Northern Territories who died in child-birth sometime in the 1930s. The child was initially given the name “Grace O’Brien” by the nurses at the hospital, in homage to their Chief Medical Officer, but was later renamed “Grace Ward,” as a ward of Korle Bu

⁶⁰ Gold Coast. *Medical and Sanitary Reports, 1924-25*. Gold Coast Colony medical reports indicate that only Africans with incomes over £200 were charged for services at Korle Bu.

⁶¹ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 68.

⁶² Patterson, *Health in Colonial Ghana*, Table 28. Patterson shows that accident victims in the colony as a whole made up over 10 percent of all hospital cases during some years in the 1920s.

⁶³ Cicely Williams believed that the locations of their abandonment were chosen as a way to represent the dislocation of colonial rule. J. Stanton, “Listening to the Ga: Cicely Williams' Discovery of *kwashiorkor* on the Gold Coast,” *Clio Medica*, 61 (2001), 156.

Hospital. Grace was raised by the nurses at the hospital until she was old enough to be sent to board at Achimota College.⁶⁴ A second example was a seven-year old boy named Akesia, who was brought to the hospital with sarcoma of the neck. The prospect of surgery terrified his parents, so they abandoned the boy. As a former nurse, Mrs. Mould, recalled, Akesia

had tracheostomy operation, the first of such operations. He braved it and survived and he became the pride of the doctors nurses and all. Like Grace Ward he also grew up in the hospital. He became very conversant with the common duties in the ward and was a useful hand to all. He assisted in laying beds in the Ward, and ran errands for the less able patients.⁶⁵

In the absence of an institution like Korle Bu, a child like Akesia might have been pawned to a priest of a local shrine for protection, where he would have grown up as servants of shrine god, but the Gold Coast Hospital offered women the choice to give up their child to doctors and nurses of the hospital, who raised the children as wards of a newly medicalised colonial state.

The in-patient experience at the Gold Coast Hospital was unique to the history of Accra because it transformed colonial subjects (who had previously retained their agency with respect to health and healing) into medical subjects (who relinquished control over the meaning of their body and their rights to determine its health status). The scale of the institution was also unique. Never before had hundreds of patients from all parts of the colony, with different religious beliefs, different ethnicities, and different classes, been clustered together in the same rooms. One can imagine how disorienting it might have been to be taken from one's family, washed down by a nurse in the ablution room, dressed in a hospital gown be asked to lie on a bed, beneath the whirl of the ceiling fans above, listening to a nurse playing jazz on the ward piano. One can also imagine how disconcerting it might have been (as it still might be today) to hear the clicking of the X-ray machine, feel the heat

⁶⁴ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 69.

of the surgery lights, or be constricted inside an iron lung. Becoming a patient at Korle Bu was much more than picking and choosing between therapists in Accra - it was a foreboding place. Submitting to the role of patient inside the hospital meant an effacement of one's cultural self and a bodily submission to the medical gaze. The old colonial hospital was just an old bungalow converted into a clinic, but Korle Bu was a concerted architectural effort to reify medical understandings of healthy and unhealthy spaces and exert control over the movement of patients -- it reflected the principles of biopower, something patients quickly recognized, and the reason why many patients ran from the hospital in fear, while others were drawn to it as an institution that offered a radically different approach to health and healing.

Section 3. Professional Distinction at the Gold Coast Hospital.

There is no official history of the lives of the physicians, nurses, dispensers and technicians who worked at Korle Bu, but *Golden Jubilee Souvenir* booklet contains many oral histories of their experiences there. It offers insight into the lives of an aspirant class of Gold Coast subjects who, despite a well-established colour bar to advancement at Korle Bu, forged their identities as medical professionals at the hospital, accumulating social capital by associating and mingling with colonial elites and acquiring cultural capital, by appropriating the tastes and pastimes of their colonial supervisors. Employees at the new hospital had to deal with coercive and sometimes oppressive conditions of submission to white medical authorities, but as a new cohort of medical workers at a brand new institution, they saw themselves as part of a new workplace culture, one that allowed them to distinguish themselves as part of a modern colonial society. Their recollections offer insight into the

⁶⁵ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 76.*

deep camaraderie of the first cohort of employees at Korle Bu and reveal the smouldering resentment they had for the indignities that they had suffered under colonial rule.

When the Gold Coast Hospital opened it suffered from a shortage of trained personnel, an advantage for women who wanted to become nurses at Korle Bu. In the 1920s, the economy of the Gold Coast was booming and most women could make more money trading in the market than they could from a hospital salary.⁶⁶ The monthly wages at Korle Bu were low, ranging from three to five pounds, but the benefit of working at the hospital was that one could mingle with black and white medical elites.⁶⁷ Because recruiting in Accra was not based on a Nightingale model that drew nurses from Anglican and Roman Catholic sisterhoods (as it was in South Africa),⁶⁸ literate graduates from government schools made up the bulk of new recruits.⁶⁹ And because demand for personnel was so high, women recruited to Korle Bu in the 1920s and 1930s were admitted “purely on their own willingness to train as nurses.”⁷⁰ There were no courses and no examinations; they learned on the job⁷¹ Mrs. Quartey-Papafio-Coker recalled how easy it was to become a nurse at the new hospital:

⁶⁶ The foodstuffs markets of Accra have been historically dominated by market women, who deal in goods such as dried fish, corn, yams, and vegetables, and processed foods, such as the staple of kenkey, were also made by women. Though salaried positions in the government service and a colonial education system that favoured boys over girls did tilt the balance of earning power in favour of men during the 20th century, women’s authority in the marketplace has endured until today. See Claire Robertson, "Ga Women and Socioeconomic Change in Accra, Ghana," in Hafkin and Bay, eds., *Women in Africa* (Stanford: Stanford University Press, 1976), 111-134.

⁶⁷ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 79. Mary Adoley Mingle considered her salary of £3 to be “scanty” for the work that she did as a sewing maid at the hospital.

⁶⁸ Shula Marks, *Divided Sisterhood: Race, Class, and Gender in the South African Nursing Profession* (New York: St. Martin's Press, 1994), 6.

⁶⁹ Lady Clifford noted that the curriculum at Government schools included hygiene and sanitation, which meant that graduates would have already been introduced to medical concepts before applying for work at Korle Bu. Clifford, *Our Days on the Gold Coast*, 206.

⁷⁰ Addae, *Evolution of Modern Medicine*, 250-51.

⁷¹ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 68.

[my cousin said that] if I accompanied her to the Gold Coast Hospital, I would be employed almost instantly. So I accompanied her, walking from Faase Quarter in Accra to Korle Bu where a brief interview took place. I was led away into a waiting room and after a little while a lady came and looked at me from head to toe, took a few measurements and ... brought me some uniforms. I had become a nurse-in-training.⁷²

Working at the hospital did not pay well but it was a strategy for professional and social advancement within colonial society. A new, secular, medical profession had emerged in Accra, which was given the Ga name *kolebu awula*, or “lady-like” employee of Korle Bu Hospital, an appellation sought after by the daughters of Accra elites.⁷³

The opening of Korle Bu also created opportunities for men who aspired to become physicians. In the 1910s, these restrictions were eased slightly, but by 1912 only 8 of the 214 physicians in the West African Medical Service were African, and the barriers to entry encouraged aspiring professionals to choose careers in business or law instead of medicine.⁷⁴ When the Gold Coast Hospital opened, the African physicians of Accra hoped that it would become the egalitarian institution that would end the racism that had plagued the West African Medical Service in the past. Prior to the opening of Korle Bu, Guggisberg had declared his commitment to breaking down the colour barriers that had excluded African doctors in the past by creating a new category of Junior African Medical Officer (at a high salary of £400), which allowed newly-trained African doctors to work at the Gold Coast Hospital until they gained enough experience to become full-fledged Medical Officers.⁷⁵ African doctors initially protested this new rank, arguing that it was just another way of

⁷² *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 72.

⁷³ Dakubu, *Ga-English Dictionary*, 31, 85. Interview, Nurse Evelyn Gilbertson, April 16, 2004.

⁷⁴ Patton, *Physicians, Colonial Racism*, 142.

⁷⁵ In 1921, Guggisberg sent J.M. O'Brien to Dakar to report on advances at French Colonial Hospitals, and to formulate a policy for a new system of hospitals and clinics in British West Africa. He returned with a negative view of the French model that emphasized large numbers of low-skilled African medical staff supervised by white physicians and medical technicians. Patton, *Physicians, Colonial Racism*, 157-58.

keeping Africans out of administrative roles in the Medical Department. But Guggisberg's dictates were followed by the Chief Medical Officer of Korle Bu, Dr. J.M. O'Brien, who appointed three African doctors as soon as the institution was opened.⁷⁶ In 1926, Guggisberg further demonstrated that he was willing to place Junior Medical Officers in positions of authority when he later posted one of the physicians trained at Korle Bu, Dr. E. Tagoe, to Dunkwa to supervise the hospital there, despite vigorous protests from the white mining community there.⁷⁷ Though the title of Chief Medical Officer would never be held by an African during the colonial era, Guggisberg and O'Brien did create many opportunities for professional training for African doctors, nurses, dispensers and technicians.

The social distinction that working at the hospital offered to nurses and doctors is reflected in the fact that hospital uniforms were often mentioned in the memories of Korle Bu by former employees. In James Town and Ussher Town, the priests and spirit mediums announced their presence by wearing white robes, white body paint, elaborate hairstyles and jewellery, a costume that they understood to be part of the tradition of worshipping the local gods and goddesses.⁷⁸ At Korle Bu, the new nurses wore clothes defined by medical knowledge of sanitation and sepsis, starched white accoutrements that defined cleanliness in the way that they could reveal dirt (see Figure 5.5 and 5.6).⁷⁹ Male employees were similarly uniformed, in white robes or aprons, and they were expected to wear Western attire of shirts, ties and trousers, underneath their hospital gear. Just as imported suits and ties were

⁷⁶ Patterson, *Health in Colonial Ghana*, 14. The doctors appointed were A-F Renner-Dove, G.T. Hammond, and E. Tagoe.

⁷⁷ Kimble, *Political History of Ghana*, 109.

⁷⁸ Field, *Religion and Medicine of the Gã People*, 6-9.

⁷⁹ For a further discussion of the relationship between class and fashion, see Marissa Moorman, "Putting on a Pano and Dancing like our Grandparents: Nation and Dress in Late Colonial Luanda," in *Fashioning Africa: Power and the Politics of Dress*, ed. Jean Allman (Bloomington: Indiana University Press, 2004), 85; see also, Thomas Turino, *Nationalists, Cosmopolitans, and Popular Music in Zimbabwe* (Chicago: University of Chicago Press, 2000).

de rigueur amongst the gentlemanly ranks of African merchants and professionals,⁸⁰ and just as Christians distinguished themselves from so-called heathens by adopting European codes of style, the dispensers and nurses at Korle Bu wore their medical attire as a “social skin” that marked them as participants in colonial medicine, and displayed their rank to their peers.⁸¹ No African men would wear the uniform of the Chief Medical Officer, and no African woman would wear the white dress of the hospital matron, but to outside observers from Accra, the uniforms distinguish the African employees as members of a secular medical class.⁸²

⁸⁰ Commentaries in the Korle Bu Jubilee retrospective consistently included references to uniforms. See *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 68-73; Stephanie Newell, “Entering the Territory of Elites: Literary Activity in Colonial Ghana,” in Barber, *Africa's Hidden Histories*, 221.

⁸¹ Turner argues that the surface of the body is not just covered out of utility, but with clothes that indicate social status. Terence S. Turner, “The Social Skin,” in *Not Work Alone: a Cross-Cultural View of Activities Superfluous to Survival*, ed. Jeremy Cherfas and Roger Lewin (London: Temple Smith, 1980), 112-140.

⁸² In hospitals in Europe, uniforms served a similar purpose of distinguishing the medical worker as a class distinct from the lower classes that might attend the hospital as patients, and distinct from the physicians who administered the hospital. See Asa Andersson, “To Work in the Garden of God: The Swedish Nursing Association and the concept of the Call, 1909-1933,” *Nursing History Review* 10 (2002), 4-19; Irene Schuessler Poplin, “Nursing Uniforms: Roman Idea, Functional Attire, or Instrument of Social Change?” *Nursing History Review* 2 (1993), 153-70.



Figure 5.5 “The Matron of the Gold Coast Hospital, Accra. Miss M. A. Henry, stops to chat with a patient during her round of the wards.” Authority at Korle Bu was always held by white employees. This photo offers a contrast between the smile of the supervisor and the silence of her unnamed black nursing assistant. The uniforms of the two women indicate their rank amongst the nursing sisters of the hospital. *Source:* Basel Mission Archive Photo, ref #: QD-30.102.0003. Circa 1945.



Figure 5.6 “African nurses are trained in every branch of medicine and surgery at the Gold Coast Hospital, Accra. Here is a class of students at a lecture by Senior Sister Mutton” circa 1940s. Instruction in nursing at Korle Bu was led entirely by British colonial medical staff. African nurses understood that they would never be able to rise to the rank of matron. *Source:* Basel Mission Archive Photo, ref #: QD-30.102.0007.



Figure 5.7. School for Dispensers, circa 1945. The perspective of this photo emphasizes equipment over personnel by placing flasks in the foreground and the dispensers in the background. Dispensers were expected to wear Western attire underneath their aprons. The position of dispenser offered upward mobility to young men hoping to practice medicine or conduct medical research alongside physicians at the Medical Research Institute. *Source:* Basel Mission Archive Photo, ref #: QD-30.102.0009



Figure 5.8. School for dispensers at Korle Bu. Mr E. Allman lecturing to third-year students. Circa early 1940s. In this photo, a white instructor points to a chalkboard listing the sorts of *materia medica* that nurses and dispensers were expected to use, including: belladonna (an alkaloid extracted from nightshade, used to dilate pupils for examination), Vitamin B complex (used for nutritional deficiencies like Pellagra), organic arsenicale (a drug used to treat syphilis and trypanosomiasis, marketed under the better known trade name of Salvarsan), Digitalis (a chemical derived from foxglove, used as a heart antiarrhythmic agent) and Cocaine (used as a topical anesthetic in eye, nose and throat surgery). These reagents were new tools of healing, and the curative aspect of treatments like Salvarsan injections spurred demand at the hospital. *Source:* Basel Mission Archive Photo, ref # QD-30.102.0008).

Participating in the new medical culture of the hospital included activities outside the daily work schedule, and social events distinguished the social life at Korle Bu from other colonial institutions because it was a place where the black and white residents of the city interacted. Collective participation in the workplace culture of Korle Bu was encouraged by the Chief Medical Officer, Dr. O'Brien. Like Guggisberg, O'Brien envisioned Korle Bu as a hospital that would eventually be staffed by mostly African-born personnel, and he became known as someone who operated the hospital as a meritocracy and who was not above working alongside African employees.⁸³

In the memories of former employees, Dr. O'Brien was remembered as a stern authoritarian. As one man who trained as a dispenser under O'Brien recalled, he was

somewhat gruff in manner, of military bearing and lame. He had been a major in the R.A.M.C., had been wounded in the First World War and won the military cross. He was a strict disciplinarian and worked like a beaver...Because Dr. O'Brien was lame his footsteps had a characteristic rhythm which made it possible to identify his approach by sound at a distance and thereby give everybody a chance "to put is house in order!"⁸⁴

As Chief Administrator, he made it clear that employees caught sleeping on duty would be sacked, and he enforced the rule when it was broken.⁸⁵ Though O'Brien was respected for his egalitarian ethic, he was not lionized in the memories of employees as Guggisberg was because he asserted control over the employees at the hospital by micro-managing their activities, behaviours, and social relations. O'Brien embodied a hybrid form of colonial, military and medical authority at Korle Bu, and as such was both feared and respected as the patrimonial leader of the institution.

⁸³ Patton, *Physicians, Colonial Racism*, 156-58; *Guggisberg*, 238-39.

⁸⁴ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 94.

⁸⁵ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 81.

Though demanding in his standards of professionalism during work hours, O'Brien reputedly knew everyone at Korle Bu by name and followed their careers closely, a characteristic that generated trust between him and his employees. He also promoted a lively social life at the institution. Sports activities were prominent in the memories of former staff members, who recalled that the hospital had football and cricket teams, and that there was a small golf course on the perimeter of the campus that was open to employees.⁸⁶ Despite his war injuries, O'Brien was an avid tennis player, and he even encouraged some of the staff to join him on the lawn tennis courts on the hospital campus after work. The camaraderie on the court was sometimes even extended into O'Brien's domestic space, as he occasionally asked hospital staff over to his house for drinks after a tennis match.⁸⁷ Though

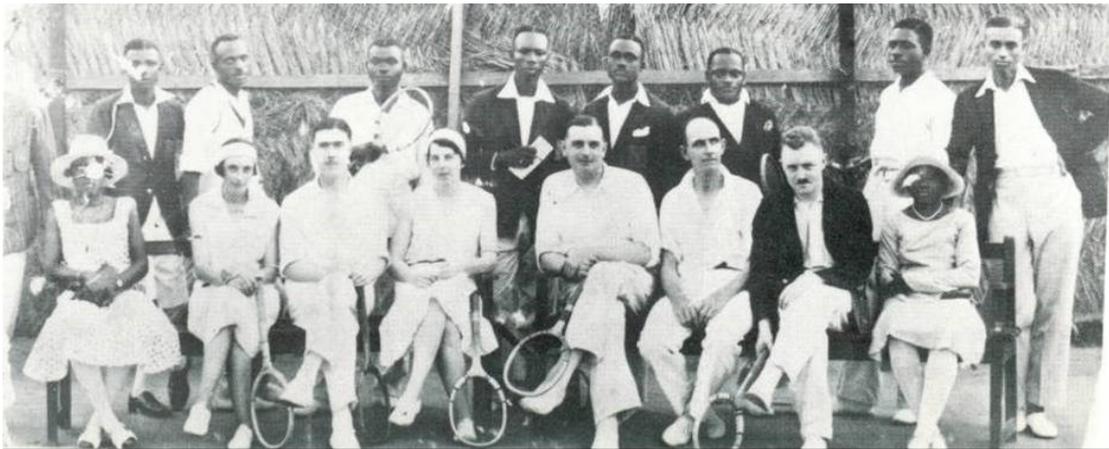


Figure 5.9. “After a friendly lawn Tennis Match, Europeans Vs Africans on the European Officers’ Courts.” This photo of hospital staff after a tennis match demonstrates the sort of fraternity that was promoted between Africans and Europeans at Korle But, but the seating arrangement exemplifies the authority of the white superiors, who are placed in the centre and surrounded by black subordinates (only two whom of seem to possess racquets) *Source: Korle Bu Hospital: Golden Jubilee Souvenir.* (Advent Publishing, Accra. 1973), 66.

⁸⁶ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 92.

the African staff would have been familiar with colonial sports of cricket and football, lawn tennis and golf were novelties in the city, and their initiation to the sports came exclusively from their white supervisors.⁸⁸ Africans and Europeans were not equals (a fact aptly demonstrated by Figure 5.9, in which colonial medical officials are seated in the centre of the photo while African subordinates sit or stand around the periphery) but at Korle Bu their relationships after-work relationships could be cordial and even friendly.

On special occasions like Christmas, the staff put together large feasts at the hospital. Everyone, white and black, administrators and staff, ate together and sang Christmas carols. As one nurse recalled,

Dr. A.J.P. O'Brien tried to bring the sunshine and warmth of cheery Christmas to the patients, African nurses and dressers of the establishment. Presents in cash amounting to over £30 were given to the nurses and dressers, supplemented by a sheep and drinkables to form the basis of a Christmas dinner: fancy biscuits and confectionary were distributed in generous measure to the patients and playthings to the juvenile invalids.⁸⁹

Christmas was a time when everyone at the hospital exchanged gifts, and the nurses recalled with fondness the gifts they received from wealthy Europeans, such as perfumes and other imported goods.⁹⁰ There were also awards during the Christmas season for the best decorated ward. While many employees at the hospital may have been Christian, Christmas at Korle Bu was more than just a religious celebration; it was a transition to a cultural timeline that differed dramatically from the calendar of Homowo. During the annual

⁸⁷ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 86.

⁸⁸ While football was a familiar sport to locals by the late 19th century and cricket had taken hold as popular sport in Accra by 1910, tennis was a new game that had only become popular in England after the First World War and probably only found its way into the Gold Coast in the 1920s. See J. A. Mangan, *The Cultural Bond: Sport, Empire, Society* (London: Routledge, 1992), 68; Moore & Guggisberg, *We Two in West Africa*, 69.

⁸⁹ *Gold Coast Independent*, January 12, 1929, 47; A game of lawn tennis (with exclusively white players and spectators) is referenced in Frenkel and John Western, "Pretext or Prophylaxis," 222.

⁹⁰ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 73.

harvest festival in Accra, the priests of the major shrines of Accra enforced restrictions on social gatherings and noise making throughout May and June, on threat of fines and confiscation of property. In July and August, the same priests opened up the fishing, harvested the first corn crop, and held public ceremonies where people could ask the gods to heal their illnesses and their social problems.⁹¹ Korle Bu was spatially and temporally divorced from Homowo celebrations and other religious and healing activities in Accra (including those conducted by Muslims) which meant that practice of medicine on the hospital campus was bound exclusively to Christian menology and the culture of interwar Britain.

Another special occasion that was well remembered was the annual Korle Bu Hospital Ball, a major social event in the city that attracted white medical professionals from around the colony, white colonial officials, the black elites of Gold Coast Society, and any dignitaries who happened to be in the colony at the time.⁹² The music played on pianos and brass horns at the Hospital Ball was emphatically different from the Kpele and Akon drumming rhythms associated with Ga healers and their spirits. Jazz was the popular music at Korle Bu social functions during the 1920s and 1930s, and “Show me the way to go home,” by Irving King, was remembered as a popular tune that was played and sung at the hospital (the song was also translated into Ga and sung in the dance halls and drinking spots of the city).⁹³ The interwar jazz culture of the Gold Coast, which later gave birth to a hybrid local music known as highlife,⁹⁴ is remembered by former employees as an inseparable part of the early years of the hospital.

⁹¹ Field, *Religion and Medicine of the Gã People*, 89-91, 106.

⁹² *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 73, 85.

⁹³ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 68.

⁹⁴ Collins, *Highlife Time*.

The degree of familiarity that British colonial officials and African staff members shared at Korle Bu resulted in some memories of mutual respect between white and black members of the staff. The British senior sisters who administered nursing at the hospital in the early years are prominent in the reminiscences of Ghanaian nurses, and were mostly remembered as gracious mentors who treated the staff with respect.⁹⁵ Similarly, some British-trained African physicians had fond memories of the white supervisors they worked under. Dr. Nanka-Bruce recalled how he met Dr. Le Fanu, a colleague at Korle Bu who spoke Twi, aboard a ship to Liverpool. In an age of segregation and social exclusion, Dr. Le Fanu was the only expatriate to speak to Nanka-Bruce during the whole two-week voyage to the UK. As the physician recalled, the rest of the Europeans “could hardly conceal their resentment of having a ‘native’ in that part of the ship.”⁹⁶ This story might have been idealised to take on a nostalgic tinge but it suggests that a professional camaraderie existed amongst white and black employees at Korle Bu, despite the overt racism that existed in the colony and the broader empire.

Although some forms of fraternization were acceptable on the hospital campus, there was still a strong distinction between colonial masters and colonial subjects. The intensity and the type of racism varied with the situations of subordination that they found themselves in, but authority was always vested in the Resident Medical Officer and the Hospital Matron and it was understood that these positions would never be held by Africans.⁹⁷ Not surprisingly, some of the staff resented the fact that they had never advanced to become the equals of their supervisors. As one British-trained physician phrased it, the black employees at the hospital were required to work under the “pressure of

⁹⁵ Cardinall, *Gold Coast*, 258; *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 68.

⁹⁶ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 94.

⁹⁷ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 77.

white supremacy” with no prospect of advancement into upper management.⁹⁸ The memories of nurses who worked at Korle Bu contain instances of the abuse of authority.⁹⁹ In particular they disliked one head nurse named Sister Evans and described her as an exacting perfectionist, “one of those Europeans with imperialistic stamp about them.”¹⁰⁰ Another nurse, Miss Marr, was described as someone “who exuded imperial arrogance from every pore and was obsessed with the idea of “putting the native in his place.””¹⁰¹ Though they were forced to accept that they were excluded from the highest ranks of power, the Gold Coast subjects who worked at the institution remained sensitive to any affront to their dignity. Guggisberg’s hope of seeing “white nursing sisters and black nurses combine together to look after the sick natives of the country” had been realised, but not without the interpersonal tensions of racism inherent in colonial rule.¹⁰² As Africans began to acquire the knowledge and skills in what had previously been the exclusive domain of Europeans, a resentment began to fulminate.

But as much as the African staff might have resented the arrogance or racism of their white supervisors, they could not oppose it; talking back was not tolerated, and hospital employees could be summarily dismissed for any insolence.¹⁰³ As one dispenser recalled, the African staff members were obliged to tolerate some of the racial slurs thrown their way, or even brush them off as motivational:

⁹⁸ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 77.

⁹⁹ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 78.

¹⁰⁰ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 68; for a parallel example from South Africa see Marks, *Divided Sisterhood*, 103.

¹⁰¹ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 94.

¹⁰² This is a quote from the back of a postcard entitled “A ward in the hospital for Africans, Accra, Gold Coast,” in the Smyly Gold Coast [i.e. Ghana] Collection, 1911-1929. Cambridge University Library: Royal Commonwealth Society Library. GBR/0115/Y30448L. Selected postcards of the Gold Coast [i.e. Ghana], West Africa 1924: series II. PC Gold Coast/7-11. 1924.

¹⁰³ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 77.

as much as the staff worked hard to justify a good report from superior officers, there were the usual abuses showered on them whenever there happened to be some slight fault. The abuses were in the form of “Hurry you son of a bush man” “You silly ape” or “You Western Kangaroo”. Funny enough these abusive expressions rather spurred the staff on to do better than expected.¹⁰⁴

These invectives may not have been remembered as grave insults, but they were not forgotten. The former employees of Korle Bu resented the way in which white supervisors belittled their subordinates, but they also recalled that such treatment was a condition of working at a colonial institution.

Though the hospital was not designed as a segregated institution, its employees still contended with the racial ideologies of the colonial society that surrounded it. As one former nurse recalled, the isolation ward was not used to prevent contagious diseases from spreading, but as a private ward for white patients:

The old Korle Bu Wards will have an interesting story to tell if they could speak. It may be observed that there was one block of these wards which was reserved as “ISOLATION BLOCK”. It was not used at all for cases requiring isolation. It was in fact used for hospitalising European patients.¹⁰⁵

The blue prints of Korle Bu Hospital did not contain racially divided wards and Guggisberg envisioned Korle Bu as a hospital for everyone in the colony. However, the dream of Korle Bu as an egalitarian space was never realized. Though the African employees at the hospital were participants in the novel medical culture of the British colonial medical institution, they were always aware that they were not equal partners in the colonial medical enterprise. They were colonial subjects in the purest sense because they exposed the ambivalence of the colonial project; their appropriation of medical knowledge was vital to the sustenance of the institution but at the same time it challenged the power of white medical elites, who placed prohibitions on black employees in order to assert their authority. The *Golden Jubilee Souvenir*

¹⁰⁴ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 77.

contains remembrances of a time when African employees could aspire to reach the heights of training in medicine, but also feel stifled by the strictures of colonial rule. They could never expect to supervise a white person, but they were also coopted into the medical system and provided with powerful medical skills. These professional attributes translated into social status, and cultural capital, as the new generation of medical professionals took their place as the elites of colonial society.

Section 4. Naa Ede Oyeadu and “Mothercraft”: Changing Notions of Maternity and the Social Medicine of Cicely Williams

*Naa webii ne;
Wobe ye feo tso
Moko na wofee.
Oshi Akwan webii ne;
Naa Ede webii ne;*

This is grandmother’s family;
We are very beautiful,
Someone wishes to be like us.
This is the road blocker’s family;
This is Naa Ede’s family.¹⁰⁶

This song, recorded by anthropologist Marion Kilson in the 1970s, was sung in dedication to Naa Ede Oyeadu, the goddess of birth and re-growth, who once had a shrine in Ussher Town. The goddess of Naa Ede Oyeadu had been resident at Abeitsa We, one of the prominent Ga family houses in Accra, and her priest played the role of interlocutor between women and the spirits of fertility, an agent of discipline for women who did not follow the taboos of motherhood.¹⁰⁷ Women who died in childbirth were not interred in household burial grounds, but “left on the ground exposed to the elements” of the *kose*, the

¹⁰⁵ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 76.

¹⁰⁶ Kilson, *Kpele Lala*, 156.

wild bush areas outside of the city, because the death of the child was believed to create a social rupture that excluded the deceased mother from being remembered as an ancestor.¹⁰⁸ The property of the deceased mother was forfeited to the house of Naa Ede Oyeadu until the paternal home of the deceased was purified by Naa Oyeadu Ede's priest¹⁰⁹ -- at the cost of one sheep, several chickens and eggs, dozens of yards of cloth, and cash fees in the range of ₵60-70, a price borne by the family of the deceased.¹¹⁰ The goddess is no longer resident in Accra because in 1905, the District Officer arrested the priest of Naa Ede Oyeadu, charged him with extortion, and sent the Gold Coast Police to demolish the shrine.¹¹¹ It was the only shrine in Accra that was officially gazetted as "suppressed" under colonial rule.¹¹²

Naa Ede Oyeadu was a prominent deity in Accra because residents of the city paid great respect to women who were able to produce many, healthy children.¹¹³ Because of the high infant mortality rate in the city, women with large families were considered wealthy and spiritual powerful because they were able to defeat the invisible forces that threatened to block conception and birth. Women who entered into marriage contracts were expected to produce children in order to maintain the conjugal union; failure to produce a child could result in a loss of status for a wife within their own kinship group, their husband's kinship group, and within their own household vis-à-vis other wives.¹¹⁴ Women who could not

¹⁰⁷ Interview, Naa Ede Oyeadu. August 23, 2010.

¹⁰⁸ Kilson, *Kpele Lala*, 156. See also Quartey-Papafio, "the Ga Homowo Festival," 231.

¹⁰⁹ Kilson, *Kpele Lala*, 156. See also Quartey-Papafio, "the Ga Homowo Festival," 231-32.

¹¹⁰ PRAAD ADM 11/1/1437, "Suppression of objectionable customs," 21-22.

¹¹¹ Kilson, *Kpele Lala*, 156; Kilson, *Diary of Kwaku Niri*, 30, 44. See also Parker, *Making the Town*, 101-02, 173; PRAAD ADM 11/1/1437, "Suppression of objectionable customs (compiled circa. 1930)."

¹¹² Field, *Religion and Medicine of the Gã People*, 6,10-11, 18-25,

¹¹³ Field, *Social Organization of the Gã people*, 216; Quarcoopome, "The Impact of Urbanization," 151.

¹¹⁴ Craddock, *Retired Except on Demand*, 57. There was so much pressure to reproduce that some women offered bribes to doctors at Korle Bu for certificates to prove they were pregnant.

produce children were thought to reside in a liminal gender state, as incomplete women suffering from a spiritual blockage of their fertility. They might even be suspected to be witches, the embodiment of an evil jealousy that devours life rather than creating it.¹¹⁵ The suppression of the Naa Ede Oyeadu shrine eliminated the priest's role as a mediator between the spirit world and practices of birth and mothering, creating a vacuum that could be filled by colonial medical practices.¹¹⁶ This section will demonstrate how the Princess Marie Louise Maternity Hospital at Korle Bu and a number of well-baby clinics around the city were able to fill the gap created by the absence of Naa Ede Oyeadu, and propagate a new culture of parenting called "mothercraft." As a central part of Guggisberg's strategy to increase the workforce on the Gold Coast, maternal and infant care became more highly medicalized than any other component of health and healing in Accra.

What brought childbirth and maternity care under the gaze of the Medical Department was a fear of depopulation in the Gold Coast Colony. In 1915, Dr. Nanka-Bruce brought to the attention of the Gold Coast Legislative Council that the infant mortality rate in Accra was 360 per thousand.¹¹⁷ He argued that this was unconscionable for a colonial government that feared that demographic stagnation would hamper the economic growth of the colony,¹¹⁸ and he strongly encouraged the colonial government to construct a maternity hospital to provide antenatal care for mothers, and to train midwives.¹¹⁹ The Medical Department was mute in its response, likely because the Principal Medical Officer was unable to initiate any change in maternal care until the cocoa revenues of the 1920s

¹¹⁵ Field, *Religion and Medicine of the Ga People*, 93.

¹¹⁶ PRAAD ADM 11/1/1437, "Suppression of objectionable customs," 22.

¹¹⁷ Gilford A. Ashitey, *An Epidemiology of Disease Control in Ghana. 1901-1990* (Accra: Ghana Universities Press, 1994), 27.

¹¹⁸ Davin, "Imperialism and Motherhood," 10.

made the expansion of the health care system possible. But when funding was available, the fear of a stagnant population made infant and maternal care a cornerstone of colonial medicine, as it was in many other colonies in Africa where similar concerns about slow population growth spurred medical interventions.¹²⁰

The growth of maternal and infant care began in 1923 when Dr. Jessie Beveridge, a Scottish missionary, opened a small infant welfare clinic in a mud hut behind the Basel Mission school in Christiansborg. Shortly after the clinic opened, and showed that it was a success, the Gold Coast Government supported the clinic with a grant-in-aid, drugs, and the salary of an interpreter.¹²¹ In 1924, Dr. G.J. Pirie, head of the health branch, conceived of a plan for infant welfare clinics around the colony, and in 1925 the Health Department opened one on Derby Avenue (north of Ussher Town) in 1925.¹²² Both the Christiansborg and Ussher Town clinics charged nominal fees for advice and treatment regarding infant care, and they were well patronized. The statistics are incomplete but those that we do have shown that the Christiansborg clinic saw 2,700 children in the second half of 1924, and Ussher Town Clinic treated 549 children in the months of February and March alone.¹²³ The construction of infant welfare clinics was followed by the opening of a maternity hospital at Korle Bu in 1928, named after Princess Marie Louise, who visited the Korle Bu campus in 1925.¹²⁴ When Governor Guggisberg removed the fees required for visits to the hospital

¹¹⁹ Addae, *Evolution of Modern Medicine*, 227; G. I. C. Eluwa, "Background to the Emergence of the National Congress of British West Africa," *African Studies Review* 14, no. 2 (September, 1971), 206.

¹²⁰ Hunt, *Colonial Lexicon*, 3.

¹²¹ Patterson, *Health in Urban Ghana*; Addae, *Evolution of Modern Medicine*, 228; Noel Smith records this as opening in 1922 (Smith, *Presbyterian Church of Ghana*, 186).

¹²² *Gold Coast Independent*, July 24, 1926, 802. See also Addae, *Evolution of Modern Medicine*, 230.

¹²³ Gold Coast Colony, *Report on the Medical Department by the Government of the Gold Coast* (Accra: Government Press, April 1924 to March 1925), 23.

¹²⁴ Collett, *Accra Diocese*, 32.

and infant welfare clinics in 1927, attendance rose quickly, and by the early 1930s, the number of children treated at Korle Bu per annum rose to over 100,000 per year.¹²⁵

The rise of medicalised childbirth and childcare not only filled the vacuum left by the absence of the shrine to Naa Ede Oyeadu, it also challenged the authority of African midwives. The category of midwife was not listed as an occupation in the Gold Coast Census during the interwar period, likely because it was a part-time vocation learned through apprenticeship but in 1921 it was briefly mentioned in one census report as an “age-long practice,” dozens of women in the city who had learned herbal remedies for barrenness, difficult menstruation, complications arising from pregnancy, and infant illnesses through apprenticeship with older kinswomen.¹²⁶ They passed on knowledge about fertility, pregnancy, childbirth and maternal care orally, beyond the purview of the colonial state, in a gendered sphere of women’s knowledge. However, without the spiritual framework that Naa Ede Oyeadu created for local customs of childbirth, and without any coordinated professional association, it appears that midwives in Accra were either sharing their clients with the hospital and the clinics, or were losing clients altogether. What the Medical Department offered to mothers in the interwar period was a set of new practices known as “mothercraft,”¹²⁷ a set of maternal skills that were learned via instruction. At the well-baby clinics, mothers were offered advice about what to eat while they were pregnant, recommendations about how to prepare for childbirth, and information about how to feed and care for infants. No longer were the bearers of knowledge about childbirth and infant care comprised of priests, spirit mediums, midwives and elders -- knowledge of mothercraft was distributed by health professionals connected to the colonial state. So pervasive was the

¹²⁵ Addae, *Evolution of Modern Medicine*, 231-34; Patterson, *Health in Colonial Ghana*, table 8.

¹²⁶ *Gold Coast Census*, 1921, 163; Acquah, *Accra Survey*, 125-27.

¹²⁷ Ana Davin, “Imperialism and Motherhood,” 55.

impact of colonial maternity and infant care on the culture of women Accra that by the late 20th century, the term *kolebu* had become a Ga term for “maternity dress.”¹²⁸

The physicians of the Medical Department believed that maternal care offered the mothers of the city a “break from tradition,” a way for women to publicly declare themselves as followers of colonial medicine.¹²⁹ To facilitate this break, and bring colonial medical praxis into the life-cycles of the subjects of the Gold Coast, the government supported the work of the Gold Coast League for Maternal and Child Welfare (which was initiated by Lady Slater, the wife of Alexander Ransford Slater, who was the Governor of the Gold Coast from 1927-32). The League, comprised of Women Medical Officers, wives of colonial officers and matrons of elite African families, extended the work of the infant welfare clinics into the homes of mothers in the city by conducting household visits to encourage mothers to follow colonial methods of child rearing.¹³⁰ Their work was most evident during Health Week, a festival inaugurated in 1922 that included public health lectures by doctors and a general cleanup of the city led by school children and other civic groups.¹³¹ During Health Week, nurses in the employ of the Colonial Medical Service ran education programs to teach women in Accra about the need to keep their baby’s surroundings clean.¹³² The grand finale of Health Week was a baby show held in the heart of Ga territory, at Bukom Square.¹³³ In

¹²⁸ Dakubu, *Ga-English Dictionary*, 85; the association with different dress styles with the new institution is not surprising considering how prominently style figures in the memories that former nurses have of Korle Bu. See *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 68-73.

¹²⁹ Gold Coast Colony, *Report on the Medical Department by the Government of the Gold Coast* (Accra: Government Press, April 1924 to March 1925), 10.

¹³⁰ Addae, *Evolution of Modern Medicine*, 231.

¹³¹ *Gold Coast Independent*, December 16, 1922, 604.

¹³² *Gold Coast Independent*, November 6, 1926, 1357; *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 42.

¹³³ “Baby weeks” were also held in Nigeria and the Gambia, see Horn, “Control of Disease in Tropical Africa: Part I,” 25.



Figure 5.10. Prizewinner at Accra baby show with mother and patroness, Gold Coast, 1920s. (photographed by Miss G. Smyly). The highlight of Health Week was the annual baby show, which was attended by prominent women from all segments of Accra society. The show offered a chance for women to demonstrate their mothercraft skills, show off their best attire, and to compete with other women for prizes. The winning baby depicted in this photo is standing in front of the (unnamed) mother and Miss G. Smyly (daughter of Chief Justice of the Gold Coast). The child is wearing rosettes and a medallion, and holding a prize of a silver cup, and the mother is outfitted in fine cloth and jewellery. In an analysis of the photography of children in West Africa, Beinart argues that prior to the 1920s, the children appeared only as a background figures on margins of group photos. During the interwar period in the Gold Coast, they were thrust into the photographic spotlight as products of imperial mothercraft, “somewhere between a fatted calf at a livestock show, and a star pupil at a school prizegiving.” *Source:* Smyly collection in Royal Commonwealth Society Library, printed Jennifer Beinart, “Darkly through a Lens: Changing Perceptions of the African Child in Sickness and Health, 1900-1945.” In *In the Name of the Child: Health and Welfare, 1880-1940*, edited by Roger Cooter, 220-243 (London: Routledge, 1992), 222-24, 226-27.

1926, the event was judged by a group of women from prominent African families and the wives of British government officials, and was attended by dozens of people from Accra, including the governor. The organizers offered trophies to the healthiest baby in different age categories, as well as consolation prizes for all the contestants.¹³⁴ The baby show was a success, attracting mothers and children from different ethnic backgrounds and from both Christian and Muslim households.¹³⁵

The rise of mothercraft corresponded with the rise in literacy in the city during the 1920s, which increased the readership of pamphlets and booklets related to childrearing. The *Mothercraft Manual*, a pamphlet written by Mabel Liddiard on the science of and morals of infant care (based on the work of New Zealand health reformer Dr. Truby King) was widely read in Britain during the interwar period and became available in Accra in the 1920s.¹³⁶ Some literate residents of the city treated it as an authority on raising children according to colonial medical principles. In an essay competition held by the Methodist Book Depot in December of 1935, a young woman recommended the book to girls who planned to be mothers:

each time or at any time I read [it] I feel still much interested as if I have not read it before. I hope to become in future a careful and healthy mother to mind my children according to the methods and instructions given in my most favourite book. For fear of forgetting some good parts in it I am treating it as my bosom friend.¹³⁷

¹³⁴ *Gold Coast Independent*, November 6, 1926, 1357; for more information on “Baby Weeks” held in Britain see Ana Davin, “Imperialism and Motherhood,” 43.

¹³⁵ *Gold Coast Independent*, November 13, 1926, 1389.

¹³⁶ Mabel Liddiard, *The Mothercraft Manual, Etc.* (London, 1924); Cathy Urwin and Elain Sharland, “From Bodies to Minds in Childcare Literature: Advice to Parents in inter-war Britain,” in *In the Name of the Child: Health and Welfare, 1880-1940* ed. Roger Cooter (New York: Routledge, 1992), 177; Philippa Mein Smith, “King, Sir (Frederic) Truby (1858-1938)”, *Oxford Dictionary of National Biography* (Oxford University Press, 2004), accessed August 3, 2009, <http://www.oxforddnb.com/view/article/34320>.

¹³⁷ PRAAD CSO 18/1/144, *Methodist Book Depot – Gold Coast*, “Report on an Essay Competition Held in the Gold Coast in December/January, 1935/1936,” IG-IH; PRAAD CSO 18/1/144, IC.

It was a significant text even for non-literate mothers who browsed its pages to look at the before and after images of sickly infants transformed into healthy babies through careful mothercraft.¹³⁸ British textbooks on mothering were also translated into the local languages. In 1926, the colonial government printed a manual for child care (written by Dr. Beveridge) for distribution as an instructional manual for feeding and caring for babies in the tropics. Entitled *Healthy Babies: Advice to Mothers*, it was translated into Ga and Twi and circulated around the city of Accra as a reference text for training the women of Accra to raise their babies according to British colonial standards.¹³⁹ Unfortunately, there are no extant copies of the translated versions, so the precise terminology used to translate concepts of mothercraft into Ga or Twi terminology is lost, but the simple fact that they were translated speaks to both demand from African mothers and the desire of nurses and doctors to introduce the women of the city to the practices of mothercraft. It also demonstrates how literacy had become part of being a good mother.

Infant vaccination campaigns were a regular component of the colonial medical budget, and in the 1920s, public small pox vaccinations for babies were patronised *en masse* by the women of Accra. Considering the long-standing local practice of ritual scarification and success of previous colonial inoculation campaigns, it is not surprising that mothers began bringing their children to inoculation clinics even before the construction of Korle Bu. The demand for the needle left doctors wondering if they were vaccinating some

¹³⁸ PRAAD CSO 18/1/144, *Methodist Book Depot*, IG-IH.

¹³⁹ D. G. Brackett and M. Wrong, "Notes on Hygiene Books Used in Africa," *Africa: Journal of the International African Institute* 3, no. 4. (October, 1930), 514. The pamphlet was authored by a Mrs. Beveridge (likely the same person as Dr. Jessie Beveridge, the missionary who opened a small infant welfare clinic in Christiansborg in early 1923). There are no extant copies.

children more than once, as indicated in a statement made by Dr. May of the European Hospital at Christiansborg in the 1920s,

In a way we're becoming too popular. Take vaccination, for instance. I think it's important that all the children should be vaccinated, so I buy huge tins of sweets. Every child gets a sweet with the injection, and now they seem to come just for the sweet. I suspect that I am vaccinating a large proportion of the child population of Christiansborg at weekly intervals.¹⁴⁰

Women were coming to get medicines to protect their children from disease, which they might have understood as a ritual inoculation, as a vaccination to confer immunity to a specific disease, or perhaps both. But as a corollary they were participating in the urban culture of mothering, which included being seen at the clinic and treating their children to imported candies. In the 1920s, constructing oneself as a woman and a mother involved participating in colonial medical infant care, including traveling to clinics for vaccinations.

As it was for Korle Bu as a whole, the demand for injections spurred attendance at the Princess Marie Louise Hospital and its outlying clinics. The infant welfare clinics offered free injections to mothers whose babies were suffering from malarial fevers, a therapy that had widespread appeal considering babies could suffer from several bouts of malaria in their first years. Treatments for yaws were also popular.¹⁴¹ During the 1920s, British nurses and doctors recalled seeing children suffering from severe sores on their faces, with noses missing, and with legs so damaged that they were lame. In response, the Health Department offered a weekly “yaws morning,” when mothers could bring their children for injections of bismuth silicate.¹⁴² It was a drastic and painful therapy for children, but it took effect more rapidly than the treatments offered by African healers and was therefore favoured by parents

¹⁴⁰ Dally, *Cicely: The Story of a Doctor*, 30.

¹⁴¹ Gold Coast Colony, *Report on the Medical Department by the Government of the Gold Coast* (Accra: Government Press, April 1924 to March 1925), 10.

¹⁴² Dally, *Cicely: The Story of a Doctor*, 28.

who were desperate to save their children from disfigurement.¹⁴³ There was no other class of healer in the city that offered such a immediate improvement in the health of the patient, and thousands of mothers from around the colony brought their children to Korle Bu and infant welfare clinics for the treatment. It was so popular that one doctor recalled giving 150 shots in a single morning.¹⁴⁴

The Princess Marie Louise Hospital was administered separately from the main Gold Coast Hospital, and its first Medical Officer was a woman, Dr. Grace Summerhayes. Only a few months after her appointment, Summerhayes had organised an antenatal clinic and established a midwife training school,¹⁴⁵ and within her first year she delivered 107 babies at the hospital. By 1931, the number of deliveries quadrupled had to 452 and the maternity hospital soon became overcrowded.¹⁴⁶ During this same period the maternity hospital admitted 183 pregnant women as in-patients, the majority for malaria.¹⁴⁷ Dr. Summerhayes recalled her work at Princess Marie Louise Hospital with a great fondness, but she was director only until 1931, when she married Dr. McRae, one of the British doctors at the hospital, and became pregnant. She left the Gold Coast to have her children in England and only returned with them as infants.¹⁴⁸ Her absence from the maternity hospital was notable;

¹⁴³ Margaret Field mentions the ubiquity of yaws amongst children in her novel, *The Stormy Dawn* (published under the pen name Mark Freshfield), Mark Freshfield, *The Stormy Dawn* (London: Faber and Faber, 1946), 79.

¹⁴⁴ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 86; Gold Coast Colony, *Report on The Medical Department by the Government of the Gold Coast* (Accra: Government Press, April 1924 to March 1925), 6; Addae, *Evolution of Modern Medicine*, 261-68.

¹⁴⁵ *Gold Coast Independent*, February 22, 1941, 61.

¹⁴⁶ Gold Coast Colony, *Report on the Medical Department by the Government of the Gold Coast* (Accra: Government Press, April 1932 to March 1931), 165.

¹⁴⁷ Gold Coast Colony, *Report on the Medical Department by the Government of the Gold Coast* (Accra: Government Press, 1929), 211.

¹⁴⁸ *Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir*, 85-86; Addae, *Evolution of Modern Medicine*, 236.

despite its position as a provider of the most technologically sophisticated maternal care, the hospital was still not considered a suitable place for white women to give birth.

In 1934, the appointment of Doctor Cicely Williams as director of the Princess Marie Louise Hospital signalled a notable change in the attitude towards infant and women's health at Korle Bu.¹⁴⁹ Born in Jamaica, Williams was one of the first women to earn a medical degree from Oxford, and she began her work as a Woman Medical Officer in a variety of clinics around in Accra, Kumasi and Koforidua. She was ideologically influenced by the work of Andrija Stampar, a professor of Hygiene and Social Medicine at Zagreb University who argued that infant care formed a fundamental part of improving the health of society as a whole. Using Stampar's model, Williams planned to incorporate "social medicine" into the mandate of the hospital in order to take into account the causes of childhood illnesses within Accra.¹⁵⁰ To get to the source of deficiencies in nutrition and to learn more about local practices of mothering, Williams allowed mothers to sleep beside their babies in the children's ward, an unorthodox approach that put her in conflict with the hospital administration.¹⁵¹ Williams worked diligently to learn some Twi and a little Ga so she could communicate more effectively with her patients,¹⁵² and approach that paid

¹⁴⁹ Dally, *Cicely: The Story of a Doctor*, 46.

¹⁵⁰ Craddock, *Retired Except on Demand*, 55; for more detail on the ideas of Andrija Stampar see M.D. Grmek, ed., *Serving the Cause of Public Health: Selected Papers of Andrija Stampar* (Zagreb, Andrija Stampar School of Public Health, 1966), 12.

¹⁵¹ Craddock, *Retired Except on Demand*, 55; Williams' approach fit into a larger concern for the health of colonial subjects that developed during the 1920s, as represented in a series of reports on global nutritional deficiencies published by Boyd Orr and JL Gilks in Britain in 1927, and by the League of Nations in 1931. Michael Woorboys, "The Discovery of Colonial Malnutrition Between the Wars," in *Imperial Medicine and Indigenous Societies* ed. David Arnold (New York: Manchester University Press, 1988), 212-3; for a critique of the work of Orr and Gilks, see Cynthia Brantley, "Kikuyu-Maasai Nutrition and Colonial Science: The Orr and Gilks Study in Late 1920s Kenya Revisited," *The International Journal of African Historical Studies* 30, no. 1 (1997), 49-86.

¹⁵² Williams, "Witchdoctors," 450.

dividends when she encountered a form of malnutrition known to Ga-speakers as *kwashiorkor*: the sickness an older child gets when the next baby is born.¹⁵³

Kwashiorkor is now known as a descriptive term for the symptoms found in children who lack protein in their diet. Cicely Williams encountered the word when she was trying to diagnose a sick baby with a distended belly and reddish brittle hair.¹⁵⁴ She found that she could not precisely determine what caused the child's illness, so she asked one of her locally trained nurses what she thought was ailing the baby. At Korle Bu, nurses normally deferred to doctors and were not used to offering their opinions about disease causality, but in this case a Ga nurse named Christine Bryant told Williams that the baby was suffering from *kwashiorkor*. Williams used her limited knowledge of Ga and, in conversation with Bryant, decided to translate the term as "the deposed one," or the sickness that the older child gets when it is weaned from the mother's breast.¹⁵⁵ When Williams followed up with the child's parent, she found that the child had been weaned early and been given a diet of only maize pap (known as *akasa* in Ga). The result was a severe protein deficiency that led to oedema and anaemia. Based on her experience, Williams knew that if the child was malnourished for months on end it could suffer from cirrhosis of the liver or possibly die.

To combat *kwashiorkor*, Williams encouraged the staff at the hospital and well-baby clinics to teach mothers how to add vitamins and protein to their children's diet. Nurses

¹⁵³ Williams, "Witchdoctors," 450.

¹⁵⁴ Dally, *Cicely: The Story of a Doctor*, 28.

¹⁵⁵ Dally, *Cicely: The Story of a Doctor*, 48, 59. See also, *Retired Except on Demand*, 62. For a more detailed explanation of how the word *kwashiorkor* is used as a term of positional status amongst siblings see George J. Fuchs, "Antioxidants for children with kwashiorkor," *British Medical Journal* 330 (2005): 1095, accessed April 9, 2010, <http://bmj.bmjournals.com/cgi/eletters/330/7500/1095>. The term is also mentioned in Field's work as a form of jealousy between the first born and child in the womb that causes illness and wasting in the first born. Field, *Religion and Medicine of the Gã People*, 165-66. It is possible Field's work on the Ga may have influenced Williams' conceptions of Ga childhood, but there is no record of them knowing one another.

started to suggest that mothers add fish to their babies' maize pap to increase protein content, and they offered a wide variety of imported British foods for the mothers to purchase (including tins of butter, bottles of cod-liver oil, jars of marmite, and bottled malt drinks) in order to supplement the nutritional requirements of the infant patients.¹⁵⁶ Cicely Williams would later become famous for her campaign against marketing sweetened condensed milk as a breast milk substitute, but when she worked in Accra, Williams considered condensed milk to be a vital supplement for babies because it was produced under sanitary conditions, contained less fibre than corn meal, and did not contain hot pepper, which she considered too strong for children.¹⁵⁷ Williams even wanted to provide the Nestle representative in the Gold Coast with the data of the success rates she had had at curing *kwashiorkor* with a diet of tinned milk, but Governor Slater disapproved because Nestle was not a British firm. The emphasis on imported goods was not surprising, as it allowed nurses to monitor the preparation of baby food so that they could be certain that its source followed rules of sanitation, but an obsession with tinned milk was also an imported anxiety from a Britain, one that had developed in Britain in the 19th century and early 20th century when Public Health officials considered unhealthy milk supplies to be a major factor in infant mortality.¹⁵⁸ In Accra, a city without a dairy industry, Ga and Twi-speaking mothers would not have known the historical significance of tinned milk but would have quickly realized that, like the consumption of patent medicines, the consumption of imported foods

¹⁵⁶ Cicely Williams, "A Nutritional Disease of Childhood Associated with a Maize Diet," *Archives of Disease in Childhood* 8 (1933), 423-33.

¹⁵⁷ Williams, "A Nutritional Disease of Childhood," 425; Craddock, *Retired Except on Demand*, 67.

¹⁵⁸ Ana Davin, "Imperialism and Motherhood," 11, 29, 34, 37: according to Jennifer Beinart, a historian of childhood in Africa, baby shows were used in many African colonies as means of guiding women toward colonial medical care and as a means of encouraging mothers to buy imported medicines. Jennifer Beinart, "Darkly through a Lens: Changing Perceptions of

was an integral part of the performance of mothercraft.¹⁵⁹ The culture of mothering that radiated outward from Korle Bu encouraged the use of commodified foodstuffs and was part of a medicalization of the lifestyles of the colonized that differed from earlier dramatic interventions like sanitary reforms, relying instead on a soft power that encouraged a competitive culture of child rearing.¹⁶⁰

The Princess Marie Louise Hospital and the infant welfare clinics made colonial medicine part of raising a family in Accra, but even when medical conceptions of maternity and child rearing penetrated the culture of Accra, women continued to seek the aid of African midwives. Dr. Williams recognised this fact when she found that women came to the hospital after visiting African midwives and herbalists who had administered herbal concoctions to their vaginas and anuses in preparation for birth.¹⁶¹ Though she considered local healing practices unsanitary and detrimental to the health of the patient, she was aware that patients transited between healing systems. She also found that mothers were not resentful or critical if she was unable to cure their babies, but were rather quite willing to go back to Accra to seek help from other healers.¹⁶²

In one particular case, Williams attempted to treat a baby who suffered from muscle spasms and an arched back, symptoms that she assumed were signs of tetanus. Williams thought that there was nothing she could do to save the baby, so she discharged the child.

the African Child in Sickness and Health, 1900-1945,” in Cooter, *In the Name of the Child*, 222-24, 226.

¹⁵⁹ Stanton, “Listening to the Ga,” 160.

¹⁶⁰ For similar attempts to encourage the consumption of commodities related to child rearing see Nancy Rose Hunt, “Le Bebe en Brousse”: European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo,” *The International Journal of African Historical Studies* 21, no. 3 (1988), 424.

¹⁶¹ Cicely Williams, “Child Health in the Gold Coast,” *Lancet* (January 8, 1938), 98-99.

¹⁶² Craddock, *Retired Except on Demand*, 70. Beinart, “Darkly through a Lens,” 232; see also Gold Coast Colony, *Report on The Medical Department by the Government of the Gold Coast*. (Accra: Government Press, April 1930 to March 1931), 167.

The mother took the baby to a local healer named Ata Ofori and, to Williams's amazement, reported back a few days later claiming that the man had cured the baby.¹⁶³ Williams described Ofori as a "witch-doctor," but she was aware that he was reputed to have cures for tetanus and meningitis. In fact, Ofori was a highly regarded, fully trained herbalist who specialized in treating convulsions in children with malaria. He was also part of a network of African healers, and participated in drumming and dancing sessions at his home while offering consulting services for spiritual problems and curses.¹⁶⁴ Williams met Ata Ofori at his home James Town, and he returned the visit with a special trip to her clinic in Ussher Town. Williams' biographer, Sally Craddock, offered this account of their first meeting:

Cicely called on one dignified, rather bald African witch doctor called Ata [Ofori] to 'learn our medicine', hoping that in return he might teach her his. For three years Cicely sent patients on to him if she thought there was nothing she could do. For three years he maintained his proud secrecy, keeping up an amicable relationship with her but always more than arm's length. Suddenly one day two very small boys arrived carrying a vast bundle wrapped in handwoven cloth. Behind them was Ata [Ofori], in ceremonial robes. This was obviously a visit of great importance. He told the boys to open the wrapping and onto the floor tipped a smelly pile of curious, almost unrecognizable things. Dried-up roots, leaves, the droppings of unidentifiable birds, lizard legs, desiccated bits of chicken wing, insects, twigs, all crazily jumbled together and all deeply significant. As he explained their uses, Cicely took notes. She was not botanist and one piece of desiccated meat looks much like another, but she managed to list eighty items before the witch doctor and his retinue had gone, leaving her excited and flattered by his unprecedented display of confidence in a white fellow practitioner.¹⁶⁵

Williams' regarded this as a breakthrough because her relationship with an African healer developed to the point where he revealed his tools of healing. She spent time with Ofori, taking walks with him to collect fresh herbs and discuss their applications. After several

¹⁶³ Dally, *Cicely: The Story of a Doctor*, 76-77.

¹⁶⁴ Interview, Dr. Barnor, August 29, 2003. Dr. Barnor' was told by his father, a devout Christian, never to go near Ata Ofori, so he never met him in person.

months, Williams had hundreds of specimens, and during her next furlough she took them back to England to have them analysed. According to Williams' biographers, when she took the samples to the London School of Hygiene and Tropical Medicine she encountered such a degree of male chauvinism, medical intransigence and outright racism that no one would help her investigate their medicinal properties.¹⁶⁶ The whereabouts of the specimens today are unknown, but were likely lost when Williams was captured by the Japanese army in Malaya during the Second World War.¹⁶⁷

Williams' accounts of her time at the hospital also show how, despite a cultural emphasis on fertility in the city, the women in Accra tried to retain as much control over their own reproductive capacities as possible.¹⁶⁸ She recalled that women came to her clinics with "their vaginas stuffed with all sorts of curious things, from grated ginger to ornaments, as treatments, cosmetics or contraceptives," and that many women asked her for advice on how to space their births and avoid unwanted pregnancies. For women who wanted contraception, Williams suggested "a sponge soaked in cocoanut oil, tied on a tape, and inserted" into the vagina, but when she realised that this was not the most effective method she could offer, she ordered Dutch cap diaphragms from England.¹⁶⁹ She later argued that she did not offer contraception as a "marital aid" but rather to allow women with too many

¹⁶⁵ Craddock, *Retired Except on Demand*, 71; Williams, "Witchdoctors," 452; Dally, *Cicely: The Story of a Doctor*, 78-79. The name of the *woytse* has been changed to Ofori, according to William's spelling, rather than Oforli, as printed in Craddock.

¹⁶⁶ Craddock, *Retired Except on Demand*, 71.

¹⁶⁷ William's samples and notes from her meetings with Ata Ofori likely went missing when she became a prisoner of war in Malaya. "A Pioneer, A Survivor: Dr. Cicely Williams: Jamaica's Gift to the Field for Maternal and Child Health Care 1893 -1992," *Jamaica Gleaner* (November 26, 2002), accessed June 4, 2014, <http://jamaica-gleaner.com/pages/history/story0037.htm>.

¹⁶⁸ Craddock, *Retired Except on Demand*, 57-58; a common form of abortion medicine fabricated by herbalists in Accra is a ball of consecrated herbs and *ti* that is inserted into the vagina to dilate the cervix. Interview, Nurse Evelyn Rose Naa Ahima Gilbertson, April 16, 2004.

children to avoid unwanted pregnancy.¹⁷⁰ Her strategy on reproduction was not necessarily driven by the cultural demands of women in Accra, but was informed by her belief that women would always choose a few healthy children over many malnourished and sickly offspring.¹⁷¹

What we know about Cicely Williams is found in two biographies, each of which has a tendency to wax hagiographically about the achievements of the doctor. Her tenure on the Gold Coast was short, so we do not have any oral memories to reinforce the significance of her influence on the culture of childrearing in Accra. However, what is clear is that she was a nonconformist physician who aspired to overcome both colonial medical dogma and indigenous ignorance about what she believed to be the objectively quantifiable benefits of medicine. She favoured an approach to medicine that anticipated better parenting with the aid of scientific advances and commodified foods and drugs, a type of social medicine that did not distinguish between the colonised and the colonisers in its altruistic intent.¹⁷²

Unfortunately, this sort of spirit was not sustainable at Korle Bu under the patriarchal direction of Resident Medical Officer Percy Selwyn-Clarke. Selwyn-Clarke and Williams clashed in 1934 over whether to focus on infant or toddler care. He was determined to decrease the infant mortality rate by focusing on newborns, whereas Williams claimed more attention should be paid to toddlers with *kwashiorkor*. Their dispute came to a climax in 1935, when Williams allowed a child with tuberculosis to remain with her mother in the children's ward, violating the hospital rules for isolating patients with infectious diseases. Williams feared the child would die without its mother nearby, but Selwyn-Clarke used this as

¹⁶⁹ Craddock, *Retired Except on Demand*, 57-58.

¹⁷⁰ Craddock, *Retired Except on Demand*, 57-58.

¹⁷¹ Craddock, *Retired Except on Demand*, 57-58.

¹⁷² Newell, *Literary Culture in Colonial Ghana*, 44.

an opportunity to transfer her out of the Gold Coast. She was relocated in disgrace to Malaya, where she continued to pursue forms of social medicine.¹⁷³

The rupture of Naa Ede's family created an opportunity for colonial maternity services from the campus at Korle Bu into the heart of the city of Accra. Although midwives continued to practice, the local occult forces that gave motivation to their work had been vanquished, leaving a cultural gap that the maternity services at the Gold Coast Hospital were able to fill. Quite suddenly, mothercraft became part of the culture of being a mother in Accra, especially for those who aspired to the bourgeois norms of colonial society. This did not mean that African traditions of infant and maternal care were extinguished. Evidence from Cicely Williams' diaries show that midwives still provided aid to pregnant women and to babies, and offered contraceptives to women. Nonetheless, colonial maternal and infant care had clearly exploited a gap in African healing culture in way that extended European-derived healing methods further into the heart of Accra than ever before.

Conclusion

The Gold Coast Hospital established a strong European-derived healing culture on the outskirts of Accra, both for patients who sought out specific cures at the hospital, and for employees who appropriated the trappings of medical modernity that the institution offered. At the new hospital, diseases were understood according to precepts that located illness exclusively within the human body, in a manner distinct from African aetiologies of disease that located the causes of illness in the world of the spirits. At the new hospital, the practice of healing at Korle Bu became the domain of physicians, nurses, sanitary inspectors and laboratory technicians, many of them drafted from the ranks of the literate elites of

¹⁷³ Craddock, *Retired Except on Demand*, 72. Williams subsequently cared for the child at its

Accra, rather than chosen by the gods. And at the new hospital, African men and women started to work with imported, European-manufactured, medical equipment rather with the than local herbaria of medicinal herbs. The story of the Gold Coast Hospital at Korle Bu, with its own set of documentary archival materials and oral histories, presents the historian with a unique set of themes ranging from changing notions of medical efficacy, new ways of controlling the bodies of colonial subjects as medical subjects, and new concepts of distinction emerging from African appropriation of colonial medicine.

What this chapter has shown is that Korle Bu was successful not merely because it was associated with new practices of medicine, but because specific therapies established the hospital as a viable alternative for patients seeking clinical care. But though we might speak of medical hegemony on the campus of the hospital, where non-European healing methods were excluded, and where physicians who attempted to create hybrid therapies were reprimanded, Korle Bu did not entirely revolutionize the provision of healing in Accra, nor did it wrest healing power away from African and other healers. For the most part, patients chose to cross the lagoon seeking out the specific therapies that Korle Bu offered, and then returned back to continue patronizing the many priests, spirit mediums, herbalists, religious experts and lay healers that continued to practice in the city. But the “great African hospital” did delineate a geographic space within which the discourses and practices of colonial medicine could be propagated.

What is truly remarkable about the early years at Korle Bu is that they are remembered with great nostalgia, as an early age when young aspiring medical professionals of Accra were offered a new cultural space within which to define themselves. The technology and commodities that accompanied the establishment of Korle Bu and its

home, but was furious because she knew the child would die if not treated.

associated clinics created new horizons of professional development for the educated classes of the city. Korle Bu created a new type of medically literate Gold Coast health worker, someone who could work (albeit largely as second-class subjects) in unison with white colonial doctors and nurses. The memories in the *Golden Jubilee Souvenir* place African doctors and nurses at the centre of health provision at the hospital, as medical actors who were indispensable to the operation of the colonial medical system. They understood the racial and patriarchal structures of power that defined colonialism and they realised that there would be a difference in standards of care offered to whites and blacks, but they nonetheless chose to appropriate medical culture.

And in particular the hospital and its associated infant welfare clinics captured the imagination of mothers in Accra, who chose to participate in a new culture of mothercraft, seeking to follow British standards of infant health and the consumption of imported commodities. After the suppression of the Naa Ede Oyeadeu shrine, priests, spirit mediums and midwives who had policed local taboos about childbirth were either jailed, outlawed or marginalized, creating an opportunity for doctors and nurses to fill a vacuum of knowledge about maternal and infant care. The infant welfare clinics and the Princess Marie Louise Hospital did not replace Ga midwifery, but they offered strong competition to it by offering cures for endemic diseases like malaria and yaws and by propagating a British culture of mothercraft. Capable administrators, like Grace Summerhayes and Cicely Williams furthered the reach of mothercraft, thereby demonstrating that the Gold Coast Medical Department had finally found a way to offer socially-embedded forms of healing that could sustain and propagate the ideas and practices of medicine amongst the African population in Accra.

Chapter 6. Therapeutic Pluralism under Martial Law: the Inter-Allied Malaria Control Group Campaign in Accra and the African “bloodstream,” 1942-1945.

The Korle watershed reaches deep into the Ga-speaking lands that surround Accra, and the lagoon has provided water, fish and salt to the people near its shores for hundreds of years. It is also the spiritual home of the goddess Korle, a Ga spirit that is understood within living and documented oral traditions as a deity that influenced the founding of the city.¹ When the British moved the capital of the Gold Coast to Accra, the colonial government included the priests of the Ga paramount shrines, which included Korle, in negotiations over land use and political representation in the city, but the Medical Department targeted the lagoon as a hazard to the health of the white population of the city. As we saw in chapter 3, this led to sanitary interventions and the eventual withdrawal of the European population to Victoriaborg. In the 1920s, miasma theory had faded away and the segregation of white and black populations in the city was discontinued, but medical officials were still wary of a yellow fever epidemic. However, with a limited budget, there was little they could do to stop mosquitoes from breeding in the stagnant waters along the edge of the lagoon. When British and American malariologists arrived in Accra during the Second World War (known locally as the “Hitler War”) they brought with them the personnel, equipment, and funding to make a concerted effort to eradicate the mosquito population from the city. This chapter is about a unique moment of medical biopower in Accra, a time

¹ The Korle Shrine is housed in Korle We, the Korle clan house, and the priest of the shrine is also the paternal head of the Korle clan. The memories of the goddess and her role in the history of Accra are perpetuated orally through the priest, linguist and shrine elders. Korle’s role in the history of the Ga state is also documented in the ethnographic works of Carl Christian Reindorf, A.B. Quartermey Papafio, Margaret Field, and Marion Kilson, see C.C. Reindorf, *History of the Gold Coast*, 22; Field, *Social Organization of the Ga People*, 163-64; A. B.

when, due to advances in technology and mobility, scientists and soldiers were briefly able to impose medical understandings of health of the urban population and the landscape that surrounded them.

The histories of medicine on the Gold Coast contain only one passing comment about the anti-malaria campaign in Accra. Scott does not mention it at all. Addae does cover the story of high malaria rates in the Gold Coast and Ghana, lamenting how the disease became the “bugbear of west African countries” but he does not mention the efforts to fight the disease during the Second World War.² Patterson is the only one to mention the campaign, and then only in a few lines, arguing that all previous measures to reduce the “myriads of mosquitoes” in the lagoon had failed until the allied armies conducted “extensive draining and oiling operations” and utilized “newly-developed insecticides.” He continues by noting the DDT might have eradicated the mosquito population if it had been used more extensively.³ None of the authors mention the central role that Korle played within the Ga pantheon of deities, nor do they offer any environmental assessment of the ecology of the lagoon. And none of these authors note the fleeting nature of the campaign, as a project that did not fit into the larger story of medicine and sanitation in the city because it was driven exclusively by wartime concerns.

In order to tell the story of the anti-malaria campaign of the Second World War, we must rely heavily on an official report compiled by the Inter-Allied Malaria Control Group (hereafter IAMCG), an ad-hoc body of British and American scientists brought together to fight malaria in Accra from 1942-45. One compilation in particular, the *Report on Malaria Service Control, Accra and Takoradi, Gold Coast*, contains military and entomological reports on

Quartey-Papafio, “The Gã Homowo Festival,” *Journal of the Royal African Society* 19, no. 74 (Jan., 1920), 126-134; for citations from Kilson, see footnotes below.

² Addae, *Evolution of Modern Medicine*, 320.

malaria control around Accra during the Second World War, and various commentaries, photos and maps of the anti-malaria campaign of the IAMCG.⁴ Though it was heavily edited in order to portray the project as successful effort to subdue tropical disease, it does contain a wealth of information about vector control, pesticide application, entomological experiments, and the involvement and resistance of the residents of Accra. Beyond the official military records, there is little documented evidence of the antimalarial campaign, so oral interview evidence, derived from memories of the veterans who were stationed in Accra, is used to offer the perspective of the African residents of Accra who witnessed the spraying and dredging efforts of the IAMCG. When put together these sources show is that the Second World War was a brief moment when medical technocrats were able to wield extraordinary power over the lived environment of the people of Accra. The disciplinary power of the malariologists of the IAMCG was largely unrestrained during the war, which allowed them, under the auspices of medical science, to reduce the inhabitants of Accra to abstracted colonial subjects. Individually, African bodies became understood as carriers of malaria that could infect white soldiers. Collectively, they became reservoirs of disease that had to be managed according to racialized notions of vector control. This approach largely blinded the IAMCG technocrats to Ga religious attachments to the Korle and provided them with the authority to dredge and spray the lagoon without regard for the health of the residents of Accra.

However, when the war ended, the limits of malaria control in Accra quickly became evident. When the US forces left the city in 1945, funding for reengineering the Korle Lagoon was substantially diminished, and the project was soon abandoned. Though new scientific and medical understandings of the watershed had emerged, the British colonial

³ Patterson, *Health in Colonial Ghana*, 36-37.

government simply did not have the financial capacity to continue to assert technocratic control over the waterway. The surge of colonial biopower had ended and the followers of Korle reasserted their role in defining the identity of the lagoon. Despite the dramatic

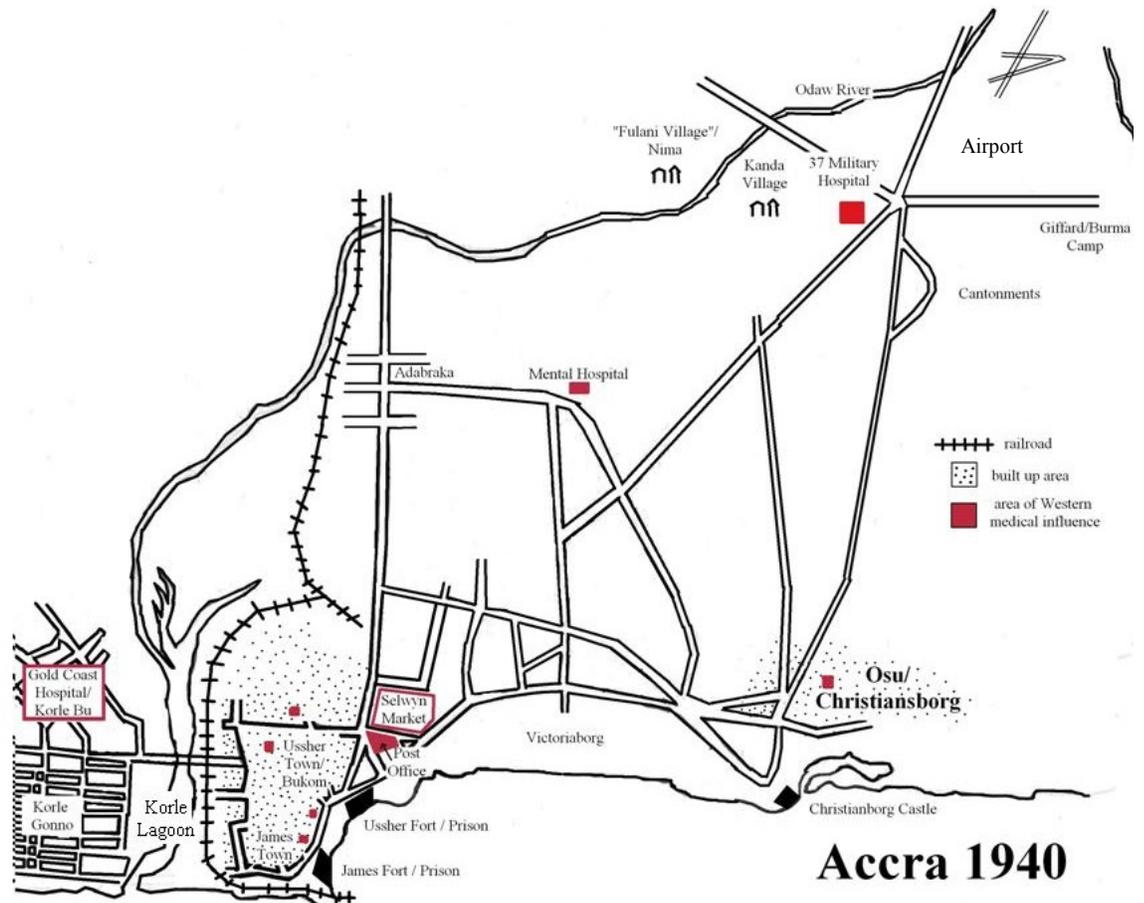


Figure 6.1. Map of Accra, 1940. This map shows the interior of the Malaria Control Area of the IAMCG, depicting the Korle Lagoon and its major tributary, the Odaw River. Allied efforts to eradicate mosquitoes also targeted the smaller Klote Lagoon at Osu and the larger Sakumo Lagoon, several kilometres to the west. The villages of Nima and Kanda are also depicted at the top of the map. In the 1940s, these villages were populated by Muslim migrants from Northern Ghana, Nigeria and French West Africa. According to military records, British and Americans claimed to have evacuated these villages during the war, but there are no oral histories in these areas that confirm that claim. Nima and Kanda are now suburbs of Greater Accra. *Source:* map by author.

⁴ PRAAD ADM 5/3/46, *Report on Service Malaria Control*.

efforts to change the urban landscape of Accra, the goddess and the other deities of the Ga pantheon of deities remained, and the residents of the city continued to adhere to a pluralistic culture of healing.

Section 1. Naa Korle Onamereko: the Goddess Korle in the History of Accra.

As we saw in chapter 2, oral traditions amongst the Ga dictate that Korle is one of the founding deities of Accra. It is said that Korle is a water spirit that was discovered when a group of hunters found two large pots containing beads on the shore of the lagoon. When the hunters took the beads home to their encampment a woman named Dede saw them and became filled with the spirit of the lagoon goddess.⁵ Afterwards, Korle became the guardian of the waters of the lagoon, and the Ga state placed the entire watershed under the stewardship of the priest of the Korle shrine, known as the Korle *wulomo*.⁶ In the family of deities in Accra, Korle became the daughter of Nai, the goddess of the sea, and the wife of Sakumo, the god of war. According to oral traditions told at Korle We, she became a moral force in the city, a spirit that distanced herself from petty rivalry, as suggested by her slogan: *Naa Korle onamereko* -- elder woman Korle, you will see me walking away (aloof and beyond reproach).⁷ Korle is a central character in the history of Accra.

The Korle Lagoon, as a geographical site, is also significant as a palimpsest of memories for the people of Accra, a place where stories about the goddess are stored and revealed. Oral traditions at the shrine of Korle are not as robust as they once were. After a

⁵ Dede is a common Ga house name for the first born girl child.

⁶ Privy Council Appeal no. 31 of 1958, “H.E. Golightly and another v. E.J. Ashrifi and others,” Judgement of the Lords of the Judicial Committee of the Privy Council, delivered on the 19th December, 1960 by Lord Denning, West African Court of Appeal (Accra, Guinea Press Ltd, 1961). This citation comes from documents in the possession of the priest of Korle We.

⁷ Interview, Korle Wulomo, December 30, 2005.

long hiatus, a new priest was installed at the shrine in 2000. As a young man, Numo Okaine Amah I has stated publicly that he has much to learn about the shrine and its role as a protector of the Gas. Much of his time is taken up with courts cases defending the rights of the house of Korle to lands around the lagoon, or seeking rents from government or industrial concerns on its shores. But the stories of the goddess survive in the minds of the elders of the house, who are passing them down to the priest and his young linguist. The story of Korle is best revealed peripatetically, by visiting the small nodes of rock piles and concrete mounds (known as *otutu*) which are tucked in and around the neighbourhoods surrounding the lagoon and dotting the seashore. These are the “children” of Korle, touchstones of memory that release historical information held within the minds of the followers of the goddess.⁸ For example, a rocky outcrop near the lagoon’s shore reminds the priest of Korle of a story about how the goddess allowed the destruction of the city by the armies of the Akwamu in the 1660s in revenge against the Portuguese merchants who built salt pits on her shores.⁹ Another site triggers memories of a time when Accra was surrounded by the armies of the Ashanti, who threatened to sack the city. Korle took human form as a woman and saved the Ga from defeat by cooking a meal that satiated the Ashanti and enabled the Ga to vanquish them.¹⁰ More broadly, the lagoon remains a sacred space where performances in honour of the deity must be conducted in order to placate her, and to win her approval for any industrial or commercial activity around the body of water. Because of the high status of the goddess within the Ga state, the British colonial government never threatened to suppress her shrine and the religious significance of the watershed continued to be perpetuated amongst the residents of Accra.

⁸ Interview with Korle Wulomo, Accra, 16 Feb. 2005; Kilson, *Kpele Lala*, 127.

⁹ Reindorf, *History of the Gold Coast and Asante*, 22.

¹⁰ Kilson, *Kpele Lala*, 127.

Like many of the lagoons along the coast of West Africa, Korle recedes during the dry season, forming mud flats and stagnant pools of water. During the months of June and July, it swells with rainfall and floods the low-lying parts of the city. Before the British dredged a channel between Korle and the Atlantic Ocean in 1927, the lagoon burst its sandy banks after heavy rainstorms every year, rushing into the sea. The breaking of the bar signaled adequate rainfall for the staple crop of corn, and prompted the Korle priest to perform a ceremony to inaugurate the planting season and to pray for the health of the community.¹¹ The lagoon was also a source of seafood, and the residents of Accra cast nets from the shore to catch mud fish and waded along its banks to collect crabs and river snails. The goddess Korle allowed fishing in the lagoon with the exception of two weeks in late July and August, during the *Homowo* harvest festival, when the Korle priest prohibited fishing in the lagoon as a way of asking the goddess to continue to supply water and fish for the rest of the year. To lift the ban on fishing the priest walked to the shore with an entourage from the shrine, and symbolically threw a net into the lagoon three times, collecting the fish and sharing them with the royal and priestly houses of the city.¹² Though the lagoon is no longer a major source of food for the people of the city today, it remains an annual site of pilgrimage for followers of Korle, and it is still a source of spiritual nourishment for those who worship the pantheon of Ga deities.¹³ Moreover, Korle is a marker of the Ga linguistic identity. By telling someone *ekoole ya nsbon* (which literally means that “his/her Korle goes to the sea), a Ga-speaker can validate the ethnic identity another Ga-speaker,¹⁴ and when phrased in the negative, it can be used as a warning that someone is a linguistic outsider. In a city that was

¹¹ Field, *Religion and Medicine of the Gã People*, 57, fn. 2; Interview with Korle Wontse, Accra, 30 Mar. 2005.

¹² Interview with Korle Wulomo, Accra, 16 Feb. 2005.

¹³ Dakubu, *Korle Meets the Sea*, 12.

¹⁴ Dakubu, *Korle Meets the Sea*, 12.

changing dramatically over the course of the 20th century, Naa Korle continued to be a regulator of Ga menology and culture.

Section 2. Attempts to Re-engineer Korle in the 1920s and 1930s.

The cocoa boom of the 1920s led to an exponential growth in traffic at the port of Accra, and the Gold Coast Government planned to eliminate the costly use of surf boats to deliver goods to freighters moored offshore by dredging the Korle Lagoon and transforming it into a deep water harbour.¹⁵ In 1919, the Public Works Department tendered the contract to a British engineer who made a down-payment of £50 to the house of Korle for permission to survey the lagoon and promised an additional £15,000 to the priest in exchange for the future lease of the waterway. The project quickly ran into difficulties, however, when the engineer discovered that the rights to the lands surrounding the lagoon were contested by the chiefs of Accra. As the city expanded across the lagoon and into lands that had been previously unclaimed territory, the chiefs of Ussher Town conducted a series of vigorous political and legal campaigns to assert paramount title to the lagoon and its lands. At the heart of these disputes, as John Parker has shown, were claims to first comer status, or the title of “true Ga.”¹⁶ Chiefs from various quarters all asserted that they had settled the lands around the lagoon first, and they challenged the rights of the Korle priest to collect the harbour fees in colonial courts. The case was tied up for several years, forcing the contractor to abandon the project.¹⁷

¹⁵ K. B. Dickson, “Evolution of seaports in Ghana: 1800-1928,” *Annals of the Association of American Geographers* 55, no. 1 (Mar. 1965), 109; W. T. D. Tudhope, “The development of the cocoa industry in the Gold Coast and Ashanti,” *Journal of the Royal African Society* 9, no. 33 (Oct. 1909), 34-45.

¹⁶ Parker, *Making the Town*, 208-10.

¹⁷ PRAAD ADM 11/1/1756, C.W. Welman, *Ga State Stools. Report on Enquiry into the Alleged Destoolment of Tackie Yaoboi, Ga Mantse*, 1921, 9-11, 14-16; the dispute surrounding the

The failure to convert Korle into a harbour was a blow to British aspirations to sanitize the city. Principal Medical Officer Selwyn-Clarke believed that the lagoon was bringing down a “plague of mosquitoes” on the city and he continued to press the government to reengineer the lagoon.¹⁸ In the mid-1920s, the Public Works Department did fill some marshy areas of the lagoon with refuse, but they awaited funding and approval from the Colonial Office to completely dredge the lagoon.¹⁹ In 1929, after two years of lobbying the Colonial Office for funding, Governor Slater received official consent for a £195,000, six-year scheme to create a sea outfall that would flush the waters of Korle into the Atlantic Ocean, and colonial engineers set to work building tidal sluice gates to regulate the flow of water.²⁰ They also made plans to dredge the lagoon and construct dwarf walls all the way up the watershed but financial retrenchment during the 1930s forced the colonial government to abandon the scheme.²¹ British engineers did build a causeway over the sandbar,²² but the sea outfall began to slowly fill with sand due to seasonal flood patterns, and the Director of Medical Services (formerly the Medical Department) admitted 10 years later that the whole scheme “might never have been undertaken at all”.²³ The 1930s was

dredging of the lagoon was part of a larger struggle to remove the Ga paramount chief, Taki Yaoboi, from office. See Gocking, *Facing Two Ways*, 185.

¹⁸ PRAAD CSO 3/1/157, *Accra (Korle) Lagoon*, 22 Aug. 1927, 3.

¹⁹ PRAAD CSO 3/1/164, *Korle Lagoon Measures to Prevent Spreading of Mosquitoes*, “Notes by J.P. Ross. President of Accra Town Council,” 11 August, 1927.

²⁰ PRAAD CSO 3/1/157, *Accra (Korle) Lagoon; Gold Coast Colony Blue Books* (Accra, Ghana, 1927-8). There are no extant records showing that the project was approved by the priest of Korle, but colonial correspondence indicates that the Colonial Secretary of the Gold Coast recommended that the committee consult with the house of Korle and the Ga chiefs. See PRAAD CSO 3/1/167 *Korle Lagoon - Application of a Committee to*, “Notes by the Secretary of Native Affairs,” 6 Oct. 1927.

²¹ PRAAD ADM 5/3/46, *Malaria Control*, 2.

²² PRAAD CSO 3/1/162. *Korle Lagoon*.

²³ PRAAD CSO 11/10, 3271, *Memorandum of the Director of Medical Services*, 2 Feb. 1943. The British plans to dredge the Korle Lagoon also went against the expert opinions of the Malaria Commission of the League of Nations Health Organization, which favoured “bonification” programs that relied on the use of quinine and the amelioration of living

largely a period of “marking time” in the Gold Coast sanitary services division, and the natural flow of the lagoon, along with the annual festival to open the fishing season, continued.²⁴

Section 3. The Anti-Malaria Campaign of the Second World War.

During the Second World War, the arrival of British and American armed forces in Accra renewed interest in sanitizing the Korle watershed. In 1941, Allied troops fighting in North Africa were cut off from Mediterranean supply routes, and had to be supplied by air from West Africa. Accra became a staging area for troops recruited in the colonies, and the city quite suddenly found itself playing a role as a stopover point for British and American aircraft.²⁵ During the peak years of 1942-43, 200-300 aircraft stopped daily at the airport in Accra for refueling and maintenance in the city, and thousands of airmen and airport crews were flown into the city.²⁶ In order to treat soldiers, sailors and airman who suffered from tropical diseases, the British built the first hospital dedicated specifically to military personnel near the airport, a 1,000 bed segregated facility (200 European beds, 800 African beds) that was known officially as the 37th General Hospital of the British Empire. The hospital was badly needed because by 1942, malaria rates among soldiers and airmen in Accra were startlingly high. Both white and black soldiers suffered, but the disease was particularly bad amongst white soldiers who had never been exposed to the disease climate of West Africa,

conditions over engineering schemes. See League of Nations. *Health Organization, Malaria Commission, Principles and Measures of Antimalarial Measures in Europe* (Geneva, 1927), 9, cited in Randall Packard, *The Making of a Tropical Disease: A Short History of Malaria* (Baltimore, 2007), 127

²⁴ Addae, *Evolution of Modern Medicine*, 74.

²⁵ F.M. Bourret, *The Gold Coast: A Survey of the Gold Coast and British Togoland. 1919-1946* (London, 1949), 154; David P. McBride, *Missions for Science: U.S. Technology and Medicine in America's Africa World* (New Brunswick, N.J., 2002), 168; F. M. Bourret, *Ghana: the Road to Independence, 1919-1957* (Stanford, 1960), 147.

reaching morbidity rates of over 50 percent per annum. This presented a major impediment to military action in the tropics, but what made it worse was a pattern of epidemic flare-ups that severely restricted the fighting ability of whole camps at a time. For instance, during the rainy season of 1942, 62 percent of the soldiers in one British camp were sent to 37th Hospital for treatment of malaria.²⁷ Allied commanders had even greater fears that the disease would spread from West Africa to the rest of the world. In north-eastern Brazil in the 1930s, 16,000 people had died as a result of the introduction of *Anopheles Gambiae* and its malaria parasites by ship from Dakar. Fearing another outbreak during the war, the Brazilian government pressured the Americans to ensure that transport planes on the Atlantic routes did not carry any mosquitoes to South America.²⁸ The British and American armed forces, who had not anticipated being so heavily invested in operations in West Africa, were thus compelled to take steps to control malaria in Accra.

Concomitant to Allied concerns about illness amongst personnel was their fear of the loss of valuable war materiel. By 1942, hundreds of Allied aircraft were refueling in Accra every week, and according to one report, 25 percent of the pilots flying from West Africa to Egypt were landing in Cairo with malarial symptoms.²⁹ Trained pilots were in short supply, and to ensure the safety of both the airmen and airplanes, it was crucial that the British keep them healthy during their short stay in Accra.³⁰ The Royal Air Force argued strongly for the case of a mosquito vector control scheme around the airport, claiming that:

Malaria control of an airfield (especially in the case of an essential airfield) shows a large credit, for the loss of only two or more heavy bombers, resulting from a poor landing by a pilot attacked with malaria during the

²⁶ Bourret, *Gold Coast*, 156

²⁷ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 28.

²⁸ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 11; Packard, *Making of a Tropical Disease*, 91.

²⁹ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 10.

³⁰ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 10.

flight (a thing very liable to happen in high altitudes of flying when the pilot has parasites in his blood), more than pays for the cost of the scheme. The cost of a Superfortress is in the region of \$600,000...³¹

When stated in such plain logistical and financial terms, the logic of fighting malaria in Accra was obvious to Allied commanders.

In the 1920s and 1930s, the fear of malaria amongst colonial officials in Accra had begun to wane as quinine became available in effective doses in pill form or as injections.³² However, the possibility that Allied soldiers might become infected due to their close contact with infected Africans concerned military medical officials. British medical exams conducted during the war showed that malaria was widespread in Accra, and in particular in villages near the airport.³³ The spectre of infected mosquitoes spreading malaria from African villages into British and American barracks alarmed Allied medical officials, a fear that was amplified when the Japanese invaded the island of Java in the Dutch East Indies in March of 1942, cutting off the world's largest source of natural quinine. By mid-1942, Allied malariologists agreed that a new strategy for controlling malaria was desperately needed.³⁴

As Accra became an increasingly significant transit point for the US Air Force, the British hoped that the Americans would see the benefits of financing the reengineering of the Korle Watershed. The British officer in charge of coordinating anti-malaria efforts in Accra, "Area Malariologist" Major Macdonald, reported with alarm that the lagoon was "swarming with Anopheline larvae" and sought the assistance of the US army in a vector

³¹ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 15.

³² Gordon A. Harrison, *Mosquitoes, Malaria and Man* (New York, 1978), 127; Philip D. Curtin, "Medical knowledge and urban planning in tropical Africa," *The American Historical Review* 90 no. 3 (1985), 595; Odile Georg, *Pouvoir Colonial, Municipalites et Espaces Urbains: Conakry – Freetown des Annees 1880 a 1914, II* (Paris, 1997), 124.

³³ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 5 & Appendix B, 1-2. A study conducted by British malariologists in 1942 indicated that the spleen rate (frequency of enlarged spleens caused by malaria) in the Accra suburbs of Nima and Kanda was 55 and 60 per cent, respectively, and that eight out of ten children tested positive for malaria.

control project.³⁵ But before the Americans would sign on to a joint drainage program, they brought their own malariologist to the city to investigate the situation. Dr Coggelshall, a specialist in tropical medicine at Michigan University, proposed a plan to prevent malaria in the city that included changes to the way that soldiers were housed, changes to soldiers' attire, and most importantly, the excavation of 45 kilometres of viaducts and ditches around city. Coggelshall joined forces with Major Macdonald to initiate the IAMCG and by the end of 1942, both the US Army and the British Colonial Office had agreed to fund the scheme.³⁶ For the first time in the history of Accra, the personnel, equipment and funding was in place to eradicate mosquito-born illnesses from the city.

The first step the Allies took to reduce instances of malaria was to restructure the living quarters of their troops. Following a pattern of segregation that had led to the development of Victoriaborg and the Ridge, the Allies built a new army residential area to the northeast of the city, next to the airport. The camp that housed British and American troops (later renamed Burma Camp in tribute to the veterans who fought in South East Asia) was specifically located a mosquito flight away (one quarter of a mile) from the nearby villages of Nima and Kanda in order to prevent the spread of mosquito-borne diseases. The change in location was soon followed by a change in attire, as the Allies changed the clothing of military personnel to adapt to the disease climate. British and American soldiers arrived in Accra wearing their cold weather uniforms, including great coats that had to be aired weekly to prevent moulding, just in case the troops were hastily recalled to Europe.³⁷ They were also required to wear wool pyjamas in the barracks at night, which were unbearably hot, especially under a mosquito net. The soldiers soon abandoned these for cotton pyjamas or

³⁴ C.M. Poser and G.W. Bruyn, eds., *Illustrated History of Malaria* (New York, 1999), 93

³⁵ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 5.

³⁶ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 5.

for nothing at all. Eventually the armies distributed warm weather clothing, but to prevent mosquito bites on the legs, the troops were required to wear long sleeves, trousers, and boots that covered the calves. Any leftover bare skin was to be covered with mosquito repellent.³⁸ The Allies also changed the way that barracks were constructed in order to prevent mosquito bites. All of the dormitories were given screened windows, and soldiers were required to sleep under bed nets.³⁹ To emphasize the need for vigilance against mosquitoes, Allied film crews projected cartoons onto screens at the barracks to exhibit the dangers of exposure to malaria (see Figure 6.2). These images depicted the mosquito vector as a “fifth column” that, in collusion with the lazy soldier who neglected to care for his mosquito netting, would attack the troops in their sleep. In Accra, where there were no Axis soldiers to fight, the enemy became the mosquito.

Until 1942, Allied doctors had distributed a daily dosage of five grains (1/3rd gram) of quinine to all army personnel, but when supplies ran low, they started to experiment with synthesized versions of the drug.⁴⁰ They tested two new versions, quinacrine (reverse-engineered from a captured German I.G. Farben product by Sterling Winthrop Co. in 1941) and mepacrine (synthesized by Imperial Chemical Industries in 1939).⁴¹ Quinacrine was a superior product because it had few side-effects but mepacrine was in greater supply so the

³⁷ Addae, *Evolution of Modern Medicine*, 158.

³⁸ James R. Busvine, *Disease Transmission by Insects: Its Discovery and 90 Years of Effort to Prevent It* (New York: Springer-Verlag, 1994), 143-44.

³⁹ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 21.

⁴⁰ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 22; See also NARA. R. 705, Major Eugene L. Vickery, “History of the Medical Section Africa-Middle East Theater, September, 1941, to September, 1945,” Prepared under the direction of the Chief Surgeon, Eugene W. Billick, Colonel, Medical Corps, Cairo, Egypt, 1945. December 11, 1945, 219.

⁴¹ David A. Williams and Thomas L. Lemke, *Foye's Principles of Medicinal Chemistry*, 5th ed. (Baltimore: Lippincot William and Wilkins, 2002) 9, Kenneth Joseph Arrow, Claire Panosian and Hellen Gelband, *Saving Lives, Buying Time: Economics of Malaria Drugs in an Age of Resistance* (Washington: National Academic Press, 2004), 130-32.

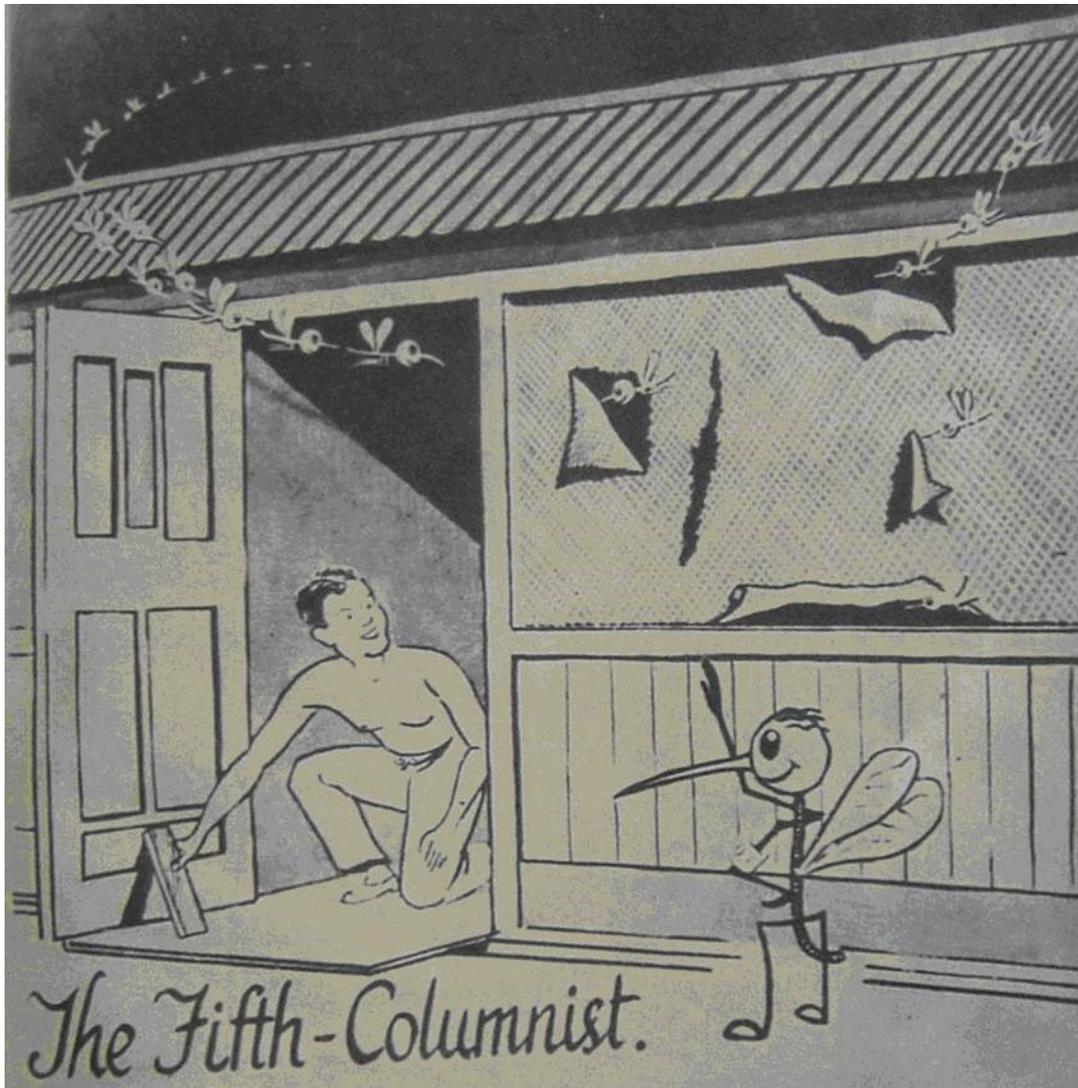


Figure 6.2. “The Fifth-Columnist.” Part of a series of cartoons produced to encourage soldiers to take precautions against mosquito bites, this slide was projected before screening movies in the barracks at 37th Military Hospital in Accra. The mosquito is transformed from pest to enemy, and the soldier who betrays the methods of malaria prevention is portrayed as a traitor. *Source:* PRAAD. ADM 5/3/46. Report on Service Malaria Control. Accra and Takoradi. Gold Coast. May 1945. Figure 68.

Allied doctors in Accra settled on a daily dose of the latter by mid-1943.⁴² The white soldiers disliked mepacrine because it caused a yellowish pigmentation on their skin, but they were forced to take it every morning with their breakfast.⁴³ African soldiers were required to take the drug too, but there is no evidence to show that it was given to African labourers working at the Allied camps. During the war, the British and the Americans intended to protect their own personnel from malaria first, and despite the belief that the residents of Accra formed a reservoir for the disease, the Allies never considered offering malaria prophylaxes to the broader urban community. Whether the supply of quinine dried up at local post offices during the war is unknown, but mepacrine became widely available after the war.⁴⁴

As the campaign commenced, the Allies hoped that chemical insecticides might save them from the expense of reengineering the Korle Watershed. The Americans were especially interested in using a silver bullet approach to eradicate the local mosquito population because they did not want to fund infrastructure projects in places they would abandon after the war. In April of 1942, the U.S. Army began spraying dust containing the larvicide paris green on any open water surrounding the camps, and started trucking pyrethrum aerosol bombs into the nearby British camps to clear the buildings of mosquitoes.⁴⁵ They then proceeded, in cooperation with the British, to spray all houses within a one-mile radius of their camps, three times a week. In July of 1944, when adequate supplies became available, they switched to spraying with dichloro diphenyl trichloroethane

⁴² PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 22; Walter Snieder, *Drug Discovery: A History* (West Sussex, UK: John Wiley and Sons, 2005), 381-82.

⁴³ Addae, *Evolution of Modern Medicine*, 159.

⁴⁴ Senah, *Money Be Man*, 158.

⁴⁵ PRAAD ADM 5/3/46, *Malaria Control*, 12; see also Timothy Mitchell, *Rule of Experts: Egypt, Techno-Politics, Modernity* (Berkeley, 2002), 46-47; Busvine, *Disease Transmission*, 132; Packard, *Tropical Disease*, 124-25.

(DDT) and by the end of the year they were spraying all villages within an eight-mile radius of their camps, including the city centre of Accra.⁴⁶ Because DDT was not considered toxic to humans, scientists believed it was safe to disperse the chemical into water supplies, so the Allies extended aerial spraying to the Korle, Kpeshi, and Klotey Lagoons, and even attempted some experimental spraying several kilometers to the west of the city, at the Sakumo Lagoon.⁴⁷

The IAMCG spraying campaigns of 1942-45 were conducted at great expense in labour and materiel. During a three-month attempt to eradicate mosquitoes around the airport in 1944, the Americans sprayed over 1,000 pounds of paris green, 2,000 pounds of pyrethrum, and 500 pounds of DDT and they still found larvae in some of the streams leading into the lagoon.⁴⁸ The British had always believed that it would be cost effective to take the time to build drainage systems that confined water to ditches and ponds, where smaller amounts of insecticides could be used, and as the war dragged on, the Americans too began to see the necessity of long-term planning.⁴⁹ In 1944, the Allies organised a Malaria Task Force, which conjointly mapped out a malaria “Control Area,” began to redredge the sea outfall and employed African crews to clear ditches and streams all the way up the Korle Watershed.⁵⁰ The Royal Army Medical Services followed up by spraying and oiling the waterways on a regular basis, a method that reduced the amount and cost of the pesticides used.⁵¹

⁴⁶ Packard, *Making of a Tropical Disease*, 141.

⁴⁷ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, 20-21.

⁴⁸ PRAAD ADM 5/3/46, *Malaria Control*, 12.

⁴⁹ PRAAD ADM 5/3/46, *Malaria Control*, 13. The British had already built a working sea outfall at the smaller Klotey Lagoon.

⁵⁰ PRAAD ADM 5/3/46, *Malaria Control*, 31.

⁵¹ NARA, R. 705, Vickery, “medical section,” 209; PRAAD ADM 5/3/46, *Malaria Control*, 17.

While the drainage scheme proceeded, Lieutenant C. R. Ribbands of the Malaria Field Laboratory and his fellow malariologists began to monitor the mosquito population in the camps and surrounding villages. An expert on *Anopheles gambiae* (the mosquito that transmits malaria), Ribbands had already researched the flight and biting habits of mosquitoes through a variety of experiments in India and West Africa.⁵² Replicating a study that he had conducted in Sierra Leone, he started collecting mosquitoes from the tents where the soldiers of the Gold Coast Regiment slept.⁵³ The mosquito crews spread sheets on the floors of the tents, and sprayed the air with pyrethrum or DDT to kill any insects inside. Afterwards, Ribbands hired local men to pick up the mosquitoes from the floor and bring them to a central laboratory at the airport for identification. With samples of mosquitoes from over one hundred different tents, or “catching stations”, Ribbands was able to create an “Anopheline index” for each part of Accra.⁵⁴

When the malariologists of the IAMCG analysed the results, they realised that, even with regular spraying at the army camps, the health of soldiers might be compromised by the in-flight of mosquitoes who had bitten infected residents in nearby villages. This fear of contagion spurred an immediate military response, summarized in the findings of a post-war American military report on the campaign:

a serious problem was the presence of numerous native villages in and near the camp area. These threatened to provide a potent source of malaria infection for military personnel. However, through the cooperation of the British Commissioner of Lands and the Inter-Allied Malaria Control Group all of these villages were moved outside the one mile zone.⁵⁵

⁵² C.R. Ribbands, “Moonlight and house-haunting habits of female anophelines in West Africa,” *Bulletin of Entomological Research* 36 (1945), 395-415.

⁵³ PRAAD ADM 5/3/46, *Malaria Control*, Appendix A, 5. See Ribbands, “Moonlight,” 395-415.

⁵⁴ PRAAD ADM 5/3/46, *Malaria Control*, 25.

⁵⁵ NARA. R. 705, Vickery, “History of the Medical Section Africa-Middle East,” 217.

This statement indicates that the Malaria Control Group had extended their estimation of how far a mosquito could fly from the standard quarter of a mile to a full mile. By this calculation, villages like Nima and Kanda (which were connected to the airfield by pathways through trees and scrub brush) suddenly posed a threat to Allied troops as indigenous “reservoirs of disease” and had to be evacuated.⁵⁶ However, it should be noted that there are no particular details about the forced removal of the inhabitants of these villages in any colonial documents, military or otherwise. If the evacuations did occur, they would have entailed the movement of hundreds of people (mostly Muslim newcomers to the city) by truck, as well as extensive documentation of claims for property. The lack of a paper trail raises the question of whether the residents of the villages were in fact relocated -- nevertheless, a new spatial reckoning of Accra had been created based on the behavior and habitat of the mosquito.

Once the IAMCG established a Malaria Control Area around the periphery of Korle Lagoon, Ribbands devised a system to collect information on the flying and biting habits of the mosquitoes that passed through it. To track the movements of *Anopheles gambiae* through the bushes of the Accra Plains, he ordered the construction of a network of mosquito sheds along the perimeter of the cordon surrounding the airport.⁵⁷ Built by African labourers in the employ of the British Army, the traps were single-room timber-frame structures based on a model developed by American entomologist E. H. Magoon, covered with screens and

⁵⁶ Addae, *Achimota in the Second World War*, 157-58.

⁵⁷ PRAAD ADM 5/3/46, *Malaria Control*, 25 and Appendix A, 7. Ribbands duplicated this experiment on a smaller scale in Sekondi. See C.R. Ribbands, “Effects of bush clearance on flighting of West African anophelines,” *Bulletin of Entomological Research* 37 (1946), 33-41.



Fig. 64

The modified Magoon type of mosquito trap used by the I.A.M.C.G. at Accra. An African is paid to sleep in the trap overnight and to collect the mosquitoes in the morning.

Figure 6.3. The Modified Magoon Mosquito Trap. A photo of one of several sheds that the Inter-Allied Malaria Control Group (IAMCG) placed around Accra to monitor the flight of mosquitoes. The trap was a modified version of a model designed in 1935 in Jamaica by entomologist by E.H. Magoon. Magoon used horses, donkeys and pigs to attract mosquitoes, but Lieutenant Ribbands of the IAMCG employed migrant workers to sleep in the traps so he could calculate the bite rate of *Anopheles gambiae* on human hosts. *Source:* PRAAD. ADM 5/3/46. Report on Service Malaria Control. Accra and Takoradi. Gold Coast. May 1945. Figure 64.

tarpaper, and fitted with baffles to let mosquitoes in at night and trap them inside at dawn (see Figure 6.3). During his research in Jamaica, Magoon used horses and mules to attract mosquitoes and had never employed human beings as bait. Ribbands, however, was specifically interested in monitoring the attraction of *Anopheles gambiae* to human hosts.⁵⁸ Since he was largely concerned with studying the attraction of mosquitoes to the white population, it would have been logical to assign an American or British soldier to live in the traps, but the Allies were shorthanded and Ribbands did not want to put white soldiers at risk of catching malaria. Instead, he hired 19 migrant workers to act as human bait in the traps.⁵⁹

Ribband's official policy was to hire immigrants from the northern regions of the colony:

Africans selected as bait were chiefly men from the Northern Territories of the Gold Coast. They were chosen because most of them were homeless and it was felt that they would welcome the fine shelters provided by the mosquito traps, however only those who could speak a few words of English were hired because they had to be able to understand the simple instructions. That the traps were home to these men was soon obvious when it was seen that they preferred to remain in the vicinity even during the daytime when they were not working.⁶⁰

The choice of so-called northerners as human bait is not surprising. These men go unnamed in the military records, but they were from the class of immigrants who were already in contact with the Gold Coast Medical Department as victims of yellow fever and relapsing fever, and as "volunteers" in experiments at the Accra Laboratory. As newcomers to the coast, they were geographically marginalised because they lived in villages on the outskirts of the city, and socially marginalized because they were not ethnically Ga.⁶¹ If they were

⁵⁸ Magoon, "portable stable trap," 363; Busvine, *Disease Transmission*, 169, 175.

⁵⁹ NARA. R. 705, Vickery, "History of the Medical Section Africa-Middle East," 215.

⁶⁰ PRAAD ADM 5/3/46, *Report on Service Malaria Control*, Appendix A, 8.

⁶¹ Addae, *Evolution of Modern Medicine*, 26.

“homeless,” it probably did not mean that they had nowhere to live, but rather that they were living in overcrowded residences, with the intention of sojourning as workers in the city.⁶² But even if they did live in crowded conditions or lack permanent residences, it is difficult to believe that they would have thought of the traps as desirable places to sleep. The sheds were small, filled with bugs, and lacking the benefit of the slightest breeze to cool the skin. It is also implausible that they thought of the traps as homes, considering that they were located in wooded areas and did not have locks to secure the doors. Moreover, the sheds were spread around a perimeter of several kilometres, and Ribbands rotated the men through the network of sheds at weekly intervals.⁶³

The men used as bait were required to stay in their sheds from sunset to sunrise. When they awoke they were to leave the traps, carefully closing the baffles to catch the mosquitoes inside as they left, so that the spraying crews could lay down a tarpaulin on the floor of the traps, spray the sheds, and collect the insects. To monitor the sleeping patterns, Ribbands sent soldiers in around the perimeter to ensure that the men serving as bait were actually sleeping in the traps and to prevent a reported “tendency to sit outside the trap at night.” The fact that Ribbands reported the need to monitor the human bait in the trop contradicts his previous statement that they saw the sheds as homes and suggests that the Africans who took part in Ribbands’ studies were not always willing and forthright participants.⁶⁴ Though there is no record of outright resistance by the migrant workers hired as human bait, it appears that they took measures to preserve their dignity, and probably did what they could to avoid mosquito bites.

⁶² For information on labour migration in the Gold Coast Colony see Jeff Crisp, *The Story of an African Working Class: Ghanaian Miners' Struggles, 1870-1980* (London, 1984).

⁶³ PRAAD ADM 5/3/46. Appendix A, 8.

⁶⁴ PRAAD ADM 5/3/46, *Malaria Control*, Appendix A, 8.

Though Ribbands and his fellow malariologists set out to fight the spread of malaria, they were not particularly interested in whether the men used as human bait contracted the disease. The extant military documents do not name the men who slept in the mosquito traps nor do they mention their medical records. What the entomologists who compiled the anopheline index were interested in was whether the mosquitos that came into the traps carried malaria, and once they had enough mosquitoes to build a data set, they began to target locations around the Korle Lagoon for spraying with pesticides and larvicides. The IAMCG dispatched crews around Accra to specifically spray DDT on African residences and into wells and ponds used as water supplies because, according to Army malariologists, it was the only way to break the 14-day larvae-mosquito-human cycle of malaria transmission:⁶⁵

By spraying the houses of native Africans in the area with pyrethrum and DDT the mosquitoes were killed at the point where they became infected and before they could incubate and transmit the plasmodia they had extracted from the African bloodstream.⁶⁶

In this passage, Ribbands and the Allied malariologists envisage the dwelling places and the bodies of the inhabitants of Accra as a setting for disease, an urban reservoir of malaria that could be cleansed with the liberal application of chemicals. Moreover, the bodies of Africans living in and around Accra are essentialised as a “bloodstream” coursing with pathogens. The social, cultural and religious context within which the malariologists were fighting the battle against malaria were nullified by the language of entomology as Ribbands and his teams objectified the inhabitants of Accra as carriers of disease.

⁶⁵ NARA, R. 705, Vickery, “medical section,” 219; PRAAD CSO 11/11/124. *Accra Anti-Malaria Scheme - Financial Implications of*, “Telegram to the Resident Minister from the Colonial Office,” 22 Sept. 1944.

⁶⁶ NARA, R. 705, Vickery, “medical section,” 213.

The Ga-speaking residents of the old quarters of Accra did not share Ribbands' enthusiasm for malaria vector control. Having already been forced to endure the indignity of sanitary inspections, they were reluctant to let the spraying crews into their compounds. Details about local resistance are limited, but there is evidence that the worshippers of Korle protested the desecration of the lagoon, reflected in this short but revealing passage from an American report on the antimalaria campaign:

The application of larvacide to [lagoon] areas was strongly resented by the local native population who associated a high religious significance to these lagoons [but the] natives [were] placated through negotiation by British authorities with the African chiefs.⁶⁷

This passage offers evidence that the residents of Accra were quite aware of the impact of a city-wide spraying campaign and were concerned about encroachment on their sacred spaces. But it also shows how colonial indirect rule allowed the British to curry favour with local chiefs as a way of disenfranchising the religious authorities of the city. How exactly the British appeased the chiefs is unknown but it probably involved sums of money to pay for the temporary rights to spray the lagoon, distributed in a manner that would allay any resistance to the campaign.⁶⁸ It so happened that the anti-malaria campaign occurred during a period of fierce stool disputes amongst the Ga *mantsemei* and at a time when the priestly stool of the House of Korle was vacant; these coincidences may have prevented the political and religious elites of the city from pressing their concerns about the spraying campaign.⁶⁹

⁶⁷ NARA, R. 705, Vickery, "medical section," 218.

⁶⁸ PRAAD CSO 3/1/162. *Korle Lagoon*. For example, in 1937 the colonial government paid £35 to acting Korle Priest Nee Tettey Quaye Molai for the rights to fill in some marshy areas of the lagoon.

⁶⁹ *Gold Coast Independent* (17 Jun. 1944), 150; *Gold Coast Independent* (30 Sep. 1945), 239.



Figure 6.4. “Spraying an Army hut with DDT.” This photo places the disinfecting machine in the foreground, emphasizing the primacy of technology in the fight against malaria. The unnamed technocratic white expert supervises the spraying while the unnamed African employees pose for the camera. No personal precautions were taken to protect people from the insecticides used because the long term effects of chemicals like DDT were not known at the time. *Source:* PRAAD ADM 5/3/46. Report on Service Malaria Control. Accra and Takoradi. Gold Coast. May 1945. Figure 63.

Section 4. Memories of the Anti-Malaria Campaign During the “Hitler War.”

The campaign of the IAMCG is almost completely missing from the historical record, and because it happened seventy years ago, it is also slipping from the collective memories of the residents of Accra. The oral history element of this chapter is necessarily slim, as there were fewer than ten veterans available to speak to who had lived in Accra during the Second World War. Fortunately, several ex-soldiers did remember bits and pieces of the campaign, as they revealed in interviews conducted between 2005 and 2006. Most of the veterans the basic elements of the anti-malaria operations, such as being locked in their barracks while the Americans sprayed the buildings with machines, being forced to take “yellow mosquito tablets,” and being ordered to dig through river beds with iron bars and rakes.⁷⁰ Only a few of them remembered anything about the mosquito traps, but those who did expressed their resentment about the inhumane treatment of the men forced to serve as human bait. Otia Badu, a veteran who had fought in Burma, recalled that the traps were set up near the Achimota forest, and that the British also tested “mosquito capes,” overcoats with holes in the cloth that were covered with sticky glue to trap insects.⁷¹ Badu claimed that the soldiers were ordered to wear the capes out at night to attract mosquitoes, but there are indications of such attire in the military records.⁷² One former member of the Gold Coast Regiment, Oblitey Commey, recalled the locations of mosquito traps at points surrounding the airport, and made the offhand comment that if the British wanted to catch mosquitoes

⁷⁰ Interview, Fuseni Bomba, December 19, 2005; Interview, Mama Moshie, December 20, 2005; Interview, Saidu Mossi, December 18, 2005; Interview, John Borketey, December 28, 2005; Interview, Andrew Nikoi Dsane, December 23, 2005.

⁷¹ Busvine records one example of the use of birdlime on clothing to collect tsetse flies in Principe in 1907, but there is no record of adhesive clothing used to collect mosquitoes in Accra. Busvine, *Disease Transmission by Insects*, 169.

⁷² Interview, Otia Badu. December 20, 2006.

they should have slept in the traps themselves.⁷³ Commey believed that all of the “northerners” who slept in the traps must have died shortly afterwards because they had “challenged their spirits” by complying with their colonial rulers.⁷⁴ Another veteran, Lamptey, recalled that the residents of Accra were not happy to see their homes doused in chemicals, and that rumours circulated during the campaign that the British were trying to poison the local population.⁷⁵ But what all of the veterans emphasized was that, despite the inhumane treatment that Gold Coast subjects faced during the “Hitler War” (as the Second World War is known colloquially in Accra) no one ever dared to challenge the authority of their officers.⁷⁶ As veteran John Borketey bluntly asserted, resistance was never an option: “whatever they tell you, you do it. Colonial days. You have no choice.”⁷⁷

Beyond the recollections of elderly veterans, memories of the IAMCG amongst the general population of Accra are sparse. No one at the Korle shrine remembers stories about Allied airplanes or spraying crews dousing the lagoon with DDT, and the story of the anti-malaria campaign is unknown by people in the older quarters of Accra. In Nima, the suburb that likely provided the migrant workers used as human bait during the campaign, religious leaders and elders have no recollection of the spraying campaign, the mosquito traps, or even the evacuation of their suburb. Nima has since become a large suburban centre with a mobile and changing population, but it is still surprising that no one remembers the antimalarial campaign. Considering that the residents of Accra rioted against British attempts to fill the reservoir in Bukom in 1889 and stoned the plague fighting crews that

⁷³ Interview, Oblitey Commey, February 25, 2005

⁷⁴ Interview, Oblitey Commey, February 25, 2005

⁷⁵ Interview, Old Soldier Lamptey, February 25, 2005.

⁷⁶ Interview, Old Soldier Lamptey, February 25, 2005; the reason that people in Accra call the Second World War the “Hitler War” is not known, but it may be due to the propaganda produced during the time that vilified Adolf Hitler as the leader who started the war.

⁷⁷ Interview, John Borketey. December 28, 2005.

tried to demolish houses in Ussher Town during Simpson's anti-plague program, it is difficult to believe that the residents of Nima simply left their homes to accommodate the IAMCG's one-mile cordon sanitaire, but there remains a gap in the historical record as memories of the event seem to have faded.

Why does the antimalaria campaign fail to resonate within the collective memory of the people of Accra? The answer may lie in the way that memories were fragmented during the feverish activity of the Second World War. The migrant workers who suffered the most by participating in the campaign were drawn from a labour pool of sojourners, men who, though numbering in the hundreds and perhaps thousands, left no mark on the memory landscape of Accra. They were unable to influence recollections about the war in Accra because they did not have a close relationship with the majority Ga speakers of the city, and as such were disconnected from the memory storage devices of the shrines. In addition, the absence of memories amongst the Ga-speaking population of the city can be attributed to the lack of a priest at the House of Korle due to succession disputes. During the 1930s, the chiefly houses of the city had contested legal rights to lands surrounding the Korle watershed, and the ownership of the property remained unresolved until 1946, when the Korle elders installed Priest Nummo Ayiteh Cobblah II. In the interim, there was a rupture in the family narrative of the House of Korle. Since the priest and other clan members were not actively worshipping the goddess during the war, the spraying and reengineering campaign was never apprehended as a meaningful event in her biography. The annual customs of the shrine that served the purpose of sedimenting traumatic occurrences into ritual memories were put on hold, and the event of the antimalarial campaign was never reborn as a revelatory memory, or as a "child" of Korle. As a result, events of the "Hitler

War” are mnemonically orphaned within the collective consciousness of the residents of Accra.

Another reason why the antimalaria campaign might have been forgotten is that it was censored and then buried under propaganda, thereby normalizing what would otherwise have been a controversial operation. The infrastructure to produce propaganda was put in place in 1939, when the Gold Coast Government created a new Department of Information to disseminate news about the war in Europe, and they produced programs in African languages to be broadcast on radio.⁷⁸ The colony also produced a weekly newspaper entitled *The Empire at War*.⁷⁹ The only independent voice in the media during the war was Dr. Nanka-Bruce’s *Gold Coast Independent*, which does not contain any information about the anti-malaria campaign. The absence of news on the IAMCG operations is likely due to government censorship, but it might not have mattered a great deal to the editor anyway because the physician was an avid supporter of the war effort and an advocate of malaria control measures. Not only did Nanka-Bruce support colonial medical efforts, he took time in 1941 to point out that the dubious activities of “Native Doctors” were a threat to the health of the population of the Gold Coast. He argued that they had to be regulated as herbalists only, and be forbidden to adopt the techniques of modern medicine. So thick were the layers of propaganda and support that even if the residents of the city had wanted to protest the activities of the IAMCG, there was no public platform for literate Africans to do so.

Moreover, the anti-malaria campaign occurred at a time when chemical therapies for diseases and chemical treatments for insect infestations were widely regarded as a benefit to mankind. In 1945, the *Gold Coast Independent* ran newspaper advertisements that

⁷⁸ Bourret, *Gold Coast*, 153-54.

⁷⁹ Bourret, *Gold Coast*, 155-6. Eight of the editors were chosen for a two-week visit to England, where they were given facilities to send radio broadcasts back to the Gold Coast

portrayed mepacrine as a weapon of war to be used against the mosquito, which was described as “more deadly than a dive bomber”.⁸⁰ And in a radio broadcast during the same year, British epidemiologist G. M. Findlay, declared that malaria killed one quarter of all children born in West Africa (an accurate statistic according to prior data) and warned the subjects of the Gold Coast that mosquitoes prefer black skin to white skin (a fallacious assertion unsustained by scientific evidence).⁸¹ Findlay exhorted residents to destroy the breeding places of mosquitoes as part of the war effort and encouraged them to take a daily dosage of mepacrine or quinine, drugs that had, he asserted, had no “poisonous effects” on the human body.⁸² It is quite possible that the inhabitants of the city, having already become accustomed to vaccination campaigns and having already become used to easy access to quinine pills and injections, actually welcomed the eradication of mosquitoes. This possibility is supported by Stephen Addae, who during an oral interview, stated that by the 1940s, the subjects of the Gold Coast might not have understood the science of malaria transmission, but were certainly made aware that mosquitoes bites led to symptoms like aches, chills and fevers.⁸³ In a parallel case, Myron Echenberg has written about a sense of resignation amongst the African population in Dakar during anti-plague efforts by the French and the Americans during 1944, suggesting that the Darkarois endured the spraying of DDT because they had accepted western aetiologies of disease transmission.⁸⁴ It is quite possible that, in the absence of any fear of the environmental aftereffects of the spraying and dredging campaign, the residents of Accra saw it more as a nuisance than a violation of their

⁸⁰ *Gold Coast Independent* (20 Jan. 1945), 13.

⁸¹ *Gold Coast Independent* (30 Sep. 1945), 237; Findlay’s assumption that malaria killed one quarter of African children in Accra is not borne out by evidence but was a likely guess based on the rates of malaria fever experienced by white newcomers to the West African tropics, see Curtin, *Disease and Empire*, 1.

⁸² Bourret, *Gold Coast*, 237.

⁸³ Interview with Professor Stephen Addae, Accra, 19 Aug. 2010.

legal rights or cultural traditions, thereby relegating the campaign into a category of negligible historical interest.

Section 5. Korle after the Second World War

In 1945, just as Ribbands, Macdonald and the area malariologists declared victory over the mosquito, the Mediterranean shipping lanes opened up again. No longer was Accra a key transshipment point across the Sahara, as soldiers and war material could be brought to North Africa directly across the Atlantic Ocean. In 1945, the number of troops stationed in the city dwindled rapidly, and the Allied forces hastily terminated their involvement in the antimalaria campaign.⁸⁵ The departure of the American forces left the Gold Coast Government unsure about whether it could sustain malaria vector control in the city. From 1942-45, the Gold Coast government had been responsible for funding only eight percent of the work done by the IAMCG, while the rest had been covered through the American lend lease program (65%) and by the British armed forces (25%).⁸⁶ After the war, the Allied forces left the Gold Coast Public Works Department with the cost of maintaining the massive drainage works built on the Korle Watershed and with the responsibility of continuing to spray DDT around the city.⁸⁷ By 1946, as the colonial economy sagged and Britain began to tally the costs of the greatest war in history, it was evident that the Public Works Department would never have a sufficient budget to conduct a perpetual campaign

⁸⁴ Echenberg, *Black Death*, 242-43.

⁸⁵ PRAAD CSO 11/11/128, *Control and Maintenance of Accra and Takoradi Anti-Malarial Drainage Scheme – European staff for*, “Letter from Resident Minister’s Office, Achimota, Accra to General Headquarters, West Africa, O.C., No. 114 Wing, Accra,” 24 May 1945.

⁸⁶ PRAAD CSO 11/11/124, *Accra Anti-Malaria Scheme - Financial Implications of*, “Telegram to the Resident Minister from the Colonial Office,” 22 Sept. 1944.

⁸⁷ *Gold Coast Medical Reports*, 1944, 6; PRAAD ADM 5/3/46, *Malaria Control*, 35.

against malaria.⁸⁸ At the end of the IAMCG campaign, the length of the drainage ditches and canals totaled over 350,010 yards, which meant that maintaining them would prove impossible -- at the end of the war the Public Works Department did not even have a budget to screen the windows of government bungalows in the city let alone reinforce miles of concrete embankments along the Odaw River.

After the war the crews working for the Gold Coast Public Works Department were further disheartened when new aerial photos of the city revealed dozens of quarries, salt pans, and borrow pits around Accra, too numerous to monitor and too expansive to spray regularly.⁸⁹ The effects of human habitation in the area had created a niche for mosquitoes to flourish, and it became obvious that the eradication program could not be sustained. The British returned to a reliance on quinine prophylaxis, accompanied by occasional spraying to prevent epidemics. In the short term, the effects of DDT made the city notably healthier, and use of the chemical became commonplace in Accra. For the price of only four pence a tin, DDT found its way into homes where people used it to control lice and bedbugs.⁹⁰ Kingsway, the largest department store in Accra, dispensed the drug at their chemist department and advertised it with the claim that DDT was “available for general use and to the eternal benefit of mankind.”⁹¹ DDT was not used in any comprehensive anti-malaria campaigns in Accra after the Second World War, and was only sprayed sparingly on the city. Nonetheless, the mosquito population of the area quickly developed a resistance to the

⁸⁸ PRAAD CSO 10/1/65, *Bungalow no. 11, Second Road, Accra, Mosquito Proofing At*, 5 Apr. 1945.

Director of Public works. Memo to Colonial Secretary.

⁸⁹ PRAAD ADM 5/3/46, *Malaria Control*, 37.

⁹⁰ *Gold Coast Observer* (16 Aug. 1946), 162.

⁹¹ *Gold Coast Observer* (7 Jun. 1946), 45.



Figure 6.5. An advertisement celebrating the attributes of D.D.T. This particular print ad was paid for by Kingsway, the largest department store in Accra, where DDT was available for 4d per tin. Source: *Gold Coast Observer* (June 7, 1946), 45.

chemical, as it did in many other parts of the world.⁹² By the 1950s, the Korle Lagoon and its tributaries once again became mired in silt and malaria was once again endemic in Accra.⁹³

Conclusion

If we take the extant documentary sources at face value, the Second World War was, indeed, a time of dramatic medical supremacy in the city of Accra. Allied fears of the infectious capacity of the “African bloodstream” allowed British and American malariologists to pathologise the bodies of the residents of Accra as an aggregate vector of disease. The war against malaria was not waged within the bodies of individual patients, but on “Africans” in general, from a perspective that allowed scientists to reduce disenfranchised migrants into entomological test subjects. Bulwarked by the power of the military and the largesse of the United States Army, the malariologists of the IAMCG were able to impose a military medical geography over the Korle Lagoon, one that silenced the spiritual topography of the sacred site and emphasized the control of mosquitoes over the health of the colonized. This spatial conception allowed for the introduction of new disease fighting technologies such as chemicals like pyrethrum, paris green and DDT. This was the apex of colonial medical technocracy in the city, and the most explicit expression of colonial biopower in the history of Accra.

However, there are many gaps, silences and unclear statements within the documentary sources about the IAMCG campaign that lead us to believe that the campaign

⁹² Packard, *Tropical Disease*, 162-63). Additionally, Rachel Carson’s popular work, *Silent Spring* raised public concerns about the effects of DDT on wildlife and led to a ban on the chemical in the USA in 1975. Rachel Carson, *Silent Spring* (New York, 1962); Valerie J. Gunter, “News Media and Technological Risks: The Case of Pesticides after “Silent Spring,” *Sociological Quarterly* 46, no. 4 (Autumn, 2005), 671-698.

⁹³ Nate Plageman, “ ‘Accra Is Changing, Isn’t It?’: Urban Infrastructure, Independence, and Nation in the Gold Coast’s Daily Graphic, 1954-57,” *International Journal of African Historical Studies*. 43, no. 1 (2010), 156.

was not as successful or extensive military officials claimed. Even at the peak of the campaign, the Allied forces were not able to eradicate mosquitoes from the Korle Watershed. Although they could temporarily kill the larvae living in the Korle Watershed, they could not meet the expenses of regularly dredging the lagoon and constantly spraying it with DDT. And though they could hire people to assist in their entomological experiments, they had difficulty finding willing and forthright participants -- even those men who agreed to participate as human bait passively resisted their orders, and had to be constantly monitored by Colonel Ribbands and his spraying crews. It is also difficult to believe that the inhabitants of Kanda and Nima allowed themselves to be trucked away from their villages because no memory of the campaign exists in these communities. The disparity between the discourses of technocratic control over the lagoon available in military records during the war, and the practical management of the lagoon at the end of the war became obvious when the British could no longer take advantage of the financial largesse of the US Army, and the governor was compelled to place the anti-malaria campaign in the control of an under-funded Public Works Department. This was tantamount to admitting failure because the drainage scheme for Accra was maintained only at a minimum cost and was never fully completed.

Moreover, it must be stated that, except for one brief dispatch from Dr. Nanka-Bruce, the campaign to eradicate mosquitoes was not accompanied by a campaign to eradicate pluralistic healing in Accra. Despite the degrading role as test subjects given to members of migrant communities during the campaign, the fact that there is no collective memory of the event in Nima indicates that it did little to rupture their sense of community, and likely did nothing to change their practices of healing. Moreover, the followers of Korle, who might have been deemed an impediment to the antimalarial campaign, seem to

have been treated with some degree of respect during the campaign, and when the soldiers were demobilized and the spraying crews departed, the identity of the lagoon as a goddess was easily revitalized. In 1946, after several years of bitter disputes over the stool, Nummo Ayiteh Cobblah II was installed as the Korle Clan leader. Cobblah became a prominent religious leader in Accra, as a moderate during anti-colonial riots in 1948, as a participant in colonial government functions, and as a friend of Ghana's first president, Kwame Nkrumah.⁹⁴ When Cobblah was enstooled, he resuscitated the rituals of the annual harvest festival of *Homowo*, asserting his rights to communicate with the spiritual forces that inhabit the lagoon. Naa Korle continued to be a moral force with the ability to define states of health in the city, and African healers continued to practice in the city, continuing the pluralistic healing culture in Accra.

⁹⁴ The ongoing disputes over office of priest of Korle were not resolved until Nummo Ayiteh Cobblah II was installed in 1946 (Funeral Program, Nummo Ayiteh Cobblah II, 2002).

Chapter 7. The Resilience of Pluralistic Healing on the eve of Independence.

By the early 1950s, Accra had become a colonial metropolis with a population of almost 200,000 people. More and more migrants from around West Africa flocked to the city to work at the port of Accra, the cocoa warehouses of James Town, and the retail businesses around Makola Market. So great was the influx of newcomers that the Ga ethnic group began to shrink in significance, forming only a bare majority of the population at 52 percent in 1954. Other linguistic groups were divided up between minorities including Ewe, Fante, Yoruba, Hausa and other smaller groupings (see Table 7.1). With such a mixture of ethnicities, the city became a dynamic place where young men and women sought their fortunes in the marketplace, and where differing ideas about healing coexisted. The city had always been an open marketplace for healing services where Ga healers had to compete to attract clients and compete with other healing traditions. But now Ga healers now found themselves as a minority in a polycultural city, where competition was heightened by the growth of colonial medicine, Christian faith-healing, Islamic healing, West African healing practices, and a rapidly expanding market in over-the-counter medicines.

In the timeline of the current historiography of medicine in Accra, the eve of Ghanaian independence is depicted as a period when colonial medicine had finally triumphed as a provider of health care to residents of Accra. According to a major survey published by the Gold Coast Government in 1958, patients in Accra were attending clinics and hospitals as a therapeutic first choice when they became ill, ending centuries of prior dominance by African healing traditions.¹ The success of colonial medicine is also reinforced in the secondary literature about the history of medicine in the city. Patterson

¹ Acquah, *Accra Survey*, 122-23.

argues that, from the “sound base” established in the early 20th century, colonial medicine was further enhanced by technological advances, pharmaceutical breakthroughs, and powerful insecticides, making “substantial progress” after the Second World War.² Addae echoes Patterson’s comments, noting the substantial progress made in the construction of new medical facilities in Accra in the late 1940s, such as the Ridge Hospital which served the elite families of the city. David Scott also notes how the control of disease was “advancing year by year,” a process “augmented by a rising standard of living and widening education facilities.”³

These authors also stress the fact that medical progress became possible because of the forward thinking policies of Governor Burns, who, in 1946, eliminated the colour bar that had excluded Africans from the top ranks of the Medical Department.⁴ The universality of medicine, according to Patterson’s logic, was revealed when the colonized took up European-derived healing practices *en masse* and began to operate their own medical health care system. Addae also mentions with satisfaction how the levers of medical power were turned over to the subjects of the Gold Coast after the war, and noted the significant role that Dr. K.A. Gbedemah played as the first Minister of Health and Labour in Kwame Nkrumah’s Government-in-waiting in 1952.⁵ Scott too argues that the Africanization of colonial medicine had created a new medical sub-culture in the colony, stating that “many of the increasing number of doctors in this country are now Ghanaians who will devote their professional lives to its service, providing a continuity of endeavor, both individually and from the profession as a whole, on a scale never previously enjoyed.”⁶ The evolution of

² Patterson, *Health in Colonial Ghana*, 30.

³ Scott, *Epidemic Disease in Ghana*, xv.

⁴ Patterson, *Health in Colonial Ghana*, 30-31.

⁵ Addae, *Evolution of Modern Medicine*, 88, 94.

⁶ Scott, *Epidemic Disease in Ghana*, xv.

medicine on the Gold Coast was now to be borne by Africans, offering continuity for the *telos* of the medicalized health and prosperity.

A plain reading of the statistical evidence contained within the records of the Medical Department makes it easy to argue that European-derived healing methods were in ascendance on the eve of independence, and the involvement of Africans in medical professions cannot be denied. However, the reasons why patients sought out European-derived therapies is much more complex. Much of the demand can be explained by the introduction of arsenic therapies, followed by sulpha drugs, and by the late 1940s, penicillin, therapies that offered quick and efficacious ways to cure the major illnesses that had dogged the inhabitants of the city for centuries. The forces of colonial biopower and cultural appropriation also played a role. The channels that guided patients towards hospitals (police, courts, ambulances, etc.) were firmly established by the middle of the 20th century, and employees of the colonial government workforce and European firms patronized colonial medicine as part of their occupational identity. Concurrently, the elite African residents of Accra patronized medical care as an identification with science and colonial progress, and encouraged their sons and daughters continued to enter medical professions, hoping that they might appropriate the forces of biopower that exerted control over colonial subjects. This chapter will expand further on the factors that allowed colonial medical activity to expand so rapidly in the colony.

However, this chapter will also demonstrate that the pluralistic healing culture of Accra continued to proliferate in the city, despite the ascent of colonial medicine. Ga healers continued to make up the plurality of healers in the city, adapting to the new medical terrain of post-war Accra by incorporating new ingredients and devices into their repertoire, and by attempting to rationalize their practices through the Ga Medical Association. Additionally,

the kinds of healers living in Accra diversified further, to include diviners from Dahomey and Nigeria, spirit mediums that channeled gods and goddesses from the Northern Territories, and worshippers of *Hauka* spirits from Niger. Religious healing also flourished during this era, as congregants abandoned orthodox churches in a search for spiritual and physical health beyond the old Christian social order, leading to a new type of Christian faith-healing. New therapies also emerged amongst Muslim immigrant populations, as they continued to find themselves marginalized and oppressed under colonial rule. In sum, the multiethnic arena of Accra continued to be a place where patients and their therapy management groups could pick and choose from a variety of healing options.

At the core of this chapter is a unique data-set about medicine and healing in Accra collected between 1953 and 1956 by Ione Acquah, an English sociologist in the employ of the Gold Coast Government.⁷ Acquah's *Accra Survey*, published in 1958, will be used in each section of this chapter because it contains a wealth of quantitative data that shows a trend of patient choice tilting towards colonial medical care, and offers statistical data about hospital attendance. Her qualitative data, on the other hand, proves the continuity of patient-driven decision making within the healing culture of Accra, a tradition that continued to allow for the coexistence of multiple forms of therapy. Though Ga healers could no longer claim to be the majority group of practitioners in Accra, they continued to practice and change their methods of healing, while hundreds of newcomers were bringing novel ideas about health and healing to the city. When set in the context of a city with an exponentially expanding population, Acquah's survey marks an ascent by colonial medicine in the city, but only as part of a diversification of a rich pluralistic culture of healing.

⁷ F. B. Dowd, "Review of *Accra Survey*," *African Affairs* 59, no. 235 (April, 1960), 165. Acquah was married to the director of Welfare and Community Services in Accra.

This chapter has five sections. The first examines the data used to show how colonial medical infrastructure expanded during the 1940s and 1950s, and how demand for treatments at hospitals and clinics grew exponentially. It also covers the much slower growth of sanitary facilities in the city. What it will show is that colonial medicine surged to prominence based on its ability to cure several major illnesses, rather than patient belief in an overall supremacy of European-derived healing. Moreover, though the colonial medical system was larger than ever before, it remained chronically underfunded and understaffed. Even as patients began to crowd the wards of Korle Bu, its status as a premier medical institution was diminishing, as it became known as a hospital for Africans rather than an egalitarian space for the neutral provision of colonial medicine. Competition from other hospitals and clinics also led to a stratification of class and race medical privilege in the city.

The second section covers the continuing story of African physicians in private practice. Six physicians, mostly from elite families, carved out substantial practices in the city by serving wealthy African clients and operating dispensaries. As a professional cadre they were connected to the upper classes of the city in terms of social and economic standing, and though not radicals, were active politically in the colony. They saw themselves as bearing the mantle of European-derived medical practice, and though they were aware that they shared their clients with African healers, they regarded non-medical practitioners with contempt as followers of traditions that were at best superstitions and at worst dangerous to human health.

The third section revisits Ga healing practices, as they appear in the Accra Survey in the 1950s, to find that for the first time in the history of the city, Ga practitioners made up a minority of healing professionals. In particular, the authority of Ga midwives was diminished by the new medical regime of mothercraft. Ga practitioners tried to adapt by

incorporating new material elements into their therapies, and by attempting to form a professional association of Ga practitioners, but they faced increasing competition from new healing cults that garnered their healing power from deities brought to the city by immigrant groups. The cult of Tigare, a deity brought to Accra from the Northern Territory as a means of enhancing fertility and thwarting the forces of witchcraft, was especially influential in the 1940s and 1950s. The story of Tigare, as well as Fon and Yoruba Soothsayers, is covered in the fourth section.

Another significant healing influence in the city was the rise of Christian faith-healing as well as new types of Muslim healing, which are covered in the fifth section of the chapter. The compelling force behind the new Christian movement was faith-healing, which was believed to be able to combat any sickness, from bodily woes to spiritual curses. These churches promised healing for both the body and the spirit in a way that paralleled what Ga healers had offered for centuries. Muslims in Accra also diversified the ways that they offered healing services. Three types of healers, the *Mallam*, the *Alhaji* and the *Alufa*, offered a wide range of therapies from herbal cures to Quranic apotropaics. Meanwhile, amongst the marginalized Zabarima community, a new type of cult emerged that portrayed colonialism as an illness that could be treated through group sessions of spirit possession.

The final section addresses the growing significance of patent medicines and pharmaceuticals in the city during the 1940s and 1950s, and demonstrates how advertisements for drugs and pills began to change after the war. As the African market became increasingly important to some drug companies, advertisements for imported medicines began to include archetypes of African men, women and children, images on which consumers in the city could model their consumption patterns. These new products

offered new opportunities for patients to heal themselves independently, without seeking help from colonial or African healing practitioners.

ACCRA 1948: AFRICANS BY TRIBE AND SEX				
Tribal Divisions	Males	Females	Totals	%
1. Ga	30,435	36,184	66,619	52%
2. Ewe	8,048	6295	14,343	11%
3. Fanti	3792	2904	6,696	5%
4. Nigerian (south)	3572	2537	6,109	5%
5. Hausa	2609	1798	4,407	3%
6. Adangme	1720	1922	3,642	3%
7 Akwapim	1534	1344	2,878	2%
8. Kwahu	1474	1149	2,623	2%
9. Zabarima	2133	149	2,282	2%
10. Asante	1305	858	2,163	2%
Total	67,666	61,399	129,065	100%

Table 7.1. Accra 1948: Africans by Tribe and Sex. This chart from the *Accra Survey* shows that, although they were by far the largest ethnic group in Accra, the city of Accra was no longer a majority Ga city by ethnicity. Though many immigrants would have learned to speak Ga to survive in the marketplace, the city was splintered in its ethnic affiliation, with Muslim migrants (who were mostly men) making up a large part of the colonial workforce. Though Ga healing continued to flourish as the Ga population grew, the healing landscape of the city was diversified by the new deities and the new Christian and Muslim influences brought by immigrants. It should be noted that Acquah did not specify whether tribal affiliations were self-identified by interviews or determined by interviewers. Source: Acquah, *Accra Survey*, 176.

Section 1. The Expansion of the Colonial Medical Infrastructure and Urban Sanitation in the 1950s.

On the eve of independence for the new nation of Ghana, the majority of the residents of Accra sought “western scientific methods of healing” as an option of first choice when they were ill.⁸ This is the remarkable conclusion made by Ione Acquah, the author of the 1958 *Accra Survey*. According to her statistics, the total number of colonial medical personnel in the city had caught up to or even surpassed the total ranks of Ga healers. The data showed that there were over 300 medical professionals working on the Korle Bu campus alone, and hundreds more doctors, nurses, and chemists working in smaller hospitals (like Achimota and Ridge) and private clinics. The majority of the physicians at the hospitals and clinics were European but many were African, and the vast majority of nurses, dispensers and technicians were Africans trained in the Gold Coast. By comparison, there were only 274 “traditional healers” in Accra, including all of the Ga-speaking shrine priests, spirit mediums, herbalists and other healers from around West Africa.⁹ By sheer numbers, it appeared that colonial medicine was finally starting to dominate health provision in the city and that Africans had appropriated the bulk of the medical professions. Considering how marginal European surgeons had been in the 17th, 18th and 19th centuries, and how limited the efficacy of medical therapies had been prior to the development of synthesized quinine and antibiotics, this implied a stunning turn in the fortunes of European-derived medicine in the Gold Coast.

⁸ Acquah, *Accra Survey*, 122-23.

⁹ Acquah, *Accra Survey*, 131-37.

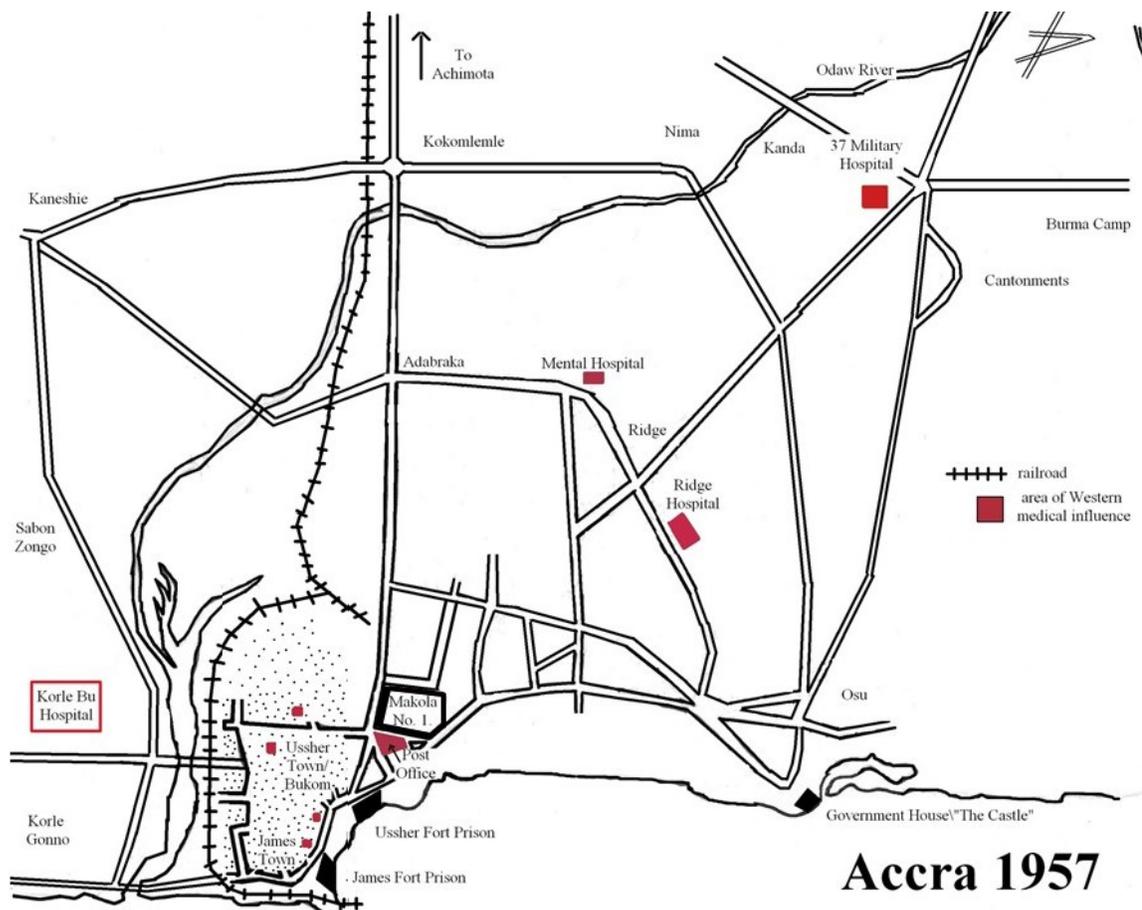


Figure 7.1. Map of Accra, 1957. On the eve of Ghanaian independence, hospitals were located in the suburbs of the city, with only a few small clinics operated by African physicians in the city centre. Korle Bu provided the majority of colonial medical care in the city, the Ridge Hospital in the former “European Reservation” became the hospital of choice for Europeans. After the Second World War, the British 37th Military Hospital continued to serve the armed forces, while James and Ussher Forts, outposts of medicine during the Atlantic slave trade centuries before, had been transformed into prisons. Meanwhile, Christiansborg Castle had become the seat of the Nkrumah government. Adabraka, Nima, Kanda and small suburbs to the north of the map housed the new Muslim immigrants arriving in the postwar period, while the new faith-healing churches sprung up in and around James Town and Ussher Town. Just to the north of Ussher Town, quinine pills were offered by the Medical Department at the central post office, while Makola Market became home to Kingsway Chemists and dozens of other merchants of over-the-counter patent medicines and pharmaceuticals. *Source:* map by author.

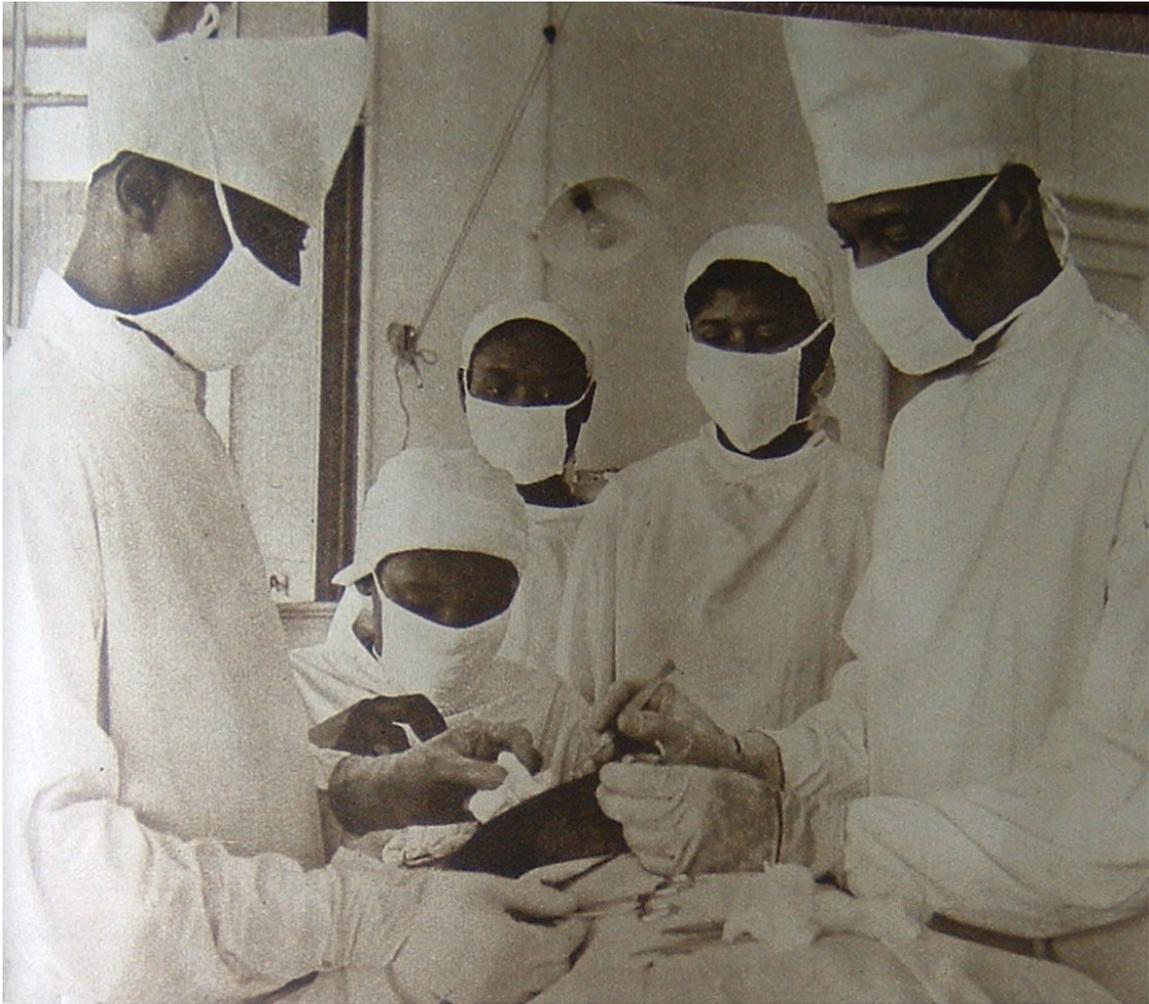


Figure 7.2. African nurses and doctors in the operating theatre at a Gold Coast hospital. Taken from a volume published by the Gold Coast Government entitled *Achievement on the Gold Coast*, this photo depicts an all-African surgical team. As a propaganda piece, *Achievement on the Gold Coast* was published with the intent of showing how Africans were in control of the technical aspects of running the Gold Coast Colony. In 1951, white physicians were still the majority in the colony but Africans did make up the overwhelming majority of nurses, dispensers and sanitary inspectors in the colonial medical service. As a celebration of colonial achievements, the overcrowding at the Gold Coast Hospital was absent from this government publication. *Source:* Gold Coast Colony, *Achievement in the Gold Coast: Aspects of Development in a British West African Territory* (Public Relations Dept, 1951), 69.

So great was the demand for colonial medical services that, by the 1950s, the long hallways and spacious wards of the stately Gold Coast Hospital were overburdened with patients. Though the British had expanded it to hold over 300 beds, the demand for services left a shortage of space inside as beds were jammed together in ways that crowded the wards beyond capacity. On the wooden benches outside, patients waited for hours, sometimes days, to see a doctor -- a situation that is not surprising considering the in-patient ward was only designed to handle only 200 patients a day but was serving an average of 800.¹⁰ By Acquah's count, the total number of visits to Korle Bu and other hospitals and clinics in 1954 was 256,580, a number that exceeded the total population of the city by at least 50,000.¹¹ Obviously, many of these visits were by the same patients and many were by people coming to the city from other parts of the colony, but the rise in attendance showed that the exponential growth of the city of Accra and of the larger colony were putting a strain on the colonial medical system.

Why were Korle Bu and the other medical facilities in the city so popular? The answer to this question can be attributed, in simple form, to the efficacy of new drugs. Though there are no specific records of the medicines provided at the dispensary, the demand for out-patient care was likely driven by four particular diseases that could be cured quickly with specific pharmaceuticals. The first was malaria, which was still the most significant contributor to morbidity and mortality (especially amongst children) in the city but that could be treated effectively with chloroquine taken orally or injected.¹² Chloroquine or mepacrine pills were available over the counter at the post office, but in severe cases

¹⁰ Acquah, *Accra Survey*, 131, 136.

¹¹ Acquah, *Accra Survey*, 137.

¹² Patterson, *Health in Colonial Ghana*, Table 9.

where it was not possible to digest the pills, patients would have been taken to Korle Bu to be diagnosed with the illness and given free injections of chloroquine solutions. The second was yaws, which had previously been treated by government doctors and nurses through free injections with sulpha drugs. Penicillin, which cleared up yaws in a matter of days, was slowly introduced in the late 1940s and early 1950s, further increasing demand for the treatments.¹³ The third and fourth were the venereal diseases of gonorrhoea and syphilis which could be remedied with injections of sulpha drugs, and even more quickly cured with penicillin.¹⁴ The demand for these sorts of chemotherapeutic treatments should not be surprising, considering that infectious disease and parasitic illnesses made up over one quarter of the causes of death in Accra in 1953.¹⁵ Taking into account the population growth in the rest of the colony, and the railroad and highway links into the interior, it is also likely that Korle Bu was patronized by patients from the entire southern Gold Coast.¹⁶

So badly did the demand for medical treatment by the growing population of Accra strain the facilities at Korle Bu that overcrowding became, in the words of Stephen Addae, “an unsavoury feature of the public health system”¹⁷ In 1953, Dr. H.B.L. Russell, the medical administrator of the Gold Coast Hospital, reported that, though the hospital was

¹³ Patterson, *Health in Colonial Ghana*, table 24; G.M. Findlay, K.R. Hill, A. MacPherson, “Penicillin in Yaws and Tropical Ulcer,” *Nature* 3921 (December 23, 1944), 795-96; J. J. Messent “Use and Effectiveness of Anti-malaria Drugs - Correspondence,” *British Medical Journal* 2 (12 September 12, 1953), 629; C.E. Reindorf, “Fifty Years of Scientific Medicine,” 119.

¹⁴ R. R. Willcox, “Venereal Disease in British West Africa,” *Nature*, 157 (1946), 416-9; Pellow, “STDs and AIDS in Ghana,” 420; Addae, *Evolution of Modern Medicine*, 359.

¹⁵ Acquah, *Accra Survey*, 140.

¹⁶ Busia’s report on Sekondi-Takoradi parallel’s Acquah’s findings in terms of common illnesses and the use of the hospital by patients from outside the city. K. A. Busia, Report on a Social Survey of Sekondi-Takoradi (London: Crown Agents for the Colonies on behalf of the Govt. of the Gold Coast, 1950), 113.

¹⁷ Addae, *Evolution of Modern Medicine*, 75.

Place where treatment received	Total number of in-patients and out-patients	% of total
Korle Bu General Hospital	105,023	40.9%
Ridge Hospital	3,762	1.5%
Achimota Hospital	45,613	17.8%
Children's Hospital	15,316	6.0%
Private Doctors	45,811	17.9%
Infant Welfare Clinics	12,307	4.8%
subtotal	227,832	88.8%
		0.0%
Korle Bu Maternity Hospital	19,413	7.6%
Maternity, Ridge Hospital	153	0.1%
District midwives	9,182	3.6%
Total	256,580	100.0%

Table 7.2. Scientific Medical Care given in Accra during 1954. This chart demonstrates the high rates of attendance at colonial medical institutions, specifically at Korle Bu. The Ridge Hospital, serving only the elites of the city, made only a small contribution to the patient totals, while the new hospital at Achimota, which was a small infirmary when the school was constructed, was expanded to 30 beds by 1950.¹⁸ The high demand at Achimota can be attributed largely to strong demand in the out-patient ward by the residents of the northern suburbs of the city, and possibly by patients traveling south from the Ashanti Region. Private physicians offered a substantial portion of medical care, and institutions related to child welfare continued to be the vanguard in the medicalization of infant and maternal care. *Source:* Ione Acquah, *Accra Survey*, 137.

¹⁸ Addae, *Evolution of Modern Medicine*, 90.

functioning, it suffered from poorly maintained equipment, poorly organized wards, ill-equipped surgical theatres, cramped in-patient facilities, and unhygienic food services. He also added that the setting of the hospital was problematic because Korle Lagoon remained “a menace to the hospital as a whole” and advocated (naively, in the context of prior attempts to dredge the lagoon) that the Public Works Department should drain the lagoon “as early as possible.”¹⁹ The vilification of the lagoon as an enemy to modern notions of health was repeated throughout the 1950s in the local press, and Henry Ofori, a Ga journalist, even went so far as to deny the significance of the deity that inhabited the lagoon, stating he thought “very little of gods who live at the bottom of black slush and odiferous waters and occupy themselves with the reproduction of mosquitoes.”²⁰

Finding adequately trained staff for the hospital was also difficult because living conditions for employees had deteriorated. The Head Nurse at Korle Bu, Miss Luscombe, appended her comments to Russell’s 1953 report, lamenting the shortage of nursing staff at Korle Bu. She argued that a lack of adequate housing on the hospital campus hindered the recruitment women of a “good class,”²¹ evidence of the way that the hospital struggled to remain a place of distinction for the aspirant classes of the city. Whereas Korle Bu had once been a well-funded hospital that had become home to a local medical culture, it was never provided with a budget during the post-war period that could sustain its status as the premier medical institution in the colony. According to Russell, nine-tenths of the equipment at the hospital was out of date and the hospital required a capital inflow of over

¹⁹ PRAAD, RG 5/1/23, *Buildings of the Gold Coast Hospital Korle Bu Accra: Additions and Alterations*. 1953. “Notes on Visit to Gold Coast Hospital,” 2.

²⁰ *Sunday Mirror*, March 29, 1955, from Plageman, “Accra Is Changing,” 156.

£750,000 to pay for new equipment.²² Russell's report was personally reviewed by Prime Minister Kwame Nkrumah and newly appointed Minister of Health, Thomas Hutton-Mills.

²³ Nkrumah sympathised with the predicament of overcrowding by commenting on the inadequacy of the out-patient ward, but with only £16,000 available for improvements in the 1953 budget, the government-in-waiting tabled the plan to renovate the hospital for future consideration.²⁴ In the waning years of colonial rule, Korle Bu Hospital was improved only by small increments, and remained overcrowded.

Not only had funding for colonial medical infrastructure slowed down and demand strained the system, in the 1950s, the role of the Gold Coast General Hospital began to deviate somewhat from the intentions of Guggisberg. Though there was no longer any formal segregation in the colony, Korle Bu began to take on a reputation as an "African Hospital,"²⁵ and white patients shunned it for a smaller colonial institution in the European residential area known as Ridge Hospital, which opened its doors in 1946 (for map of hospital locations, see Figure 7.1). Black patients were not excluded from Ridge Hospital, but its fees were higher than the nominal fees charged at Korle Bu, so it remained an establishment of distinction for the elites of the colony, such as British officers, and the European, African, Indian, Lebanese and Syrians merchant classes.²⁶ With the exception of a brief moment in the 1920s and 1930s, when Korle Bu served both white and the black

²¹ PRAAD, RG 5/1/23, *Buildings of the Gold Coast Hospital Korle Bu Accra: Additions and Alterations*. 1953, "Minutes of the Meeting Held in the Prime Minister's Office. 29th July, 1953, Gold Coast Hospital," 2.

²² PRAAD, RG 5/1/23, *Buildings of the Gold Coast Hospital*, 62.

²³ PRAAD, RG 5/1/23, *Buildings of the Gold Coast Hospital*, 3; Michael R. Doortmont, *The Pictures of Modern Africans and African Celebrities by Charles Francis Hutchison: A Collective Biography of Elite Society in the Gold Coast Colony* (London: Brill, 2005), 266

²⁴ PRAAD, RG 5/1/23, *Buildings of the Gold Coast Hospital Korle Bu*, 3.

²⁵ F. Belam, "Random reminiscences of the R. A.M.C. 1909-1949," *Public Health* 64 (1951), 117-18.

²⁶ Acquah, *Accra Survey*, 132-33.

populations in the city, the spatialization of health care in the city followed patterns established by the British in the 1890s, with Europeans residing and seeking therapies in the suburbs, the areas formerly designated as the “European reservation.” Though African elite families now joined them in these areas, a contradiction remained as some of those elites would have been on the staff of the Gold Coast Hospital. On the eve of independence, the racial divisions that had previously defined the geography of Accra quickly became class divisions as Ghanaian elites took up the residences and habits of colonial officials.

Like the hospitals, public health amenities in the city were rapidly overwhelmed by the expanding population. After the withdrawal of allied armies in 1945, the maintenance of the sanitary infrastructure was left to the Public Health Department of the Municipal Council of Accra, which was “grossly understaffed.”²⁷ The colonial government still found money to fund a small army of sanitary inspectors, who continued to monitor the behavior of Accra residents by entering their compounds and houses in the search for mosquito larvae and other sanitary violations. In fact, the same inspectors were used to aid Acquah in the collection of data for her report, using their right to enter homes to collect information about bathing habits, use of latrines, food preparation, and other quotidian details related to public health. This allowed for a continued presence of a colonial medical gaze in the homes of the residents of the city, but according to Acquah and other sources, the ability for the colonial government to intervene in the lives of Gold Coast subjects based on their medical needs was waning due to a lack of resources and staff.²⁸

²⁷ Acquah, *Accra Survey*, 137.

²⁸ Acquah, *Accra Survey*, 60.



Figure 7.3. “A classroom scene from the School of Sanitation and Hygiene in Accra, circa 1951.” Despite a deficit in sanitary infrastructure in Accra, the British continued to train sanitary inspectors to conduct weekly house-house inspections in Accra. They were required to check for mosquito larvae in man-made holes, water tanks, gutters, kitchens and homes in an effort to fight mosquito and fly borne diseases. This photo offers the first look at the inspectors who had become such a major part of daily life in Accra -- dressed in khaki uniforms, sanitary inspectors were perceived by the residents of Accra as agents of the colonial state, and their intervention into the domestic spaces of women was resented. *Source: Gold Coast Colony, Achievement in the Gold Coast: Aspects of Development in a British West African Territory* (Public Relations Department, 1951), 67.

By the 1950s, the sanitary infrastructure of Accra, especially in Ussher Town and James Town, was collapsing under the weight of population growth. In his annual report for 1953, the Medical Officer of Health in Accra declared that the city had passed the stage when “camp sanitation” could sustain the health of the population and that the city was in desperate need of a sewer system, a wastewater system, and an expanded supply of fresh water. In 1954, there were only 600 toilets in the entire city, mostly in the newly constructed suburbs, which meant that two thirds of the population had to use poorly maintained latrines with barrels to collect human waste. Open areas in the city were used as garbage dumps and cesspits, which contaminated the subsoil and the water mains that ran through it.²⁹ Sporadic outbreaks of typhoid were a problem in the city, especially near the Korle Lagoon during the rainy season when people collected contaminated water from streams leading into the lagoon.³⁰ The city desperately needed a makeover of its entire sanitary infrastructure, but the British were preparing to leave the colony so there was little incentive for them to commencing improvements to the infrastructure that would cost millions of pounds.

Above all other diseases, malaria continued to pose the biggest health threat to the growing population. During the rainy season, the disease caused high rates of morbidity in adults and high rates of infant mortality,³¹ but attempts to re-engineer the Korle Watershed had been abandoned and the Department of Public Works could not afford to continue aerial spraying DDT. Instead of a comprehensive campaign to fight the disease, the Sanitation Department conducted piecemeal efforts to prevent epidemics in the city, sending

²⁹ Acquah, *Accra Survey*, 138.

³⁰ Acquah, *Accra Survey*, 139.

mosquito brigades on spraying patrol around the city, prosecuting people through the so-called “larvae courts.” The Medical Department did initiate a health education campaign, producing educational films through the Gold Coast Film Unit,³² sending vans with loudspeakers around the city to spread the word about malaria control, by funding health education in the schools, and offering chloroquine for sale at a low cost through the post office.³³ They were also fortunate that resistance to chloroquine amongst the *anopheles* mosquito (the species that spreads malaria) had not yet developed, which meant that though malaria was widespread, it was eminently curable.

The dire state of sanitary affairs in Accra was contrasted starkly by the situation in the European Residential areas, where all houses were fitted with “electricity, water, baths, washbasins, and stoves.” Most of them also had electric fans, water heaters, and showers. Refrigerators were supplied free to Europeans in the employ of the government or major commercial firms, and the sanitary crews of the Municipal government were hired to clean compounds.³⁴ Even the so-called “boy’s quarters,” small dwellings for servants within the compounds, were wired for lights and provided with running water and bathrooms. Though urban segregation had been officially ended in the 1920s, the legacy of the separation of colonial elites from the crowded quarters of Accra continued in terms of the distribution of sanitation resources, and in terms of their patronage of Ridge Hospital. The contrasts evident in a short trip from the leafy eastern suburbs of the colonial elites through the urban core of the city to the crowded wards of Korle Bu clearly illustrated the priorities of a colonial government that was more concerned with austerity and decolonization.

³¹ Acquah, *Accra Survey*, 137.

³² UNESCO, *Visual Aids in Fundamental Education* (1952), 82-85.

³³ Acquah, *Accra Survey*, 138-39.

³⁴ Acquah, *Accra Survey*, 62.

Propaganda pieces like *Achievement on the Gold Coast* portrayed a modernizing health care system but the reality was that the rising demand for colonial medicine was not matched by adequate funding or infrastructure planning -- a situation that echoed a legacy of government disinterest in the health of the residents of Accra.

Section 2. African Physicians as Bearers of Colonial Medical Tradition.

The burden in meeting the demand for medical services in Accra was replaced somewhat by African physicians in private practice, but in the mid-1950s, the number of Africans with clinics in the city amounted to only six out of a total of 84 physicians in the colony.³⁵ Most of the men practicing were from elite professional families, including Dr. Christian Elias Reindorf, Dr. Charles Odamtten Easmon, and Dr. Frederick Victor Nanka-Bruce. Trained in the UK, these African-born doctors perpetuated a professional class that had been established by British-trained African physicians at the turn of the century, building clinics in James Town and Ussher Town where they could minister to the needs of as many as 30 patients per day, and dispense the latest medicines. Evidence suggests that their clientele was drawn from all walks of life in the city as they were willing to treat those who could not afford to pay, but the fees that they charged indicate that their primary clients came from a stratum of Ga elites in the city.³⁶

As leading members of Accra society, the physicians of the 1950s were able to put decades of racial discrimination behind them and finally assert their role as leaders in colonial society. With their own clinics and dispensaries, and a new battery of pharmaceuticals at

³⁵ Patterson, *Health in Colonial Ghana*, Table 2.

³⁶ Acquah, *Accra Survey*, 134; Interview, Dr. Barnor, August 29, 2003; H. B. L. R., "F. V. Nanka-Bruce, O.B.E., M.B., Ch.B.," *British Medical Journal* 2, no. 4830 (August 1, 1953), 289-290. Online resource (<http://www.panafrican-med-journal.com/content/article/9/15/full>).

their disposal, the African-born physicians of Accra now had the tools that they needed to offer therapies that were at least as efficacious as those provided at hospitals. And as the city grew, they were able to minister to the needs of a rapidly growing African merchant and professional class, providing a steady income regardless of any salaries they might draw at colonial hospitals or clinics. They were also influential members of colonial society in Accra, setting standards for upper class social behavior by maintaining memberships at the major clubs in town, including the Rodger Club and the Accra Turf Club (the physicians of Accra, it seems, were particularly keen on horseracing).³⁷ Though not at the vanguard of the independence movement, they were active politically too, as representatives on the Legislative Council, on the Accra Town Council, and in Ga chiefly politics.³⁸ Dr. Nanka-Bruce, in particular, critiqued the colonial government in his editorials in the *Gold Coast Independent*. During his tenure with the Aboriginal Rights Protection Society he advocated for increased educational and professional opportunities for Africans, and the opportunity to participate more fully in imperial affairs, but maintained a loyalty to the British crown over his own local ties to West Africa. As a British-trained practitioner, he was a keen supporter of increasing colonial medical interventions into the lives of colonial subjects, and was the first president of the Gold Coast branch of the British Medical Association, founded in 1951. His fidelity to British overrule was rewarded with the

³⁷ H. B. L. R., "F. V. Nanka-Bruce, O.B.E., M.B., Ch.B.," *British Medical Journal* 2, no. 4830 (August 1, 1953), 289-290.

³⁸ Frank Edwin et. al., "The development of cardiac surgery in West Africa - the case of Ghana," *Pan African Medical Journal* 9, no. 15 (2011).

<i>Doctor*</i>	<i>Out-patients</i>	<i>In-patients</i>	<i>Bed accommodation</i>	<i>Staff</i>		
				<i>Nurses and nursing assistants</i>	<i>Dispensers</i>	<i>Others - clerks, unskilled, e.g. cleaners, attendants</i>
A	2,259	-	-	3	1	2
B	4,000	100	9	4	2	2
C	10,950	52	4	2	1	1
D	3,000	200	9	9	1	2
E	10,000	250	20	10	1	4
F	15,000	-	-	3	4	2
TOTAL	45,209	602	42	31	10	13

* Doctors B,D,E, and F gave approximations as they had no complete records.

Table 7.3. Patients and Staff of Private Doctors in Accra, 1954. After the Second World War, the number of African physicians in private practice did not increase dramatically, but their capacity to treat patients at large clinics with dispensaries supplemented the colonial health care system in the city. Even though professional discrimination in the colonial medical service was officially abolished, African physicians were able to make a living outside of colonial hospitals, serving a growing population of professionals and merchants, as well as tending to the needs of needy patients in the core of Accra. Source: Acquah, 135.

Order of the British Empire, and a role as special delegate from the Gold Coast to witness the coronation of King George VI in 1937.³⁹ Dr. Nanka-Bruce may have been the most prominent physician in Accra after the Second World War, but he represented a new cadre of doctors who had graduated from universities in the UK with the assumption that they would become the medical leaders of Gold Coast Society.

The physicians of the 1950s did not leave behind any memoirs. However, interviews with several of the physicians who trained under them and who were acquainted with them personally give us a sense of what it was like to be a British-trained African physician in post-war Accra. In a series of oral interviews conducted between 2004-2012, Drs. Emmanuel Evans-Anfom, Mathew Arnum Barnor, and Jacob Benjamin Quartey Papafio, shared their memories about their occupational relationships and, at times, friendships with their professional elders. What these interviewees claimed was that the physicians working in Accra on the eve of independence believed themselves to be the bearers of medical tradition, not just passed down from their colonial supervisors at Korle Bu, but passed down as scientific knowledge through generations of medical professionals in both Africa and the UK. As such they saw themselves as the inheritors of a type of knowledge that befitted a privileged financial and social status in the city. They were aware of the rich traditions of African healing culture that surrounded them, and some of them even knew African healers personally. Dr. Barnor noted, for example, that all of the physicians knew of Ofori Ata, the healer who had interacted with Cicely Williams in the 1930s, and were aware that he was a drummer, soothsayer and herbalist who was “held in high esteem” by the residents of

³⁹ H. B. L. R., “F. V. Nanka-Bruce,” 290.

Accra.⁴⁰ And some of the physicians also had a quiet respect for locally generated therapies that made use of well-known local herbs, and it is possible that they even used them as home remedies, as so many other people did in the city.⁴¹ However, they had little time for African healers with a religious bent, who they labeled as “juju men” with “fetishes”; they simply could not have any professional intercourse with African healers that might neglect practical scientific treatments for illnesses.⁴² As bearers of medical knowledge, physicians in the 1950s considered most “native doctors” to be charlatans (or in the words of Dr. Nanka-Bruce, “dangerous frauds”)⁴³ who profited on the ignorance of the local population.⁴⁴

This does not mean that the doctors of the 1950s refused to share their patients with African healers. They were quite aware that African healers may have even had the majority share of patient visits in the city.⁴⁵ However, in their estimation, the popularity of native doctors was due to their accessibility rather than the efficacy of their treatments. As Dr. Barnor pointed out, African healers were in every village, and they were willing to accept payments in goods like gin, eggs or chickens, while medical doctors were only in the cities, and they only dealt only in cash.⁴⁶ Moreover, the physicians of the 1950s believed that scientific medicine would eventually win over patients due to its efficacy, so they were not concerned about competing with non-western therapies. Rather, the African physicians of the 1950s thought of themselves as operating within a distinct field of social interaction,

⁴⁰ Interview, Dr. Barnor, August 29, 2003.

⁴¹ Interview, Dr. Barnor, August 29, 2003; Interview, Dr. Evans-Anfom. March 24, 2005; Interview, Dr. Quartey-Papafio. September 9, 2003.

⁴² Interview, Dr. Barnor, August 29, 2003.

⁴³ Gold Coast Independent, July 8, 1933, 630.

⁴⁴ Interview, Dr. Barnor, August 29, 2003; Interview, Dr. Evans-Anfom. March 24, 2005.

⁴⁵ Interview, Dr. Barnor, August 29, 2003. According to Dr. Barnor, a special study conducted by Dr. C.O. Easmon sometime in the 1960s, indicated that herbalists did 70% of the work of healing in the city, while medical doctors provided only 30%. The whereabouts of this documented report are not known.

⁴⁶ Interview, Dr. Barnor, August 29, 2003.

based on a set of scientific principles that revealed a world of pathogens, both visible to the human eye and visible only with medical equipment or by diagnostic inference. In particular, they explicitly justified their practices in contradistinction to superstition or irrationality, embodied in the practices of so-called juju men or charlatans. They also remained connected to upper class colonial society, a world of private clubs, horse racing, political activity, that they shared with African lawyers and merchants in Accra, who were beginning to envision themselves as future elites of an independent nation, but one that would remain associated with the social and cultural world of Imperial Britain.

Section 3. The Diversification of West African Healing practices in Accra.

Echoing the well-established metanarrative of the progress of colonial medicine in her historiography of healing on the Gold Coast, Adell Patton argued in his 1996 *Physicians, Colonial Racism, and Diaspora in West Africa*, that when patients discovered the efficacy of sulphur drugs, antibiotics and antimalarials “traditional healers suffered diminishing status in the eyes of African patients.”⁴⁷ This argument appears to be borne out by Acquah’s survey data, which shows that patient behavior in the city had finally changed to form a bias towards “scientific medicine” as a first choice of therapy. More specifically, her quantitative evidence shows a direct relationship between levels of education and the patronage of colonial medicine (see Table 7.4), especially amongst men. Taking these findings at face value, the conclusion that a reader of the *Accra Survey* would reach would be that it would only be a matter of time before a colonial education system that emphasized universal

⁴⁷ Patton, *Physicians, Colonial Racism*, 17-8.

<i>Type of education received</i>	<i>Treatment sought when ill</i>							
	<i>Scientific only</i>		<i>Traditional only</i>		<i>Both scientific and traditional</i>			
	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>	<i>%</i>
1. No schooling	32	62	9	6	3	6	118	24%
2. Primary Schooling	14	11	-	-	4	-	29	6%
3. Middle Schooling	193	71	1	1	6	-	272	54%
4. Commercial and technical	5	-	-	-	-	-	5	1%
5. Secondary and teacher training	50	18	-	-	1	-	69	14%
6. University or equivalent professional training	7	1	-	-	-	-	8	2%
TOTAL	301	163	10	7	14	6	501	100%

Table 7.4. Educational Background of 325 Males and 176 Females in relation to treatment sought when ill. These numbers, derived from questionnaires distributed by Ione Acquah's survey team, demonstrate a trend towards seeking out colonial medicine as a healing option of first, and only, resort across all educational classes. However, the data is suspect because the method of collection was not transparent, and the respondents are mostly educated, male residents. *Source:* Acquah, *Accra Survey*, 122.

scientific knowledge would, indeed, lead to a “diminishing” of the status of African healing and the decline of non-scientific healing practices. Acquah’s findings, however, deserve some major qualifications. This section will challenge the assumption that colonial medicine had triumphed on the eve of Ghanaian independence by reassessing the data underlying Acquah’s assertions, offering evidence of the resilience of Ga healing traditions, and tracing the influx of new West African healing methods in Accra.

The first point that must be made about the data used in the *Accra Survey* is that there was little transparency in Acquah’s methodology. Most of the records utilized by Acquah must have come from surveys, questionnaires, or municipal or government records, but Acquah rarely offered the provenance of the numbers she chose to use. Considering the difficulties of communication between colonial officials and African healers in the past, especially in formal situations like court room cross-examinations, and the tensions inherent between local residents and data collectors like sanitary inspectors, it is probable that Acquah’s survey team did not always receive frank responses to their questions. For instance, when the survey teams queried patients about the number of times they visited the hospital versus the number of times they visited Ga healers, they did so with the use of questionnaires. How these questionnaires were formulated, printed and distributed is not known, so we are unable to tell who might have filled them out in written form, or who might have been asked the questions by one of Acquah’s assistants. It is possible that patients were not forthright in their responses, because the healing rituals conducted in the city were often shrouded in secrecy, and it was often seen as inappropriate for people to be visiting so-called “fetish priests,” especially for patients who were either Christian or

Muslim.⁴⁸ Acquah herself admitted that “secrecy is maintained by many people who avail themselves of magical methods of cure or protection, it is not possible to measure the extent to which it is practiced in Accra today.”⁴⁹ Unlike Margaret Field, who conducted extensive ethnographic work and concluded that the educated residents of the city were like the “froth on the surface” of a deeper Ga culture,⁵⁰ Acquah did not take a participant observer approach to her research, nor did she attempt to determine how patients rationalized their quests for therapy. Thus, it is quite possible that Acquah simply did not have the capacity to collect accurate statistical data about the behavior of patients in Accra.

Secondly, by Acquah’s own admission, biases of class distinction clearly informed responses to questions made by her survey teams. The “attitude of the more educated class,” according to Acquah, was that “outwardly at least, one should show a preference for the scientific methods of treatment.”⁵¹ Moreover, employees of the government, the municipality, and large European private firms, admitted to Acquah that they “by nature of their employment, attend the hospital when they are ill,” perhaps concealing their desires to go elsewhere.⁵² This suggests that decision to choose a hospital or clinic over other healing options was not always made by the patient, but rather was strongly influenced by the expectations of the workplace. Considering that out of an estimated male working population of 45,000, approximately 20,000 were working for the colonial government, the Accra Municipality, or the United Africa Company,⁵³ seeking medical treatment (and its

⁴⁸ Acquah, *Accra Survey*, 123.

⁴⁹ Acquah, *Accra Survey*, 122.

⁵⁰ Field, *Religion and Medicine of the Ga People*, 85.

⁵¹ Acquah, *Accra Survey*, 123.

⁵² Acquah, *Accra Survey*, 123.

⁵³ In 1954, Acquah’s data showed that 13,578 men were working for the colonial government, 3,239 for the Municipal Council, and approximately 3,000 were in the employ of the United Africa Company. It is likely that hundreds more were working for European companies in the city or were in the colonial armed forces. Acquah, *Accra Survey*, 64.

linking oneself to a colonial medical paper trail) may have simply been required; as in the past, employees might have been required to bring doctors notes to their workplace to prove that they had a medically certifiable illness. In the same way that the coercive apparatus of the state -- the police and the courts --channeled patients to clinics and hospitals in cases of trauma in order to maintain a paper trail, employers (especially European ones) might have expected their patients to go to hospitals and clinics for cures.⁵⁴ African healers, though perhaps literate in some cases, simply could not provide medical documentation suitable for employers or for the functionaries of the colonial state. These qualifications weaken Acquah's assertion that colonial medicine was a preferred choice of most patients in Accra.

A third qualification of Acquah's data is that contained such a strong bias towards educated respondents that a trend toward scientific medical healing was overstated.⁵⁵ According to the 1948 Gold Coast Census, less than 20% of the residents of Accra had attended colonial schools, and half of those had achieved less than a Standard VII elementary education.⁵⁶ With so many people falling into the category of "no schooling," one can extrapolate from Acquah's own data that there was a tremendous amount of movement between therapies, sustaining the pluralistic network of healers in the city.

⁵⁴ Some examples from the *Gold Coast Independent* of patients directed into colonial medical care include a homicide where the body was sent to mortuary for post-mortem (March 15, 1941, 85), a woman sent to the medical department for observation and subsequently declared a lunatic (March 22, 1941, 89), and a girl who was hit by a bus who was sent to Korle Bu and then to the mortuary (June 17, 1944, 149).

⁵⁵ Acquah, *Accra Survey*, 122.

⁵⁶ Acquah, *Accra Survey*, 108.

Type of healer	Tribal divisions							Total
	Ga and Adangme	Akan	Ewe or Dahomey	Northern Ghana and beyond	Hansa or Northern Nigeria	Southern Nigeria	Sierra Leonean	
Herbalists	83	31	28	10	2	12	1	167
Midwives	6	6	1	3	-	-	-	16
Medicine men	1	3	11	2	-	-	-	17
Muslim Healers	2	1		3	5	3	-	14
Fetish Priests:	-	-	-	-	-	-	-	0
Tigare cult	3	2	-	-	-	-	-	5
Individual fetishes	7	3	1	-	-	-	-	11
Fetish Priestesses	20	1	2	-	-	-	-	23
Soothsayers	1		19	1	-	-	-	21
TOTAL	123	47	62	19	7	15	1	274

Table 7.5. List of Traditional Healers Classified by Type and Tribe. The *Accra Survey* showed that Ga healers continued to make up the plurality of practitioners in the city. How Acquah assigned healers to these “tribal divisions” (which are actually a variety of linguistic/ethnic/regional distinctions) is not known, but the table does indicate that there were a wide variety of therapeutic options available to patients in the city. *Source:* Ione Acquah, *Accra Survey*, 123.

Moreover, the bias towards educated informants left a major gap in statistical knowledge about women, as girls were in the minority in colonial schools.⁵⁷ Considering the influence of the *woyei* over the time period covered in this dissertation, and the ongoing work of African midwives, limiting the number of responses from women may have excluded a great deal of information about women's reproductive health and the treatment of childhood maladies. Acquah even suggested, in another part of the *Accra Survey*, that much of the knowledge of herbs in Accra was perpetuated domestically by elderly women, which makes it problematic that women made up a minority of interviewees.⁵⁸

Unfortunately, though we can have reservations about Acquah's data, there is little we can do to confirm or deny Acquah's assertion that patients in Accra had begun to "avail themselves of western scientific methods of healing."⁵⁹ There is simply no data offered in the colonial medical records that can tell us whether patients chose hospitals or clinics first, exclusively, or as part of a process of seeking health that included visiting multiple healers. As Patterson has noted, medical reporting on even the basic services in the colony became scanty during the 1930s, and never restarted the sort of robust reporting of patient statistics that existed for the 1920s, leaving few documentary sources with which to gauge changes in patient behaviour.⁶⁰ However, the *Accra Survey* does contain a surprising amount of information about non-medical types of healing in the city, though much of it is in the form of archetypal descriptions of African healers or interviews with healers. A closer look at this quantitative material suggests that the residents of Accra had a much broader definition of illness than was represented in the statistics, and that they patronized Ga healers,

⁵⁷ Acquah, *Accra Survey*, 111-2.

⁵⁸ Acquah, *Accra Survey*, 123.

⁵⁹ Acquah, *Accra Survey*, 123.

⁶⁰ Patterson, *Health in Colonial Ghana*, x.

soothsayers from Dahomey, and a wide variety of shrine priests. In fact, in contrast to the assertion that colonial medicine became the primary choice for patients in Accra, Acquah's evidence shows that Ga healing methods continued to flourish in the city. According to Acquah, patients frequently alternated between colonial medical therapies and Ga or other West African therapies, especially if a patient was unable to find a quick cure at a hospital or clinic.⁶¹ The degree to which this pluralism occurred, Acquah admitted, was beyond quantitative assessment due to the secretive nature of patients and practitioners, but she asserted nonetheless that many people used charms, spells, and apotropaic objects to "ward off sickness,"⁶² and the *Accra Survey* includes a breakdown of several types of what Acquah calls "traditional" practitioners. In sum, we can read the *Accra Survey* in two ways -- as both an account of the growth of colonial medicine as well as an account of the diversification and growth of other healing traditions in the city.⁶³

The *Accra Survey*, which was conducted in order to assess how urbanization and colonial development was changing the city, in particular the "traditional social structure," divides different aspects of Accra society into categories of traditional and modern. In the case of health care, Acquah used "traditional" categorically as a subject heading for all non-medical practices in the city. The term was also used discursively to conceptually separate what she considered to be modern colonial medical practices from African healing methods that she considered as part of a legacy of African culture in the city.⁶⁴ The tag of "traditional" in the *Accra Survey* is borne mostly by Ga healers, which registers dozens of practicing herbalists and at least 20 "fetish priests" and "fetish priestesses" (see Table 7.5).⁶⁵

⁶¹ Acquah, *Accra Survey*, 123.

⁶² Acquah, *Accra Survey*, 123.

⁶³ Acquah, *Accra Survey*, 8-9.

⁶⁴ Acquah, *Accra Survey*, 123.

⁶⁵ Acquah, *Accra Survey*, 176.

To Acquah, Ga healers followed practices “as they were carried on before the days of western contact,” and she referred to them (following the assertions of Reindorf and Field) as the descendants of a theocratic class that once ruled the city.⁶⁶ In particular, she noted that the *wulomei* and the *wontsemei/woyei* attached to major shrines were still paid respects by the entire Ga-speaking community (including Christians), especially during the *Homowo* festival.⁶⁷ Homowo was a time when *wulomei* and the *wontsemei/woyei* appeared in public, to announce their authority over religious and health matters, an increasingly important statement in light of a constant influx of newcomers to the city. The rituals of Homowo included an assertion of control over the spaces of the city, as priests and spirit mediums worshipped at the network of *otutui* mounds, the supernatural grid that defined the urban geography of the worship of the *jemawoƷi*.

For the most part, Acquah’s descriptive passages of these Ga practitioners follow those given by Margaret Field. This is not surprising considering that Margaret Field was living at Achimota during the time of the survey and would have been the leading authority on Ga medicine and religion in the city. However, the Accra Survey also leaks out some interesting tidbits about hybrid healing activity. Most of the Ga healers who appeared in the *Accra Survey* were described as full-time practitioners who made a living selling cures and taking in patients for long term treatments. Others were said to dabble in herbs on the side, specializing in maladies like barrenness, impotency, leprosy, convulsions, arthritis, venereal diseases, and even illnesses that would be considered psychological by western standards.⁶⁸ But the *Accra Survey* reveals that, during the 1950s, there was a great deal of competition

⁶⁶ Acquah, *Accra Survey*, 16, 142-43. Acquah does not footnote Reindorf but was clearly informed by his belief that the Ga state had been a theocracy several centuries ago. C.C. Reindorf, *History of the Gold Coast*, 105.

⁶⁷ Acquah, *Accra Survey*, 142.

⁶⁸ Acquah, *Accra Survey*, 125.

between healers and that pay was generally low. Acquah noted that, as in the past, basic herbal treatments were “given in homes by elderly female members of the household who are familiar with several traditional herbal cures.”⁶⁹ Expert herbalists who took in patients could normally expect to earn only a few shillings per treatment, and only earned large sums by taking patients for extended forms of therapy.⁷⁰ This competition for clients appears to have led to new remedies for new concerns emerging amongst the growing urban population, including medicines to help school children pass tests, spiritual assistance in helping adults achieve colonial accreditations, and talismans to protect cars and trucks from accidents.⁷¹ Acquah also noted that Ga healers increasingly complemented their locally derived remedies with patent medicines bought in the marketplace, and there is concurrent evidence from an article in the *Gold Coast Independent* that suggests that herbalists were selling patent medicines and pharmaceuticals alongside local remedies.⁷² Acquah sidelined these innovations in healing practices and healing products in the same way as Margaret Field had in the 1920s, relegating them to the category of quack medicines sold by charlatans who did not properly fit within the social structure of the Ga.⁷³ Her goal, like Field’s, was to demonstrate that African healers continued to subscribe to the belief that the healing power of a remedy was derived from the *woji* within it, not its chemical properties, but this did not

⁶⁹ Acquah, *Accra Survey*, 122.

⁷⁰ Two decades later, Marion Kilson confirmed that there was a wide divergence in the material prosperity and the degree of professionalism amongst the *tsifatsemei* of Accra, see Kilson, *African Urban Kinsmen*, 89.

⁷¹ Acquah, *Accra Survey*, 123. Fictional examples of such medicines are noted in Margaret Field’s novel, *The Stormy Dawn* (written under the pen name Mark Freshfield). Mark Freshfield, *The Stormy Dawn* (London: Faber and Faber, 1946), 23, 130.

⁷² Acquah, *Accra Survey*, 124. Medicine peddlers travelled around the suburbs of Accra and out into the regions of the colony to vend patent medicines and pharmaceuticals alongside local herbal reagents. For an example see the *Gold Coast Independent*, January 18, 1945, 11.

⁷³ Acquah, *Accra Survey*, 124.

mean that Ga healers were not altering the ways in which they fabricated and consecrated their medicines.⁷⁴

Further evidence that changes were occurring within the Ga healing community is that a group of herbalists attempted to organize themselves according to a code of professional standards that would offer a modern face to their organization.⁷⁵ In 1946, under the leadership of a former teacher with a master's degree in science, they formed the Ga Medical Association, which claimed a membership of 150 by 1955. The idea of a society to promote the aims of herbalism was not new on the Gold Coast. In the 1930s, J.A. Kwesi Aaba, a herbalist from Takoradi, had attempted to coordinate knowledge about herbal cures in the Akan-speaking regions of the Gold Coast by forming the Society of Herbalists.⁷⁶ Aaba referred to himself as an "African Scientific Herbal Doctor,"⁷⁷ and he published a 36-page textbook in 1934 entitled *African Herbalism: A Mine of Health Part One*, which he hoped would restore the status of what he referred to as African "medical herbalism." Aaba received the support of Kobina Sekyi, the leader of the Aborigines Rights Protection Society, who wrote the forward to his book, and the Society was later supported in the colonial legislature by nationalists such as J.B. Danquah and Nana Sir Ofori Atta.⁷⁷ But despite support from members of the Gold Coast elite, support, petitions made by Aaba and the Society for government recognition were routinely rejected.⁷⁸ The Medical Department of the Gold Coast regarded the association with "sympathy," recognizing that there might be some merit

⁷⁴ Acquah, *Accra Survey*, 124-25; herbalists in Accra today tend to specialize in certain herbal cures for specific diseases, but they still claim their healing authority from the knowledge of the spirits within the herbs or from personal deities. Interview, Tsofatse Lamptey, June 9, 2003; Interview, Tsofatse Gabriel Neequaye, June 30, 2003.

⁷⁵ Acquah, *Accra Survey*, 125.

⁷⁶ Abena Dove Osseo-Asare, *Bitter roots: African science and the search for healing plants in Ghana, 1885—2005*, Doctoral Dissertation, Harvard University, 2005, 101.

⁷⁷ Patterson, *Health in Colonial Ghana*, 29.

⁷⁸ Patterson, *Health in Colonial Ghana*, 29.

to the analysis of African herbal cures, but they did not have the budget or political motivation to fund such research. They also stated that the association had never brought forth specimens of medical plants for analysis.⁷⁹

The Ga Medical Association followed in the footsteps of Aaba's Society of Herbalists as an ethnically bounded organization with the aim of modernizing herbal medical practices. The goals of the Ga Medical Association included isolating the medicinal properties of traditional herbal remedies, reproducing local remedies as mass market products, and offering therapies that preserved "the power of both body and mind to old age which can be found in the Greek Lexicon as Hygienia" (see Fig. 6.4)⁸⁰ The allusion to the Greek goddess of health was a means of framing the purposes of the society as both scientific and holistic, in a way that would be understood by educated elites but that would not abandon long-standing precepts about the supernatural forces that resided within healing reagents. However, despite its hopeful beginnings, the Ga Medical Association also disappeared from the historical record after less than a decade.⁸¹

The Society of Herbalists and the Ga Medical Association demonstrate that practitioners who continued to follow the healing traditions of the Gold Coast felt the need to organize themselves collectively in order to reimagine their role in an increasingly competitive healing landscape, however there were some key obstacles that they were unable to overcome. The first was that they did not have the support of the colonial government because their practices were not technically legal according to a strict reading of the Native Customs

⁷⁹ Patterson, *Health in Colonial Ghana*, 30.

⁸⁰ Acquah, *Accra Survey*, 125.

⁸¹ S. Kirson Weinberg, "Mental Healing" and Social Change in West Africa," *Social Problems* 11, no. 3 (Winter, 1964), 263.

- a. to encourage the study of medicinal herbs in West Africa
- b. To study how and when to gather herbs
- c. To study the drying and storing of herbs scientifically
- d. To study the medicinal properties of herbs
- e. To study the curative classes to which plants belong
- f. To study the various processes for obtaining the medicinal virtues of plants and to ask the Government's help for a research branch to aid the intended compilation?? of materia medica on African medical botany
- g. To study the causes of diseases together with the diseases of women and children, as well as the study of anatomy and physiology.
- h. To study the regulation of medicinal doses
- i. To study the manufacture of pills, syrups, and medicinal bitters and their various uses.
- j. To study all matters relating to the physical and mental well-being of human creatures, such as the food they eat, the water they drink, the air they breathe, the clothing they wear, the room in which they live, their personal habits, the disease and accidents to which they are liable, and the influence exerted upon them by locality, occupation, custom, etc. (The above aims at securing bodily and mental vigour, and at preserving the power of both body and mind to old age which can be found in the Greek Lexicon as Hygienia).
- k. To study special courses in African scientific culture, i.e. all African sciences.
- l. To study botanic medical aid to midwifery as recommended to botanic midwives, under midwife ordinance, Cap. 64, section 4 (I) (c) and 5.
- m. To establish regular lectures on African medical botany
- n. To group the medicinal virtues of herbs: roots, barks, leaves, seeds, fruits, nuts, flowers, etc.

Table 7.6. Aims of the Ga Medical Association. Formed in 1946, the Ga Medical Association claimed 150 members by 1955. Led by herbalist and former primary school teacher (who was rumoured to have a university degree in science) the association formed to “uphold and enhance the reputation of herbalists” in Accra. The aims chart out a transition from the study of herbalism to the mass production of herbal medicines, but the organisation did not last longer than ten years, likely due to the secret and proprietary nature of the recipes prepared by its members. Source: Acquah, *Accra Survey*, 125.

Regulation Ordinance, which forbade the use of non-western medicines.⁸² The second was that they did not yet have a national politician to champion their cause -- it was not until almost ten years later that President Kwame Nkrumah would bring together healers under the Ghana Psychic and Traditional Healers Association in 1963.⁸³ Without the openness that legality would bring, and without state support, it is difficult to see how healers would willingly expose their trade secrets to other healers. The *wulomei*, the *wontsemei/woyei* and the *tsofatsemei* of Accra, though united linguistically, ethnically, and geographically, were still an internally diverse group of competitive healers who were yet to be convinced that central organizing body was necessary in order to help them modernize their therapies.

Acquah's Survey showed that Ga healers were able to adapt and sustain their traditions despite rapid change in Accra, but in the case of infant and maternal care, there is strong evidence to show that the authority of Ga midwives was weakening. Following the suppression of the Naa Ede Oyeadu shrine in 1905, the establishment of infant welfare clinics and the construction of the Princess Marie Louise Children's Hospital in the early 1920s, a genuine transformation in the provision of reproductive healing began to occur. By the 1950s, colonial doctors, nurses and midwives became the primary bearers of knowledge and practice about child birth and child rearing, and thousands of women visited the hospital for antenatal, perinatal, and postnatal care. Though statistics for births are imprecise, it is likely that, on the eve of independence, the overwhelming majority of babies in Accra were

⁸² E.N. Mensah, "Status of Traditional Medicine Development in Ghana," lecture. Accra, April 27, 2011. expressfsgroup.com/tm.co.uk/5.doc; Senah notes that the colonial government did not officially recognise any organizations of indigenous healers, which may have been the reason for its inability to sustain itself. Senah, *Money Be Man*, 61.

⁸³ Twumasi and Warren, "Professionalisation of Indigenous Medicine," 122.



Figure 7.4. Princess Marie Louise Hospital at Korle Bu, circa 1950. In this photo, the lawn of Princess Marie Louise Hospital at Korle Bu is transformed into a meeting place for nurses, mothers and children, demonstrating how medicalized mothercraft had become prominent the city. The setting was staged for the camera, but statistics support the fact that women felt comfortable offering their children colonial medical care (which, in this picture, is offered exclusively by black nurses despite the fact that the position of Head Nurse was still exclusively held by white women). *Source:* Gold Coast Colony, *Achievement in the Gold Coast: Aspects of Development in a British West African Territory* (Public Relations Dept, 1951), 64.

either delivered at the maternity hospital or attended to by one of 28 district midwives trained at Korle Bu.⁸⁴ The children's hospital continued to sponsor weekly maternity and infant welfare clinics in different parts of the city, offering lectures on child care, free examinations for babies and infants, and free tinned milk and cod liver oil to mothers who could not afford them.⁸⁵

So pervasive was the new colonial culture of mothercraft that Acquah was able to state that "all children are taken to the clinic during the first year of their lives."⁸⁶ Meanwhile the numbers of Ga-speaking midwives (who had apprenticed with older kinswomen to learn herbal remedies for barrenness, difficult menstruation, complications arising from pregnancy, and infant illnesses) was diminishing rapidly.⁸⁷ Acquah noted that all of the non-Western midwives interviewed by the survey team were middle aged or elderly, a stark contrast with the younger nurses trained at Korle Bu. The profession of Ga midwife was in obvious decline.⁸⁸

However, though the childbirth and maternity care had been channeled through colonial medical institutions, Ga healers did continue to provide a wide variety of services in relation to fertility, pregnancy, childbirth and the care of infants. This type of involvement, by the *woyei* in particular, in reproductive health was evident in this summary of interview data contained in the *Accra Survey*:

When a pregnant woman consults a Woyo she is first given protective treatment in order that the evil acts of witches or bad medicine men will not affect her. There is a widespread belief that these evil spirits must be warded off to safeguard the unborn babe in the womb. This protective treatment

⁸⁴ Acquah, *Accra Survey*, 133-36.

⁸⁵ Acquah, *Accra Survey*, 134-35.

⁸⁶ Acquah, *Accra Survey*, 135.

⁸⁷ Acquah, *Accra Survey*, 125-27.

⁸⁸ Acquah, *Accra Survey*, 126.

consists in making six incisions at the back of both wrists, at the base of the neck and behind the waist. Into these cuts is rubbed a black powder, the composition of which is known only to the practitioners. The pregnant woman is then given a waistband from which are suspended charms tied up in pieces of material. This waistband must be worn continuously during pregnancy, for it is said to prevent miscarriage. In addition, the pregnant woman must acquire a new sleeping mat, chamber pot, and large enamel basin which will be used after the birth of the child, and, as they are included in the protective medicinal rites, they are said to be protected from evil forces. Certain herbs are given to the woman with which she must bath on seven successive days, for through the performance of this she is committed to the care of the god. After this has been done she must then visit the Woyo once a week for a routine examination.⁸⁹

The *woyei* continued to generate fertility rituals that included ritual incisions, consecrated bundles, herbal baths, nutritional advice, and the evocation of the power of deities, all of which were conducted according to practices learned through apprenticeship but also through advice garnered in the spirit world. While the vocation of midwife, which had been practiced by elder women who were knowledgeable about childbirth and infant care, may have been appropriated by colonial medical experts, and while educated Christian women from elite families may have shunned Ga maternity customs, the power of the *woyo* over fertility and infant health remained a vibrant part of Ga culture. Unfortunately, Acquah could not provide statistics about how many women visited *woyei* when they became pregnant, but their presence in the qualitative data of the *Accra Survey* demonstrates that, despite the destruction of the Naa Ede Oyeadu shrine complex, Ga healing methods continued to have significance for pregnant women and newborn children.

Was Ga healing, as an ethnically circumscribed tradition, in decline? Had it, to use the words of Patton once again, “suffered diminishing status in the eyes of African patients?” The answer is yes, in proportion to other West African healing traditions. The answer is also yes in comparison to colonial medicine. But these simple answers that do not

⁸⁹ Acquah, *Accra Survey*, 126-27.

accurately reflect the changing culture of pluralistic healing in Accra. The population of Accra was growing exponentially and, though we do not have any statistical account of the numbers of Ga healers in Accra prior to the Second World War, it is possible that there were actually more *wulomei*, *wontsemei*, *woyei* and *tsogatsemei* in the city than ever before. In that respect, it is hard to say that a group of professionals numbering over 100, making up almost half of the African healers in the city, who were still embedded within a vibrant Ga culture, were suffering diminishing status. Moreover, it is difficult to argue that colonial medicine had caused a decline in the reputation of African healing when, as we will see in the next section, so many new types of African healing traditions were emerging in the city.

Section 4. Immigrant Gods in Post War Accra.

After the Second World War, Accra was flooded with young men and women who were both searching for work as well as immersing themselves in the excitement of one of the largest cities in West Africa. It had become, in the words of John Parker, a “colonial city” of immigrant groups, many of whom formed urban niches beyond the authority of the Ga *mantsemei*.⁹⁰ As filmmaker Jean Rouch noted in conversation with Ione Acquah, Accra attracted migrants from around West Africa who were looking for work that paid cash, which they could use to buy commodities and take back to their villages.⁹¹ In a video montage of life in Accra in his 1950 film *Jaguar*, Rouch included footage of commodities sold in markets, including imported alcoholic drinks, sunglasses, cigarettes, clocks, bicycles, and

⁹⁰ Parker, *Making the Town*, 237. Jack Arn had a similar view of urban development in Accra, arguing that the roots of ethnic spatial divisions dated back to 1910, when the Colonial Government began to recognize “stranger headmen” as leaders. Arn considers a Muslim suburb like Nima to be a location of peripheral capital and social formation. Arn, “Third World Urbanization,” 440.

⁹¹ Acquah, *Accra Survey*, 68; Jean Rouch, *Jaguar* (Paris: Les Films de la Pléiade, 1954) (1967).

bottles of patent medicines.⁹² For migrants in particular, Accra was a centre for conspicuous consumption, epitomized by the “Jaguar” (*ɛɛzɛɔuman* in Hausa), the young dandy who spent lavishly on clothes and sauntered from drinking spot to drinking spot, smoking cigarettes. This demographic change was especially notable in suburbs like Nima, Kanda and Kaneshie, where newcomers could establish their own communities beyond the direct authority of Ga chiefs and priests.

With the new migrants came a wide variety of religious and healing practices. This section will discuss the prominence of three categories of healing subcultures that emerged the city in the post-war era, including itinerant herbalists with hybrid cures, soothsayers from Dahomey and Nigeria, and new shrines to imported deities from the Northern Territories. Some of these traditions may have been present in the city before the war, but Margaret Field only briefly alluded to non-Ga healing methods because she felt Ga healing practices were the most important ethnomedical tradition in the city.⁹³ For the post war period, the sources are much better, with the *Accra Survey*, government records, and oral histories providing detail about the plurality of healing traditions in the city.

The *Accra Survey* distinguishes between Ga herbalists, who sourced their herbal reagents from within a 20 mile radius of the city, and a different class of itinerant herbalists (without a specified ethnicity, but probably non-Ga), who made much grander claims about the expanse of their knowledge of medicinal flora. The movement of such migrant healers was facilitated by the absence of regulatory bodies, as they could claim to be familiar with the herbaria of distant regions, or to be members of international herbalist associations, without any system of verification. One of these herbalists appears in the *Survey* as a wandering healer:

⁹² Jean Rouch, *Jaguar*.

One educated herbalist acquired his skill, all of which he paid for, from non-kinsmen. First he settled in a town in Trans-Volta Togoland for three years, where he studied under the local herbalists. Then he practiced for a short while there before he went to Half Assini in Southern Ghana, where for one year he studied under another herbalist. From there he went to Ashanti to the villages around Lake Bosomtwi where he acquired further herbal knowledge. In addition, his father, who lived in Northern Nigeria, also sent him by correspondence several Hausa remedies. He is now settled in Accra as a full-time herbalist and corresponds with healing societies in all parts of the world. In this country he regards himself as the representative of an organisation called the Universal Religious Alliance and Permanent World Parliament of Religions. He states that this organisation is “a world brotherhood of friendly co-operation through all religious fathers, fraternities and inspired philosophies under the fatherhood of God.” He appends several letters to his name: D.D., Ph.D., D.Sc., and M.N.I.M.H. (Lond.) The latter stands for “Member of the National Institute of Medical Herbalists (London).” In his room his a framed certificate showing that he has been accepted into the Fellowship of the National Institute of Therapeutics of Calcutta (India). There is also an American certificate bearing testimony to some religious study. He has not, however, qualified in medicine or theology in any university. The title he gives himself is “Botanic-Medical Practitioner of Accra”⁹⁴

This particular healer went unnamed, but he was used as an example of one of many herbalists who congregated in the city, bringing with them claims of knowledge about rare medicinal flora, claims to knowledge about the spirits resident within herbs, and claims of certification by international sources. The tone of Acquah’s writing suggests she did not take the assertions of such herbalists seriously and she did not bother to verify the overseas references of her archetypical herbalist. The organizations of the Universal Religious Alliance, the World Parliament of Religions and the National Institute of Medical Herbalists, were, in fact, viable organizations in the 1950s,⁹⁵ but to Acquah, the appeal to membership in

⁹³ Field, *Religion and Medicine of the Gã People*, 13.

⁹⁴ Acquah, *Accra Survey*, 124.

⁹⁵ All-Asia Great Modern Spiritual Revival Movement, *The Spiritual Front and Moral Forces of the World: General Report of the 25th Grand Assembly of the Permanent World Parliament of Religions, Fraternities and Philosophies, Under the Aegis of the Universal Religious Alliance*, (Rangoon, Burma: Universal Spiritual Union, 1955); The National Institute of Medical Herbalism offered a

such international organizations spoke to the vagaries of the rapidly changing profession of (non-Ga) herbalism in Accra.

A new type of African practitioner following traditions with a more definite provenance in the *Accra Survey* were the Afa (Fon) or Ifa (Yoruba) soothsayers. Acquah notes that soothsayers from Nigeria and Dahomey brought a system of diagnostics to Accra that involved divination by casting beads, cowrie shells, or kola nuts into earthenware pots. Fon soothsayers claimed to be able to predict the future, but like Ga healers, they also made a living by tending to a wide variety of bodily and social illness.⁹⁶ To heal specific ailments, they prescribed herbal concoctions which they claimed could cure “lunacy, impotency, sterility, paralysis, rheumatism, stiffness, epilepsy, eye troubles, [and] wounds.”⁹⁷ As an example of a soothsayer therapy session, Acquah chose to include an account of an elderly patient who visited an Afa soothsayer to find out why her grandson was ill:

The soothsayer sat on the floor before the altar. He took a two-shilling piece from the client and then took the chains and other articles from the canvas bag. After fingering the two-shilling piece he handed it back to the woman, instructing her to place it between her lips and to whisper to it all that she desired on her grandson's behalf. Meanwhile the diviner, through incantations, was in communication with Afa. He passed his fingers through the chains and other objects taken from the canvas bag, constantly picking up the chains and throwing them towards the enamel dishes and the red earthenware pot under the altar. The position in which the objects on the chain fall reveals the message which Afa has for the enquirer. Each combination of positions has a special name and significance.⁹⁸

Though migrants from southern Nigeria had probably been passing through, and perhaps settling in, Accra for centuries, this is the first account that we have of the unique practices of Afa divination in the city. Unlike Ga practices, which involved the slaughter of chickens

correspondence course, see *Postal Domestic Course in Medical Herbalism* (Birmingham, U.K: The National Institute of Medical Herbalists, 1950).

⁹⁶ John S. Mbiti, *African Religions & Philosophy* (London: Heinemann, 1990), 173.

⁹⁷ Acquah, *Accra Survey*, 130.

⁹⁸ Acquah, *Accra Survey*, 130.

in divination ceremonies,⁹⁹ Afa divination included nuts or shells strung together, and were cast onto the dishes to provide binary, yes or no, answers to any questions asked of the oracle. The incantations were part of a set of verses of poetry that could be selected by the diviner according to his or her assessment of the needs of their client.¹⁰⁰ In the particular reading recorded by Acquah, the soothsayer divined that the grandson would soon recover his health, but only if the woman refused to take him to colonial physician. And the son would only stay healthy if he made sacrifices to the soothsayer's deities to prevent further illness.¹⁰¹

Fon and Yoruba soothsayers offered clients visions of the future as well as extended regimens of healing. The cost of a reading was two shillings, but further treatments could be very expensive, reaching over one pound per session.¹⁰² Acquah notes that soothsayers had a clientele made up of wealthy patients and that charging fees as high as £40 (a sum equivalent to more than a month's salary for a senior physician at Korle Bu post-war Accra)¹⁰³ for serious illnesses was not unusual. This amount may have been exaggerated by soothsayers in order to elevate their status, but it reflected the presence of a class Africans, possibly immigrants from other colonies, who were willing to pay for the services of diviners. Unfortunately, Acquah did not specify whether their clients came from Yoruba, Fon, Ewe, Ga or other ethnic groups, or whether class and status dictated who would define their social status by consulting a soothsayer. However, the high price of hiring a soothsayer

⁹⁹ Field, *Religion and Medicine of the Ga people*, 138.

¹⁰⁰ Peter Morton-Williams, William Bascom & E. M. McClelland, "Two Studies of Ifa Divination. Introduction: The Mode of Divination," *Africa: Journal of the International African Institute* 36, no. 4 (October, 1966), 406-31; J. D. Y. Peel, "The Pastor and the "Babalawo": The Interaction of Religions in Nineteenth-Century," *Yorubaland*," *Africa: Journal of the International African Institute* 60, no. 3 (1990), 342-44.

¹⁰¹ Acquah, *Accra Survey*, 130.

¹⁰² Acquah, *Accra Survey*, 130.

speaks to a stratification of prices within the African healing market. It may be that, in the same way that the elite classes of Accra aligned themselves with colonial medical care, wealthy immigrants in Accra distinguished themselves by having a soothsayer in their employ.

The West African healing traditions present in Accra were further diversified by deities from the Northern Territories of the Gold Coast. Acquah mentions the presence of several immigrant gods from the Akan-speaking regions (including Kwaku Fri, a god from Nwoase in the Ashanti Region), and from the Northern Territories (including Kunde from the region of the Black Volta, Tongnaab from the region of the White Volta, and Tigare, from the village of Ipare, near Wa).¹⁰⁴ If one follows the logic of Margaret Field, who argued that the rise of foreign gods in the southern Gold Coast was a result of jealousies generated by prosperity in the cocoa economy, these new deities were initially sought after as foils against witchcraft.¹⁰⁵ They subsequently found their way to Accra when Ga-speaking supplicants travelled north to buy rights to the cult of the deity, and brought the gods' paraphernalia south to build a new shrine.¹⁰⁶ By the 1950s, dozens of new gods were housed in shrines located all around the city.

The most prominent among the imported deities in Accra was Tigare, a witchfinding deity that gained a widespread following during the middle of the 20th century.¹⁰⁷ Tigare was

¹⁰³ Acquah, *Accra Survey*, 27. Based on salaries for senior administrators in the Gold Coast Government.

¹⁰⁴ Acquah, *Accra Survey*, 164.

¹⁰⁵ Margaret J. Field, *Search for Security: An ethno-psychiatric study of Rural Ghana* (Northwestern University Press, 1960), 87.

¹⁰⁶ For a map and brief description of the provenance of these deities see Allman and Parker, *Tongnaab*, 136-41.

¹⁰⁷ Charles Anyinam, "Traditional Medical Practice in Contemporary Ghana: A Dying or Growing "Profession"?" *Canadian Journal of African Studies / Revue Canadienne des Études Africaines* 21, no. 3 (1987), 330; Margaret Field's informants told her that Tigare was in the Ashanti Region by the First World War. Field, *Search for Security*, 90.

very expensive to acquire, but once a fee ranging from £40 to £600 was paid to its shrine at Ipare, it became a mobile deity that could be worshipped anywhere. Initially brought to the city to fight a perceived outbreak of witchcraft,¹⁰⁸ the powers of Tigare broadened in the context of Accra, as the priests who administered the shrine of the god adapted to local concerns about health, fertility and good fortune.¹⁰⁹ Tigare was unique in Accra, because it was a cult that one could access simply by eating a kola nut in front of the priest and paying initiation fees.¹¹⁰ Anyone could become a supplicant to a Ga deity, but Ga religious traditions did not involve fees and rituals of initiation into a healing or anti-witchcraft society.

Because of Tigare's relatively recent arrival in Accra, some oral sources about its activities in the city are still available. Okomfo Numo, a herbalist and spirit medium who channeled Tigare in Accra, stated during an interview that the god was brought to southern Ghana in 1943 by a Ga-speaker, Elder Kwabena, to increase the fertility of local farms.¹¹¹ Before he began to worship Tigare, Elder Kwabena had been a spirit medium who channeled multiple deities,¹¹² but the reputation of the savannah gods to thwart witchcraft and sorcery drew him northwards to Ipare in the late 1940s, and he returned to establish the first shrine to Tigare in Accra.¹¹³ The first documented evidence of a Tigare priest in Accra was in 1948, when it was recorded in a court proceeding that 300 devotees were worshipping Tigare at a shrine in a suburb of Accra.¹¹⁴ Shrines later sprung up in Nsawam to the north

¹⁰⁸ Field, "New Shrines," 141.

¹⁰⁹ James B. Christensen, "The Tigari Cult of West Africa," *Papers of the Michigan Academy of Science, Arts and Letters* 39 (1954), 392-93.

¹¹⁰ Christensen, "The Tigari Cult," 392.

¹¹¹ Interview, Okomfo Numo, February 6, 2004. Okomfo Numo passed away in 2012.

¹¹² Interview, Okomfo Numo, February 6, 2004.

¹¹³ Interview, Okomfo Numo, February 6, 2004.

¹¹⁴ Acquah, *Accra Survey*, 143. The shrine was in the village of Apenkwa, five miles to the north of Accra.

of the city, and in the Ga-speaking village of Labadi to the east,¹¹⁵ and by 1955, there were five Tigare priests residing on the outskirts of Accra¹¹⁶ with an average weekly attendance that varied from 15 to 30 devotees.¹¹⁷ Okomfo Numo worshipped and channeled Tigare throughout the post-war period, making a substantial living by taking in patients of all ethnicities.¹¹⁸

To the people of Accra, Tigare was initially known as a god of fertility, and his followers were largely women who wanted to have children. A passage from a 1949 court case shows that a married couple joined the Tigare cult because they had suffered the deaths of several of their young children, and they wanted to protect the three children that they had left.¹¹⁹ Other imported gods, like Tongo,¹²⁰ had been employed as fertility spirits in the past, but Tigare was known as a foil to witches and sorcerers, provided that his supplicants followed the taboos of his shrine.¹²¹ As such it played the role of a prophylactic cult, which allowed patients to take preventative action against future problems. The suppression of the shrine of Naa Ede Oyeadu, which had created a gap that was already being filled by colonial maternal and infant medical care, may have also offered an opening for Tigare, especially considering popular opinion held that the malicious forces of witchcraft were on the rise in the city of Accra.¹²²

¹¹⁵ PRAAD RG 16/2/144, “D. Ako Anogywan VS Agoe Toboase,” case no. 442/49, July 12, 1949, 97-98.

¹¹⁶ Acquah, *Accra Survey*, 143. One at Apenkwa, one at Nima, one at Aladjo, and two at Bubuashi

¹¹⁷ Acquah, *Accra Survey*, 143.

¹¹⁸ Interview, Okomfo Numo, February 6, 2004.

¹¹⁹ PRAAD RG 16/2/151, “Ama Amoahba vs Owula Cobblah/Simons,” case no. 103/53, February 17, 1953, 29.

¹²⁰ PRAAD RG 16/2/17, 536-41.

¹²¹ PRAAD RG 16/2/140, “Dadjamah Quarshie vs Aba Nye,” case no. 587/48, December 22, 1948, 723-51.

¹²² Interview, Okomfo Numo, February 6, 2004. Okomfo Numo passed away in 2012.

Another aspect that enhanced the authority of the Tigare cult was uniqueness of its shrine culture. The steadfast nature of the god's rules, which were rendered textually in a manner borrowed from Christian doctrine,¹²³ included the following six decrees:¹²⁴

1. Thou shalt not steal
2. Thou shalt not covet thy neighbour's wife
3. Honour thy father and thy mother
4. Thou shalt not bear false witness against thy neighbour
5. Love thy neighbour as thyself
6. Thou shalt not administer medicine of noxious or poisonous nature¹²⁵

To this mixture of Old Testament commandments (and colonial legalese) were added a number of uncodified pledges against the use of curses or witchcraft.¹²⁶ Like the oath medicines used during the Atlantic slave trade, anyone who violated the taboos of the shrine was believed to suffer misfortune, illness, or even death.¹²⁷ Tigare also added a new subculture of music, dance, dress, and material culture to the healing traditions of Accra. The priest of Tigare danced to a rhythm unique to the god, which meant that a shrine had to employ a retinue of musicians, including someone who knew the lead role of the *odono* (a double-headed, hourglass-shaped drum strung with leather chords to alternate tones) and someone who could play a Tigare bell pattern that differed substantially from the Ga or Fante rhythms.¹²⁸ The dancing differed too. Tigare movements contained elements of Muslim Sufi whirling, accentuated twists and twirls of a heavy cotton smock emblazoned

¹²³ Christensen, "The Tigari Cult of West Africa," 393; Acquah, *Accra Survey*, 143.

¹²⁴ Christensen, "The Tigari Cult of West Africa," 393; Acquah, *Accra Survey*, 143.

¹²⁵ Acquah, *Accra Survey*, 143 (from Busia, *Sekondi-Takoradi*, 80).

¹²⁶ Acquah, *Accra Survey*, 143; Busia, *Sekondi-Takoradi*, 80; Christensen, "The Tigari Cult of West Africa"; Interview, Okomfo Numo, February 6, 2004.

¹²⁷ Acquah, *Accra Survey*, 128-29.

¹²⁸ From website of Yacub Addy, professional drummer from Avenor, a village near Accra, and part of the Addy musical family trained by his father, Okomfo Akoto, who was a *woytse*. Yacub Addy, Personal Website, accessed August 18, 2009, http://www.yacubaddy.com/RPI_site/high/drums/tigari.html; Interview, Mustapha Tettey Addy, December 30, 2009; Interview, Boi Quartey & Lawrence Tetteh, Thursday, July 17, 2003.

with consecrated leather bundles. While in trance a Tigare priest knelt before elders and touched his hands to the ground, actions alien to coastal dances.¹²⁹ The material culture of Tigare shrines also differed from those built by the Ga, because they followed an aesthetic brought south from the savannah region of the Northern Territories, and included “northern accouterments” like black pots, swords, carvings of lions.¹³⁰ Tigare also accepted different gifts; drinks and cash were welcome, but his oblation of choice was kola nut, a mild stimulant used as an offering to deities north of the rainforest. Though Tigare was neither a Christian or Muslim spirit, its followers had appropriated and mixed together powerful ideas, practices and material cultures from both major religions.

The vengeful nature of northern gods like Tigare were meant to complement the work of local deities, but according to Okomfo Numo, the Ga *wulomei* were displeased by the presence of Tigare, and they sought to persecute its worshippers in an effort to protect the established shrines of the city. For this reason, worshippers of Tigare tended to live outside Ussher Town and James Town, in the newer suburbs of the city. Okomfo Numo settled in Bubuashi, north of Korle Lagoon, to avoid the interference and competition of the traditional shrines and Ga spirit mediums associated with those shrines.¹³¹ The colonial government also saw Tigare as an interloper. Okomfo Numo claimed he was persecuted by the colonial government, and related a story about how he had been harassed by the police at the request of the Accra Town Council. Numo claimed that he always struggled to achieve legitimacy as a healer in the face of opposition from Ga priests, Ga elites on the Town Council, and the Gold Coast Government. This sort of persecution is confirmed in the post-war court records of the city, which contain examples of Tigare priests being jailed

¹²⁹ Christensen, “The Tigari Cult of West Africa,” 396.

¹³⁰ Parker, “Witchcraft, Anti-Witchcraft,” 412; Christensen, “The Tigari Cult of West Africa,” 392-94; Interview, Okomfo Numo & apprentice Kwabena Nia, February 4, 2004.

and fined for the use of “obnoxious medicines,” for conducting trials-by-ordeal,¹³² or for sexually exploiting patients at their shrines.¹³³ No such efforts were ever taken to suppress the major shrines of Korle, Sakumo and Nai, most likely because the British wanted to maintain cordial relations with the Gas of central Accra.

The new healers and deities that arrived in Accra during the postwar period posed a threat to the established healing culture of the Ga, and to colonial control over the religious and cultural makeup of Accra. But they also diversified and stratified the number of healing options in the city for Africans who were looking for everything from herbal cures, to clairvoyance, to witchcraft inoculation. Though it is possible that particular immigrant groups did patronize their own healing traditions more than others, Acquah’s herself noted that a “high number” of patients “place reliance on all forms of healing available.” She was not able to quantify this movement between African healers, but data taken from oral interview evidence shows lateral movement between traditions. Okomfo Numo, for instance, claimed that he drew clients from the majority Ga population as well as other ethnic minorities. For patients who were accustomed to living within a pluralistic healing culture, immigrant practitioners with new gods and new practices were not a threat; they simply offered more ways to challenge age old problems like infertility, and tackle new problems like witchcraft.

Section 5. Christian Faith-healing and New Healing Practices in Muslim Communities.

¹³¹ Interview, Okomfo Numo, February 6, 2004.

¹³² PRAAD RG 16/2/167, “Tow Seyino vs Wia,” case no. 551/62, November 23, 1962, 614-18.

¹³³ PRAAD RG 16/2/31, “Yao Adobia and Nkran Quaye vrs Obosomfo Amartey,” Case no. a25/50, April 26, 1950, 425-88, 432-36, 440-54, 465-66; Christensen, “The Tigrari Cult of West Africa,” 395-96.

Along with the arrival of new spirits from around the Gold Coast came novel Christian and Muslim ways of healing. One hundred years after being codified in Ga and Twi by the Basel missionaries, the spiritual forces of God, Jesus and the Holy Spirit began to play a more significant role in defining how people in Accra understood states of health. And about eighty years after the establishment of the first Muslim community in Accra, Islamic healing practices began to rapidly diversify in the city. Thousands of Accra residents flocked to the new services provided by pastors who promised both physical and spiritual health, while thousands of people took advantage of a network of dozens of Muslim healers living in the city. Unlike the previous century, when Christian and Muslims lived in small communities, the major religious healing traditions had become an integral part of the pluralistic healing culture of Accra.

As the work of Paul Gifford, Birgit Meyer and Rijk van Dijk has shown, the growth of Pentecostal and charismatic church movements in the 1980s and the 1990s ushered in an era of the so-called “mega-churches” that offered new methods of healing based especially on the power of Christ to wash away sins and cleanse the spirit.¹³⁴ But the *Accra Survey* shows that a Christian revival movement that emphasized faith-healing was already well underway by the 1950s. Before the Second World War, the Christian community was comprised almost exclusively of four major (so-called “mainline”) denominations: Roman Catholic, Methodist, Anglican and Presbyterian.¹³⁵ The churches for these congregations were built on the edges of Ussher Town and James Town in the late 19th century and the early 20th century, and before the war, 90 percent of Christians in the city attended their

¹³⁴ Gifford, *Ghana's New Christianity*; van Dijk, “Contesting Silence”; Meyer and Geschiere, *Globalization and Identity*.

¹³⁵ Smith, *Presbyterian Church of Ghana*, 140-41.

services.¹³⁶ Unlike western Nigeria, which was swept by an Aladura (“praying people” in Yoruba) revivalist movement in the 1930s, the new Christian churches that emerged in the 1920s and 1930s had little impact in Accra. Only one Aladura church, the Christ’s Apostolic Church, won converts in the city before the war, but it faded into a small congregation by the 1950s (due to a splinter movement that resulted when the church’s American missionary founders took quinine pills, in violation of the church’s prohibition against taking medicines).¹³⁷ Even the prophetic movements of William Wade Harris and Samson Opong, which were so influential in other parts of the Gold Coast, made little headway in Accra.

But in the 1950s a Gold Coast version of an Aladura movement did sweep through Accra. Several churches were brought to Accra by Gold Coast subjects who had lived in Nigeria, including the Church of the Lord (1953), The Redeemed Church of Christ (1955) and the Eternal Sacred Order of Cherubim and Seraphim Society (1949). Unlike mainline congregations that had built their churches on the periphery of the old city, the new churches established branches inside James Town, and held public, outdoor baptisms of new members.¹³⁸ There are no records of membership in these churches, but interviews with elders and ministers of mainline churches in Accra indicate that the less educated classes made up the largest proportion of followers.¹³⁹ The mainline churches, with their links to the educated strata of Accra society, maintained their role as social arenas for the elites of the city, and continued the traditions of attire, music, liturgy, English language training, and

¹³⁶ Acquah, *Accra Survey*, 146.

¹³⁷ Allan Anderson. *An Introduction to Pentecostalism: Global Charismatic Christianity* (Cambridge: Cambridge University Press, 2004), 117.

¹³⁸ Baeta, *Prophetism in Ghana*, 119.

Country of Origin	Previous denomination of Founder	Church	Orthodox, Prayer healing or Syncretist ^e	Year established	Adherents			Total
					Male	Female	Children	
Ghana	Methodist	1. The Nazaire Healing Home	S. and P.H.	1935	639	1278	-	1917
Ghana	Methodist	2. Musama Disco Christo Church	P.H.	1922	120	180	80	380
Ghana	Presbyterian	3. National Baptist Church	O.	1888	200	100	80	380
Ghana	Methodist	4. The Apostolic Faith Mission	P.H.	1948	80	90	60	230
Ghana	Anglican	5. The Divine Healer's Temple	P.H.	1953	50	150	20	220
Ghana	Presbyterian	6. The Apostle's Revelation Society	P.H.	1939	70	65	50	185
Nigeria	Methodist	7. The Eternal Sacred Order of Cherubim and Seraphim	P.H.	1949	60	90	-	150
Ghana	Methodist	8. The Universal Church of Christ	P.H.	1945	50	20	70	140
Ghana	Anglican	9. First Century Gospel Church	P.H.	1922	45	57	30	132
Ghana	Methodist	10. Accra Congregational Church	O.	1924	34	36	50	120
Ghana	Anglican	11. Redeemed Church of Christ	P.H.	1955	37	58	-	95
Nigeria	Presbyterian	12. Christ's Apostolic Church	P.H.	1938	42	30	11	83
Ghana	Methodist	13. Saint Michael's Healing Mission	P.H.	1938	20	60	-	80
Nigeria	Anglican	14. The Church of the Lord	P.H.	1953	50	30	-	80
Ghana	Methodist Episcopal American Negro Church	15. Benlah Christian Methodists Episcopal Church	O.	1949	30	10	36	76
Ghana	Methodist	16. The Twelve Apostolic Church	P.H.	1953	24	46	-	70
Ghana	Apostolic	17. La Christ African Tabernacle	Aim to be P.H.	1948	12	4	5	21
Totals					1563	2304	492	4359

Table 7.7. Independent Churches in Accra, 1955: Year of Establishment and Membership. Source: Acquah, 148.

¹³⁹ Interview, Theresa Tanor. June 29, 2010; Interview with Anglican Minister Quayson,

theology established by European missionaries in the 19th century.¹⁴⁰ But the promise of healing at the new churches, in particular for the perennial concern of infertility and for new anxieties of witchcraft, must have appealed to all classes of Accra society. According to Acquah, every single one of the new churches in postwar Accra were founded by former members of the mainline congregations who developed an interest in prayer healing.¹⁴¹

The two most successful congregations in postwar Accra were the Nazarite Healing Home (founded by a pastor from the Gold Coast but based on the faith-healing principles of Zionist churches in South Africa) and the Musama Disco Christi Church (established by a Fante prophet from the Central Region),¹⁴² both of which focused on faith-healing. During public services, the pastors did not define the types of illnesses that would be treated. Rather, the patient/congregant was asked to declare what was making them sick, to which the pastor and the congregation would respond with boisterous healing rituals that included exuberant singing, dancing, drumming and tambourine shaking, making use of European hymns along with African rhythms. The pastors also anointed sufferers with oil, laying hands upon the congregants and using group prayer to call on the power of the Holy Trinity.¹⁴³ Many services were held in Ga, but there were also services in English and Twi, as well as multilingual services with assistants translating the sermon into different languages

August 1, 2003; Interview, Pastor Abednego Agoe Bortey, August 6, 2003.

¹⁴⁰ Acquah, *Accra Survey*, 146-47. Acquah lists the links between the Anglican, Methodist, Presbyterian and Roman Catholic churches and their social organizations that “bring people together during the week.”

¹⁴¹ *Accra Survey*, 149.

¹⁴² The Musama Disco Chisti Church was founded by Joseph William Egyanka Appiah, a Fante from Abura Edumfa in the Central Region of the Gold Coast Colony. Baeta, *Prophetism in Ghana*, 26-62. Acquah does not state who founded the Nazarite Healing Home, but it was a very strong witchfinding and sorcery fighting movement in South Africa. Bengt Sundkler, *Bantu Prophets in South Africa*, 2nd ed. (London: Oxford University Press, 1961), 254.

¹⁴³ Acquah, *Accra Survey*, 149; Baeta, *Prophetism in Ghana*, 50-54.

simultaneously, as is common in Ghana today. The 1950s was a time of improvised revival when the core elements of the Bible that had been translated by Basel Missionaries in the late 19th century (such as the Ga terms of *Nyonyimo* (God), the cleansing virtues the blood of *Yesu Kristo* (Jesus Christ), and in particular the breath of the *mumo kroykroy* (the Holy Spirit)) were redeployed for the purpose of healing.

Some churches emphasized the healing power of the Holy Trinity to the extent that they rejected any sort of healing not based on faith. For example, members of the Musama Disco Christi Church were initially forbidden to accept health care from any source, either local or colonial, unless they were required to produce a note from a doctor for an official government purpose.¹⁴⁴ Even local herbal malarial medicines were prohibited. In the place of African and European healing, congregants prayed for the health of sick church members, even to the point of going to their bedrooms to help them pray to overcome a major illness.¹⁴⁵ It was not until the late 1950s that this rule was relaxed, as educated members of the congregation demanded choices of local or colonial medical care.¹⁴⁶ The Nazarite Healing Home did not restrict its members to one type of healing, but it utilized the same methods of group prayer and performance as the Musama Disco Church.

The new churches expanded rapidly during the 1940s and 1950s, despite the fact that none of the new congregations had established priesthoods or permanent buildings. As movements rather than institutions, they made their presence known by renting halls for prayer sessions, marching through streets with brass bands, gathering on beaches for mass baptisms, or meeting in groves of trees for silent devotionals.¹⁴⁷ In particular, they offered

¹⁴⁴ Baeta, *Prophetism in Ghana*, 54.

¹⁴⁵ Interview, Theresa Tanor. June 29, 2010.

¹⁴⁶ Interview, Theresa Tanor. June 29, 2010.

¹⁴⁷ Acquah, *Accra Survey*, 150.

hope for patients who felt their well-being was compromised by the sickness-causing malicious forces that had troubled the residents of Accra for decades, including infertility and witchcraft. Acquah included the text from a poster for James Town based Redeemed Church of Christ, advertising a revival service led by the Nigerian “Rev. the most Prophet Apostle Dr. ADE OLA AJASA”:

PREACHING AND REVIVAL SERVICE Do you want life and salvation free of charge? If so, come quickly. You who are barren and sick and whom the physician has failed to heal and you who have difficulties in life. BRING ALL YOUR TROUBLES. With faith, You will be helped and healed by prayers. It is free. If you are worried by witches, come with one mind. If you are thirsty for the word of God, come and drink from the fountain without charge.

A service of this variety would have been improvised in an open air public space -- any spot that the pastor could reserve or rent in the city -- and it would be judged not according to the authority vested in him by church officials, but by the exuberance of his preaching and the perceived healing outcomes of his performance. If people were impressed, they would have shown their gratitude when the pastor called for a collection, and would have spread the word about the abilities of the preacher.¹⁴⁸

As J.D.Y Peel noted about the rise of Aladura Churches in Nigeria, two motivations drove the growth of locally-generated forms of worship in West Africa.¹⁴⁹ The first was a desire to purge churches of the trappings of European culture that limited the freedom to express one’s spirituality. Some examples of this were the dress codes and musical repertoires that excluded the use of African cloth or African rhythms during services. In this

¹⁴⁸ Mullins, *Therapy, Ideology, and Social Change*, 45; John Peel accredited the revivalist movement of Christianity in the 20th century in Nigeria to multiple factors, such as the ability of the churches to facilitate commerce, to maintain peace between villages and regions, and to offer sanctuary to former slaves and childless women. But he also stressed the importance of healing in winning the confidence of Christian converts. Peel, *Making of the Yoruba*, 127, 129, 149-50, 221, 228.

sense, the new churches were part of a burgeoning African nationalism that sought to localize Christian worship on African cultural terms. They were also a break from the past because they reconfigured liturgy to emphasize the role of the Holy Spirit as a tool of blessing, revelation and especially healing. These churches promised salvation for the bodily self, the social self and the spiritual soul -- a holistic approach that merged religion and healing in a way that Ga healers had been doing for centuries and in a way that Ga patients demanded.

The healing practices within the Muslim community were also diversifying during the postwar period. By 1954, the number of inhabitants in the city who were counted by British officials as Muslims had risen to an estimated 45,000, one quarter of the total population of Accra. These numbers included a rising number of Ga converts (amounting to 2,000 by 1951) who converted to Islam due to dissatisfaction with indigenous notions of spirituality and concerns that Christianity was a colonial imposition.¹⁵⁰ However, the rapid growth of Islam in Accra was largely due to the increase in the number of West African soldiers in the city (many of whom were Muslims), migrants from parts of West Africa where Islam was prominent, and (to a lesser extent) migrants from Lebanon and Syria. The African Muslims of Accra were still lumped together colloquially in British records as “Hausas,”¹⁵¹ but it was evident that the Muslim community in Accra was becoming increasingly diverse.

With increasing ethnic diversity came an increasing number of healing practices. In a chart of African healers, the *Accra Survey* counts one Akan, two Ga, three Northern Gold Coast, five Hausa and three Yoruba healers who had undergone “years of schooling in

¹⁴⁹ Peel, *Religious Encounter and the Making of the Yoruba*, 264; J.D.Y. Peel, "Syncretism and Religious Change," *Comparative Studies in Society and History* 10, 2, 1968, 128-29.

¹⁵⁰ J.N.D. Anderson, *Islamic Law in Africa* (London, 1970), 282; Mumuni, “Islamic Non-Governmental Organizations,” 142.

Muslim schools.” This tally of “Muslim healers” excludes many of the clerics living in the city would have dabbled in medicines, as well as the many Muslims who might have had lay-knowledge of healing and who might have been practicing herbalism or some sort of specialized tradition of divination in the city. With a population of over 40,000, it is more likely that the number of Muslim clerics and healers totaled in the hundreds. Nonetheless, there was remarkable diversity even within the learned 14 healers accounted for, which Acquah divided into three levels of specialization: the *Mallam*, the *Alhaji*, and the *Alufa*.

The first category, the *Mallam*, is very broad considering it refers to any sort of Muslim cleric, and Acquah is not specific about what sort of specialization the *Mallam* had except that they would have focused largely on studying and teaching the Quran, but might dabble in healing on the side.¹⁵² This might include prayer or the production of consecrated medicines but it was peripheral to the work they would do at the *madrassa* and the mosque. Though it is not recorded, it is here that *Al-Tibb al-nabawi*, or the medicine of the prophet, might have been in use. As Muslim clerics, *Mallams* were presumably better versed in the Islamic *hadith* related to healing than less-educated Muslim practitioners.

The second group of healers living in Accra were those with the honorific title of *Alhaji*, or someone who had made the pilgrimage to Mecca. These men may not have been identifiable as clerics, but they had the financial means to travel to Mecca and some of them returned claiming to have gained proficiency in therapies related the *Unani Tibb*, such as herbal remedies (made from local and imported herbs), circumcision (for boys), inoculant scarification (with different varieties of *ti*), and animal horn cupping (according to centuries

¹⁵¹ Acquah sometimes lumps together the Muslim population as Hausa, but at other times divides the Muslim population by ethnicity, Acquah, *Accra Survey*, 35, 117, 128, 144.

¹⁵² Acquah, *Accra Survey*, 128.

old healing traditions based on balancing fluids in the body).¹⁵³ Holding the title of *Alhaji* might have signified that one had learned healing techniques as knowledge gained during pilgrimage, but it is not likely that any of these practices were new to the residents of mid-20th century Accra, due to the mixing and matching of Islamic and local therapies that would have taken place amongst Hausa and Tabon communities in the past.

The most powerful healers within the Islamic community in Accra, according to the *Accra Survey*, were the *Alufa*, who were described by Acquah as a “powerful Muslim Medicine” men who specialized in preventative medicines such as the production of apotropaics and rituals of divination.¹⁵⁴ As mentioned in chapter 3, *Alufa* was Yoruba term for healer, and in Accra it seems to have been applied specifically to people with specialized learning and experience in the Islamic healing arts. As a qualitative supplement to the *Accra Survey*, Acquah interviewed an *Alufa* who had conducted the pilgrimage, and had become a well-known healer with many wealthy Syrian and Lebanese clients.¹⁵⁵ Acquah’s *Alufa* was born in the Northern Territories of the Gold Coast, where he had apprenticed as a herbalist while at the same time attending a *madrasa*. While living in Accra, he had adapted his therapies to include local concoctions that resembled those of Ga healers and was able to make a version of *ti* comprised of sulfur and crocodile scales, but was also proficient in the production of amulets and other Islamic therapies.¹⁵⁶ The appropriation of local herbs by Muslim therapists was not incongruent with the plural make up of Accra in the post-war period, and represented an openness by non-Western healers to the exchange of healing tools.

¹⁵³ Acquah, *Accra Survey*, 128.

¹⁵⁴ Acquah, *Accra Survey*, 128.

¹⁵⁵ Acquah, *Accra Survey*, 128.

¹⁵⁶ Acquah, *Accra Survey*, 128.

The “powerful medicine man” described by Acquah, once again, stands as an archetype for a statistical category. In reality, the category of “Muslim healer” was a rather fuzzy one. The *Alufa* described did producing medicines that were identifiable as part of Islamic healing tradition, such as the production of slate wash or amulets containing passages, but he also practiced herbalism within a West African idiom, and the material culture of his apotropaic medicines followed local motifs. In fact, there is nothing that strictly separates the work of the *Mallam* from the *Alhaji* from the *Alufa*, and it may have been that Acquah’s informants were noting distinctions of social rank and level of education within the Muslim healing classes rather than distinct subgroupings of healing practice. But what these titles do tell us is that particular ethnicities, such as Hausa, Yoruba, Ga, seem to have little bearing on healing authority amongst Muslims, as healers mixed and matched Islamic practices as well as indigenous herbal and consecrated medicinal traditions. They also reveal an Islamic culture in the city that was not concerned with legal distinctions between categories like *Al-Tibb al-nabawi* (Medicine of the Prophet – as passed down through Hadith), *Sunnah* (normative Islamic tradition) or *bid’ah* (practices regarded as innovations, breaking with tradition).

We do not have much data about whether the Muslim healers in Accra had non-Muslim clients but considering the conversion activity in the city, dissatisfaction with Ga or Christian faiths, and a commitment to pluralistic healing amongst the residents of Accra, it is likely that people from all walks of life in Accra (what Acquah referred to as the general “public”) patronized Muslim healers.¹⁵⁷ In one specific case in 1948, a driver named Mr. Nell, who was not Muslim but who paid Mallam Alhadji Tidjani £12 for a talisman to

¹⁵⁷ Acquah, *Accra Survey*, 128.

prevent road accidents.¹⁵⁸ Additionally, interview evidence from the work of anthropologist Bruce Gindal in the 1970s demonstrated that Sisala migrants from Northern Ghana sought help from mallam irrespective of their devotion to Islam.¹⁵⁹ And interview evidence from Accra today suggests that the patronage of Islamic healers is even more widespread, as the majority of patients who seek help from Muslim healers come from non-Muslim traditions.¹⁶⁰ This is not rich data to work with, but it is enough to suggest that Muslim practitioners had a tradition of serving people outside the limits of the Islamic community.

Islam can be used as a category with which to capture the diversity of healing practices in Accra but it is not sufficient to capture all of the practices and beliefs of the people who migrated to Accra from Muslim regions of West Africa. In the 1950s, a unique type of healing culture developed amongst a group of Zarma-speaking migrants from western Niger known in Accra as the Zabarima. At the time, the Zabarima were the fastest growing segment of the Muslim population in Accra, numbering over 4,000 by 1954.¹⁶¹ Working the most menial of jobs, such as carrying loads around the market, recycling used flour bags, or scavenging for used tins and bottles, the Zabarima were a marginalized immigrant group in Accra, and their religious and healing practices reflected their social station.¹⁶² The Zabarima migrants fell under the broad category of Muslims, but many were also worshippers of a pantheon of deities known as the *Hauka* (a Hausa word meaning

¹⁵⁸ In the case, Mr. Nell claimed that Mr. Tidjani did not make the talisman, so Mr. Nell asked for his money back. RG 16/3/10, "N.A.P. Nell versus Mallam Alhadji Tidjani," 113-16.

¹⁵⁹ Bruce T. Grindal, "Islamic Affiliations and Urban Adaptation: the Sisala Migrant in Accra, Ghana," *Africa*, 43, no. 4 (1973): 339.

¹⁶⁰ Interview, Mustapha Dowuona, July 2, 2003; Interview, Muhammad Musah Laryea, June 15, 2006; Interview, Alhaji Thunder, July 4, 2007.

¹⁶¹ Acquah, *Accra Survey*, 68.

¹⁶² Acquah, *Accra Survey*, 69.

“crazy”).¹⁶³ Jean Rouch, a French filmmaker who followed the activities of migrants around West Africa, claimed that at the peak of the *Hauka* movement in the Gold Coast there were approximately 100 named *Hauka* gods in West Africa, and that approximately 30 percent of Zabarima migrants to the Gold Coast were possessed. Unlike Ga priests and spirit mediums, who often worshipped and practiced in public, the followers of the *Hauka* cult operated in secret, and would have been unrecorded if not captured on film by Rouch, who was invited to one of their gatherings in a village suburb of Accra.

Jean Rouch’s footage of a Hauka spirit possession ceremony is striking. It includes several men and one woman gathered together around a *Hauka* shrine in a courtyard decorated with fluttering Union Jacks. Rouch narrates that those gathered are suffering from illnesses caused by sorcery and witchcraft, and that they have come to seek the help of the Hauka deities.¹⁶⁴ On the cue of a note from a violin, each of the participants become slowly filled with spirits representing colonial officials (including a governor general, an engineer, soldiers of different ranks, and a doctor's wife). They perambulate chaotically before the camera, making grotesque faces, foaming at the mouth, and engaging in violent arguments. The film climaxes with a frenzied meal of partially-cooked dog meat soup.¹⁶⁵ Afterwards, the spirits slowly leave the bodies of the possessed, and the migrant workers load themselves onto a lorry bound for their regular lives in Accra.

¹⁶³ Jean Rouch, *Cine-Ethnography*, Stephen Feld ed. and trans. (Minneapolis: University of Minneapolis, 2003). 189-90; According to the *Accra Survey*, there were 2,282 Zabarima immigrants (2133 men and 149 women) living in Accra in the year that Rouch filmed *Les Maitres Fous*. Acquah, *Accra Survey*, 176.

¹⁶⁴ Paul Stoller has argued that the Hauka gods and goddesses of Niger played a significant role as protectors against witchcraft. Paul Stoller, *Cinematic Griot: The Ethnography of Jean Rouch* (Chicago: University of Chicago Press, 1992), 157.

¹⁶⁵ The consumption of dog meat as a ritual feast was also associated with Tigare at the time. Nii Addokwei Moffatt, “Dog Meat, A New Craze In Accra,” from an article written for the *Daily Graphic*, republished on GhanaWeb.com, July 8, 2004, accessed August 18, 2009, <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=61222>.

When Rouch screened the film in Paris in 1954 under the title *Les Maitres Fous* (The Mad Masters) it created a scandal. Some critics thought the film was a fake, made with paid actors; others considered it racist because it portrayed its subjects as ethnographic specimens.¹⁶⁶ Anthropologist Marcel Griaule called the film a “travesty” because he felt it stereotyped Africans as savages and he urged Rouch to destroy it.¹⁶⁷ More recently, *Les Maitres Fous* has been celebrated as depicting a form of anticolonial mimicry that expresses the colonial mentalities of African subjects.¹⁶⁸ As Rouch had always argued in defense of the film, he had documented the *Hauka* cult because it made a bold statement about the psychological effects of colonialism, and because it represented a kind of social healing that allowed immigrants to cope with their subordinate status under white colonial rule.¹⁶⁹ The “mad masters,” as Rouch had always maintained, were not Africans but the colonial ruling classes, who, within the *Hauka* cult of spirit possession, had become spirits that represented the authoritarian structure of colonialism. The most powerful god was Gomno, the “governor,” a deity represented by a colourful mound with a pith helmet -- an image that Rouch paralleled by interposing a scene of the Gold Coast Governor Arden-Clarke at an official ceremony in Accra wearing full regalia. Other prominent characters represented the network of colonial officials in the colony, including the engineer (who marches relentlessly back and forth like a train), the doctor’s wife (who mediated disputes and attempted to heal the relationships between the other gods), and the sergeant-at-arms (who screamed and yelled at all of the participants). These spirits were the antithesis of the benevolent colonialism that Guggisberg and other governors of the Gold Coast Colony hoped to

¹⁶⁶ Kien Ket Lim, “Of Mimicry and White Man: A Psychoanalysis of Jean Rouch’s *Les Maitres Fous*,” *Cultural Critique* 51 (Spring, 2002), 40-41.

¹⁶⁷ Lim, “Of Mimicry and White Man,” 40.

¹⁶⁸ Paul Stoller, *Cinematic Griot*, 159-60.

propagate -- rather, they were a menacing crowd of military and technocratic elites who fumble about, fighting, arguing and screaming.

Rouch claimed that when the *Hauka* priests saw the film, they were so impressed that they intended to expand their performances of worship, integrating film into their ceremonies as a record and celebration of the power of their “mad masters.”¹⁷⁰ However, Rouch’s influence was cut short when *Les Maitres Fous* was banned in the Gold Coast Colony because it contained “cruelty to an animal and insult to the Queen.”¹⁷¹ After the ban of the film, the worshippers of the *Hauka* continued to practice in the city, garnering followers from people of Songhay, Zerma, Peul, Bella, Hausa, and Kanuri ethnic origins, but the malevolent colonial gods disappeared from their processions after independence in 1957.¹⁷² The use of the icons and archetypes of colonial power that were so important as a means of expressing the power of the *Hauka* spirits during the colonial era, vanished after independence, including the doctor’s wife, who was no longer an arbiter of disputes in the spirit world.¹⁷³

The *Hauka* cult is not properly an Islamic form of religion or healing. The cult did include Islamic spirits, in the form of characters like Fatima (the Lady from the Red Sea), Dogo Malia (the Very Tall Gentleman from the Red Sea), and Istanboula (the Great Muslim

¹⁶⁹ Michael M. J. Fischer, “Raising Questions about Rouch,” *American Anthropologist* 99, no. 1 (March, 1997), 140-3.

¹⁷⁰ Jean Rouch, “Jean Rouch Talks about His Films to John Marshall and John W. Adams (September 14th and 15th, 1977), Interview,” *American Anthropologist* 80 (1978), 1009.

¹⁷¹ Rouch, “Jean Rouch Talks about His Films,” 1009.

¹⁷² Mathias Krings, “On History & Language of the ‘European’ Bori Spirits, Kano, Nigeria,” in *Spirit Possession, Modernity & Power in Africa*, ed. Heike Behrend and Ute Luig (Madison: University of Wisconsin Press, 1999), 61 & fn. 15; Jean Rouch and Steven Feld, “Jean Rouch with Enrico Fulchignoni: Cine-Anthropology,” in *Ciné-ethnography*, vol. 13 of *Visible Evidence*, ed. Steven Feld (Minneapolis: University of Minnesota Press, 2003), 163.

¹⁷³ In an interview with John Marshall and John W. Adams, Jean Rouch pointed out that there was never a “Kwame Nkrumah” Hauka because the cult was largely a product of the

from Istanbul) as well as lesser figures with Muslim names,¹⁷⁴ but these gods did not drive the action in ritual that Rouch filmed. More prominent were the colonial gods, who offer the viewer access to the imaginations of the most marginalized of colonial subjects in Accra, as they reveal the violence inherent the armed force, political coercion, and medical authority of colonial rule. Whether or not the participants in the Hauka cult healed themselves by appropriating the roles of their oppressors is not clear, but after decades of conscription into *corvee* labour, military service, and medical experiments, it is not surprising that a cult like the Hauka could sustain itself as an expression of the exigencies of the most marginalized people in Accra. The character of the doctor's wife, for example, though playing a mediating role in the drama, is complicit in the project of colonialism, adding strength to the argument that many colonial subjects regarded medical workers as brokers of colonial power. More poignantly, one can see the localization of *Hauka* rituals in Accra as an attempt to heal a new ailment -- the injustices of British colonialism, which were experienced most viscerally by migrants to Accra.

The forms of healing connected to Christianity and Islam in Accra changed rapidly in the postcolonial period, reflecting the ethnic diversity and the religious needs of the residents of postwar Accra. While the pastors of the new churches may have intended to minister to Christians who had abandoned the mainline denominations, and while Muslim healers may have sought out wealthy Muslim clients, healers from both traditions soon began to take on patients from all walks of life in the city. As the data in the Accra Survey shows, the population of the city was actively moving between therapies, and religion did not seem to be a barrier to this trend. Despite the growth of the medical infrastructure,

colonial period (Jean Rouch, *Cine-Ethnography*, Stephen Feld ed. and trans. (Minneapolis: University of Minneapolis, 2003). 193.

Christian and Muslim healing cultures flourished, driven forward by the agency of the religiously devout and by the needs of patients, who maintained their own communities, and expressed their own forms of agency, despite the power of the colonial state.

Section 6. Patent Medicines and the African Consumer in the 1940s and 1950s.

The *Accra Survey* contains no information about the sale of herbal remedies, patent medicines or pharmaceuticals, an oversight considering the wealth of information provided about other therapeutic traditions in the city. But despite its omission from Acquah's report, there is other evidence to show that, during the 1940s and 1950s, the markets of Accra continued to be clearinghouses for medicinal products. Operating beyond the purview of government regulation, the market for herbs continued unabated at Makola and other locations, though there was not yet any production of bottled herbal medicines produced exclusively in the Gold Coast. The demand for patent medicines, however, continued to grow in prominence as they filled the shelves of department stores like Swanzy's and Kingsway, and were available at Makola market also. Pharmaceuticals were also in demand. Though normally distributed through Medical Department dispensaries, they were also misappropriated from Korle Bu and other locations, sold by nurses and dispensers, and redistributed through the marketplace.¹⁷⁵ The demand for mobile medicines that could be taken privately, on terms dictated by each individual patient, continued to be a major element of the healing culture in Accra.

Patent medicines, in particular, had become an integral part of the practice of self-medication in Accra. In the newspapers of the Gold Coast Colony, patent medicine ads

¹⁷⁴ Paul Henley, "Spirit Possession, Power, and the Absent Presence of Islam: Re-Viewing *Les Maîtres Fous*," *Journal of the Royal Anthropological Institute* 12, no. 4 (2006), 748.

¹⁷⁵ Acquah, *Accra Survey*, 128.

made up as much as one third of their advertising content.¹⁷⁶ The *Gold Coast Independent* of January 18th, 1945, for instance, contained advertisements for Vogelers Curative Compound, Mendaco Mouthwash, Kolynos Dental Crème, Milk of Magnesia, Clark’s Blood Mixture, Zam Buk Herbal Ointment, all on one broadsheet page.¹⁷⁷ Advertisements for the tried and true proprietary medicines of Atwood Bitters, Woodward’s Gripe Water, and Sloan’s Liniment were still on the shelves, were less frequent by the 1950s, but they had already established themselves in the marketplace. While patent medicines had largely disappeared from the shelves of stores in the UK and the USA by the 1940s, they continued to sell well in Africa, and patent medicine wholesalers pitched their medicines directly to the individual consumer as aids to personal health. Most of the advertisements continued to be produced in the UK or USA and then replicated in Gold Coast newspapers, but starting in the 1940s, images of Africans began to appear in ads for some of the most popular brands, reflecting the importance of the West African market and the long tradition of self-medication in Accra.¹⁷⁸

The United Africa Company’s Kingsway Department Store, for instance, began to target Africans as its primary market for a wide variety of patent medicines, antibiotics, and antimalarials. To promote its large stock of imported medical goods, Kingsway hired an advertising agency to produce ads containing images of Africans consuming imported medicines as a means of staying healthy and increasing personal productivity. In 1943, a Kingsway ad appeared in the *Gold Coast Independent*, promoting “medicines and tonics” such as Dr. Lynn’s products, as well as some Kingsway branded products, including aspirin, cough mixtures and eucalyptus oil. The ad contained two images of black colonial workers,

¹⁷⁶ *Gold Coast Independent*, 1943-46.

¹⁷⁷ *Gold Coast Independent*, January 18, 1945, 9.

¹⁷⁸ *Gold Coast Independent*, March 1, 1941, 65.

SUCCESS
in your job

depends on
GOOD HEALTH

Natural ability, industry and perseverance are not enough if you are to make progress in your work. You must impress employers by the vigour of your work, only fully displayed when you are in perfect health. Then promotion comes fast, increments are substantial. Medicines and tonics are sometimes necessary to tone up your system and you obtain the best at Kingsway Chemists.

Kingsway medicines, which have a deservedly high reputation for purity and efficacy, include: Kingsway Aspirin Tablets, Kingsway No. 200 Cough Mixture, Aspirinova Balm and Liniment, Lyndwood's Chlorodyne, Kingsway Eucalyptus Oil and Dr. Lynn's Purgers, Tongue Syrup, Bock, Kidney and Bladder Pills.

Take your prescriptions to be made up at

KINGSWAY
CHEMISTS LTD
Branches throughout NIGERIA & the GOLD COAST

W.A.F. 40-21

Figure 7.5. Advertisement for Kingsway Chemists, 1943. This advertisement by Kingsway Chemists links the healthy lifestyle provided by the consumption of pharmaceuticals to the health of the cocoa economy. A causal relationship is created between the consumption of pills and medicines (listed at the bottom of the ad) and physical and mental vigour at work, symbolized by the labourer taking a core sample of a cocoa bale and a clerk in an iconic pith helmet grading the beans. *Source: Gold Coast Observer, January 15, 1943, 479.*

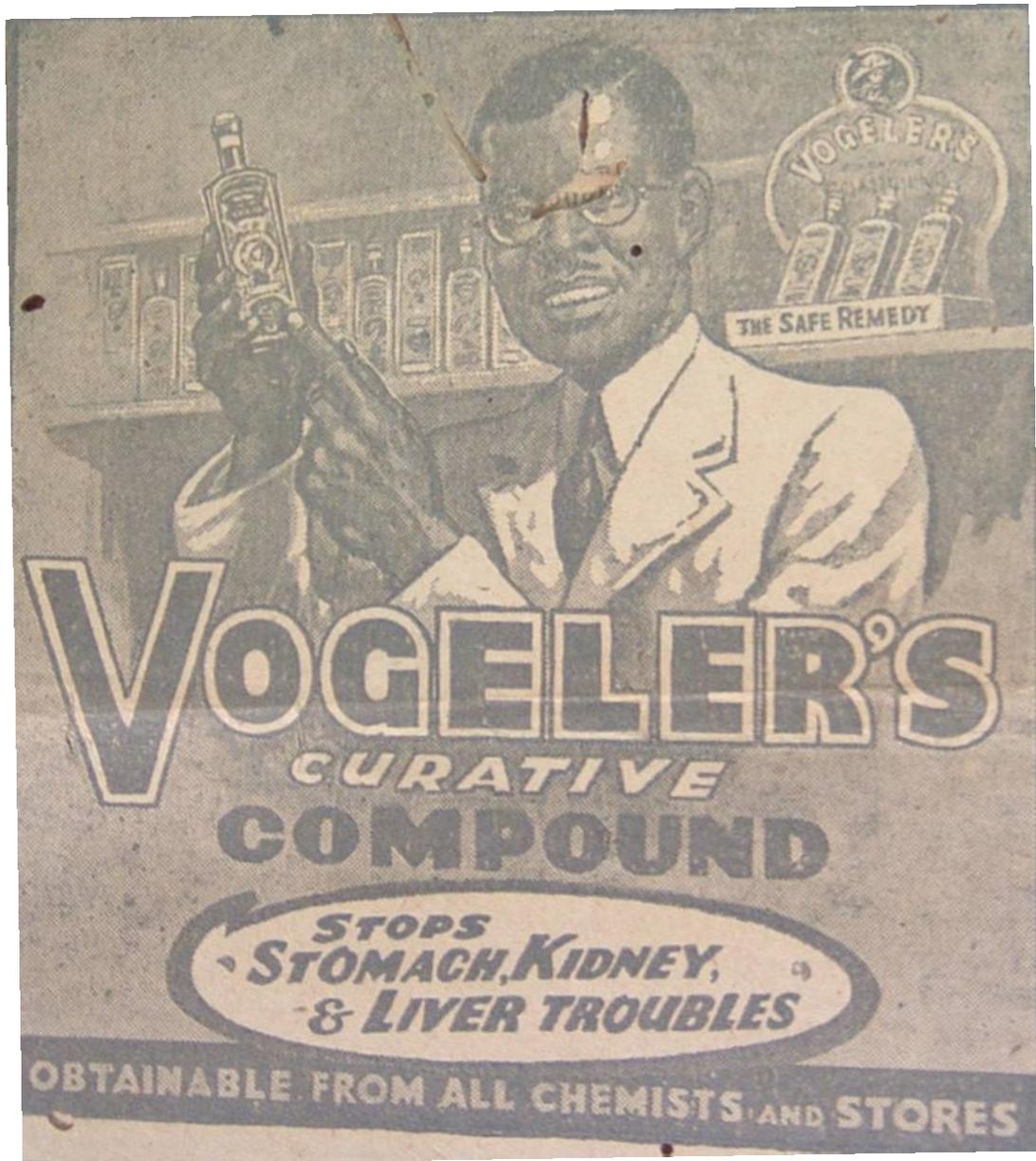


Figure 7.6. Advertisement for Vogeler's Curative Compound, 1945. This advertisement for Vogeler's Curative Compound, a diuretic popular on the Gold Coast for several decades, features an African dispenser. Other advertisements featured white nurses instructing African women and children to take Vogeler's¹⁷⁹ but this image was the first to feature an African standing alone in a position of authority. Wearing a white coat, a tie, and spectacles, this artistic rendering is evidence that the face of the bio-technician in Accra had become a black one. *Source: Gold Coast Independent*, March 31, 1945, 78.

¹⁷⁹ *Gold Coast Observer*, November 19th, 1942, 295.

a porter in the background taking core samples of a bale of cocoa and a clerk in a pith helmet counting and weighing a sample of beans (see Figure 7.5). For the first time in the history of the Gold Coast, African workers were depicted as significant actors in the cocoa economy, the largest source of revenue for the colony, but their success, according to the advertisement, depended on maintaining “vigour” in the workplace, something that imported medicines promised to provide.

The Kingsway advertisement was one of a new generation of images containing African characters that emerged during the Second World War that linked individual achievement and bodily health to the consumption of imported medicines. Vogeler’s Curative Compound, a diuretic that had been invented by Englishman Charles Vogeler in Baltimore, Maryland in the 1880s, was sold in the UK using images of robust, scantily clad women, who extolled the virtues of the medicine as a blood purifier in the accompanying text.¹⁸⁰ Vogeler’s Curative Compound disappeared from British and American markets when the company folded in 1913, but the patents were sold to the American Home Products Corporation (now known as Wyeth Pharmaceuticals) and the Curative Compound continued to sell in West Africa well in the mid-20th Century.¹⁸¹ The marketing of Vogeler’s changed radically, when in 1945, an image of an African medical worker appeared in an advertisement (see Figure 7.6). Previous advertisements for Vogeler’s in Gold Coast newspapers had featured white nurses instructing African women and children to take the medicine, but this image was the first to feature an African alone. Wearing a white coat, tie, and spectacles, the

¹⁸⁰ United States. Patent Office. *Annual Report of the Commissioner of Patents*, 1885, 360; Meyer *Brother’s Druggist* 26, no. 10 (1905), 113. Ad for Vogeler’s Curative Compound, *Black and White* 14, no. 336 (July 10, 1897), 53.

¹⁸¹T.A.B. Corley, “Interactions between the British and American Patent Medicine Industries 1708-1914,” *Business and Economic History* 16, no. 2 (1987), 123.

artistic rendering of a black bio-technician attached the consumption of Vogeler's with the behaviours and dispositions of the medical classes of the city.

Sarsaparilla, an American medicinal root was sold in the city in the 18th century, disappeared from the historical and botanical record after that point but reemerged in the 1940s, this time as a purgative called Dr. Lynn's Iodised Sarsaparilla. Dr. Lynn's was just one of many advertisements for purgatives in the newspapers in Accra, but it stands out because of the imagery used in its 1948 advertisement in the *Gold Coast Observer*: a black man transformed from a slouched position of poor health into a vigorous, striding colonial worker (see Figure 7.7).¹⁸² Drawing on iconic images of the ape to man progress of evolution, this advertisement portrayed the colonial subject as a rapidly evolving consumer of imported medical goods with a final image of a man in khaki trousers and a white shirt, rolling up his sleeves to work.¹⁸³ In a marked change from its former role as a herbal simple used by Ga healers to cure the "clap,"¹⁸⁴ sarsaparilla was now sold medicine that could invigorate the colonial workforce.

Advertisements for Paludrine, a branded antimalarial tablet sold throughout West Africa in the 50s, also contained localised images.¹⁸⁵ As a new pill on the market, Paludrine (made from *proguanil*, an antimalarial antifolate discovered in 1947 at Imperial Chemical Industries) set a new trend as an antimalarial chemical sold beyond the purview of the Gold Coast

¹⁸² *Gold Coast Observer*, April 30, 1948, 631.

¹⁸³ The advertisement for Dr. Lynn's Sarsaparilla preceded the iconic image of the "March of Progress" by Rudolph Zallinger from the cover of anthropologist F. Clark Howell's Time-Life book *Early Man* (1965; Revised 1968), which popularized the Frontispiece of Thomas Huxley's *Evidence as to Man's Place in Nature* (Williams and Norgate, 1863) that compared the skeletons of various apes to that of man.

¹⁸⁴ De Marees, *Gold Kingdom of Guinea*, 173-74.

STEP FORWARD TO VIGOROUS HEALTH

To relieve constipation — that insidious cause of many illnesses — Iodised Sarsaparilla is a proved and palatable specific. Mild in action, its blood-purifying ingredients eliminate skin disorders, and tone up the whole system to renewed vigour.

Keep fit by taking

DR. LYNN'S Iodised SARSAPARILLA

Obtainable from all branches of
THE UNITED AFRICA CO. LTD. and KINGSWAY CHEMISTS LTD.

O.L.B.

Figure 7.7. Advertisement for Dr. Lynn's Iodised Sarsaparilla. Drawing on iconic images of the progress of evolution from ape to man, this advertisement shows the progress of the colonial worker from a state of lassitude to “vigorous health.” Sarsaparilla had been available as a herbal simple on the Gold Coast since the 18th century, but was never grown locally. After the Second World War, it was marketed as a blood cleanser, iodized to make it more palatable and easier to digest. *Source: Gold Coast Observer, April 30, 1948, 631.*

¹⁸⁵ Acquah, *Accra Survey*, 136.

THE FISHERMAN WHO CAUGHT MALARIA

Belo had arranged to go fishing with Kofi

I'm sorry Kofi - but Belo is ill in bed with malaria

BUT WHEN KOFI CALLED FOR HIM...

Kofi was sorry for Belo because he had malaria

... and then

... and sorry for himself because the fishing trip was spoilt

he remembered!

The wonderful white tablets the schoolmaster sent him when he had malaria

He quickly went home and asked his mother for some 'PALUDRINE' tablets...

... which he gave to Belo's mother to give to Belo

and here they are next Saturday - off fishing!

MALARIA can strike suddenly and spoil your dearest plans! But those little white 'PALUDRINE' TABLETS are an excellent remedy. They are safe and effective, and have no unpleasant after-effects.

'Paludrine'
THE SAFE REMEDY FOR MALARIA

IN WRAPPED STRIPS OF 10 PENNY A TABLET

STOCKED BY KINGSWAY CHEMISTS LTD.,
WEST AFRICAN DRUG CO. LTD.,
AND THE UNITED AFRICA CO. LTD.

MANUFACTURED BY
IMPERIAL CHEMICAL (PHARMACEUTICALS) LTD.



Figure 7.8. Advertisement for antimalarial Paludrine. Paludrine, produced in the UK by Imperial Chemical, was the most common brand of synthesized quinine on the Gold Coast. The advertisement branded Paludrine as a lifestyle drug and marketed it towards mothers and children. *Source: Ghana Daily Express, September 5, 1953, 2.*

Medical Department.¹⁸⁶ Though chloroquine was still effective against malaria and was available at a low cost at colonial post offices, and though local herbal remedies were still widely available, Paludrine was able to carve out a market share in the city due to its low cost (a penny per pill), its unique form of packaging (the bubble pack strip), and most importantly, its novel form of advertising.¹⁸⁷ In Figure 7.8, a cartoon advertisement for Paludrine used local names for its characters, including two common names for boys in Accra (Kofi, an Akan day name for a boy born on Friday, and Belo, a Muslim name commonly used in West Africa). Paludrine ads targeted mothers and children as a way medicalizing child and infant care, and as a way of distinguishing the modern mother and child from those who might treat malaria with herbal remedies, an extension of the medical practices of mothercraft that had been established in the 1920s. It also showed a schoolmaster recommending the pills to Kofi, demonstrating a link between colonial education and the consumption of imported medicines.¹⁸⁸ This sort of pharmaceutical advertisement offered a vision of family life that linked health to the colonial education system and to the market for imported goods, and using gender and family archetypes that followed Western norms.¹⁸⁹ It also attempted to clearly distinguish its product from

¹⁸⁶ J.F. Ryley, "The Mode of Action of Proguanil and Related Antimalarial Drugs," *British Journal of Pharmacology* 8 (1953), 424. Proguanil was introduced before some malaria parasites became immune to chloroquine, which started in the 1970s in Africa, see J.F. Trape, "The Public Health Impact of Chloroquine Resistance in Africa," *American Journal of Tropical Medicine and Hygiene* 64, no. 1 (January, 2001), accessed October 5, 2014, <http://www.ncbi.nlm.nih.gov/books/NBK2616/>.

¹⁸⁷ *Accra Evening News*, May 6, 1952, 4.

¹⁸⁸ The connection between the consumption of pills and education is also expressed in Mark Freshfield's novel, *The Stormy Dawn*, when students at a preparatory school in a town north of Accra purchase packets of "brain and memory pills" by mail order from newspaper advertisements. Mark Freshfield, *Stormy Dawn* (London: Faber and Faber, 1946), 78.

¹⁸⁹ Such images were also replicated in Kingsway Chemist ads that linked health with education. See *Gold Coast Independent*, March 1, 1941, 69.

competitors, using a close up depiction of the “ICI” brand name on the pills and showing Kofi handling the strip of pills. Though herbal remedies were still widely available and consumed, the particular remedy of quinine had been transformed into an affordable pill form, allowing the residents of Accra to buy and sell the product beyond the control of colonial medical authorities. The presence of a strongly branded quinine-derivative medicine led the way for future branded derivatives (such as Larium (mefloquine), Malarone (atovaquone/proguanil), and Flavoquine (amodiaquine)), which also became available over the counter or in marketplaces in Accra.¹⁹⁰

In the postwar period, older varieties of patent medicines, such as Atwood’s Bitters, Sloan’s Liniment and Woodward’s Gripe Water, were no longer dominated advertising space in the newspapers of the Gold Coast, but they remained on store shelves and were sold in the markets. Rather than being displaced, these medicines were supplemented by new varieties, some produced by Kingsway for the West African market, and many other new medicines which targeted Africans with regional ad campaigns. Unfortunately, Acquah’s Accra Survey does not contain data about these medicines, nor are there any oral memories for medicines like Vogeler’s Curative Compound or Dr. Lynn’s Iodised Sarsaparilla (likely because their ads disappeared from the pages of newspapers in the 1960s, and seem to have disappeared from the marketplace by the 1970s). However, in the 1950s the ad campaigns for these prominent brands offered a new vision of self-medication for Gold Coast subjects, evidence of a continuation of a culture of self-medication in the city. Despite the rise of new African deities, colonial medicine, Christian faith-healing, and Islamic healing, market medicines continued to thrive, adapting rapidly to the needs and dispositions of African consumers.

¹⁹⁰ Richard C. Dart, *Medical Toxicology* (Lippincott Williams & Wilkins, 2004), 468.

Conclusion

Following along with a well-established metanarrative of the progress of colonial medicine in Africa, Stephen Addae argued that by the 1950s, “African’s confidence in modern medicine had been won.”¹⁹¹ As this chapter has shown, this statement deserves some important qualifications. Ione Acquah’s *Accra Survey* offers statistics to show that the colonial medical system, with its headquarters at Korle Bu Hospital, became the exclusive choice of some patients in their quests for therapy. Without question, colonial medicine was no longer on the margins of the healing culture in Accra because it served needs that could not be met efficaciously by other healing systems. And certainly, the status and power of African medical professionals was in ascent, as they gradually took over positions of power at colonial hospitals and built private clinics to serve wealthy clients. African-born physicians, nurses, midwives, and dispensers wore the mantle of colonial authority, and as such, became iconic figures as purveyors of medicalized health. Nonetheless, Governor Guggisberg’s promises of an effective, egalitarian and hegemonic medical system were never fulfilled. The Medical Department aimed to ameliorate the general health of the residents of Accra, but they were never provided with adequate budgets to achieve their medical or sanitation goals, and any aspirations to rebuild the city according to medical precepts were simply untenable during a period of political unrest and imminent decolonization. Where colonial medical services excelled was their ability to cure specific illnesses such as malaria, yaws, syphilis and gonorrhoea, but in the postwar era, Korle Bu hospital was underfunded, overcrowded, and now regarded as the “African Hospital” rather than a model colonial institution.

¹⁹¹ Addae, *Evolution of Modern Medicine*, 75.

Moreover, the “confidence” that patients may have shown in colonial medical professionals did not necessarily mean that they no longer trusted the various non-medical healers living in the city. Though no longer the majority, Ga healers continued to play a major role in serving the broader health needs of the patients of Accra. There were still more than eighty Ga herbalists in the city, and Ga priests and spirit mediums still tended to illnesses involving something more than sickness of the body. They also continued to participate in Homowo, dictating the religious calendar of the city and maintaining their role as a professional class of healers. Additionally, some of them began to adapt to the changing circumstances in Accra by fabricating hybrid therapies that incorporated pharmaceuticals, and by forming an association to advocate for official acceptance of Ga herbal and spiritual healing practices.

As the ethnic composition of Accra changed, so did the diversity of healing options. With the influx of thousands of immigrants came new deities, like Tigare, a hybrid cult that attracted supplicants from various ethnic and religious communities in the city. The residents of the city also increasingly sought physical and spiritual aid from the Holy Trinity, with the help of a new cadre of Christian pastors who attracted followers with the promise of Faith-healing. The richness and diversity of Islamic healing amongst the established Hausa community, within the converted Ga community, and amongst immigrants from predominantly Muslim parts of West Africa was also evident in the postwar era. Islamic healing practices, including medicines derived from the Quran, were widely available in Accra, but Muslim healers also offered herbal cures and consecrated medicines based on local and regional ethnic traditions. Additionally, some ethnic groups that would have been normally lumped together as “Hausas” or “Muslims, made innovations in their healing cultures in order to deal with their marginal status as immigrants in a colonial city. The

Zabarima, for instance, channeled deities representing deities from Niger, colonial officials, and Islamic characters. These new therapeutic options attracted clients interested in holistic services that could thwart bodily and spiritual illnesses.

The patent medicine market, which continued to offer the residents of Accra the option of bypassing healing professionals entirely through the process of self-medication, also flourished in the post-war era. In the 1950s, Accra was populated by an increasingly literate population, who, with ready cash, could choose to conspicuously consume over-the-counter medicines rather than visit Ga healers or colonial doctors. The patent medicine companies encouraged this change in the medical marketplace by co-opting images of Africans into the iconography of their advertising, hoping that Africans would identify with images of healthy workers, mothers, and students. Medicines like Paludrine ushered in an era of branded pharmaceuticals, releasing products that were once distributed exclusively by the colonial government into an open market where people could consume them according to their own regimes of self-medication, or in order to model themselves according to lifestyles presented in advertising.

What the *Accra Survey* confirms is that these multiple healing options, for which the data was so thin in previous eras, were deeply entrenched within the healing culture of the city. As Acquah's data, oral interviews and supporting documents prove, the pluralistic therapeutic network of the city continued to flourish, despite the growth of colonial medical options. We still do not have precise data to show if some ethnic or religious groups preferred their own types of healing; it is possible that they did. But there are many accounts that demonstrate that the tradition of seeking multiple therapeutic options was not broken in the 1950s. By Acquah's own admission, the movement between therapeutic options, in particular for those people who had not been drawn into colonial culture via education or

through occupation, continued. The physicians who practiced in the city in the 1950s reinforced this point by stating that they were quite aware that they were treating patients who had either come from, or going to, another type of healer. Women in the city also hedged their bets, visiting herbalists, priests, and doctors, in particular during pregnancy, while inclusive cults like Tigare brought people from all walks of life together in the desire to fight occult forces such as witchcraft. Christian pastors offered health to the masses, regardless of ethnic or religious background, and Muslim healers produced apotropaics for people from all classes and faiths in the city. Finally, the open market in medicines, which began to include goods previously distributed exclusively through colonial government channels, continued to offer the opportunity to medicate oneself in anonymity, far from the reach of a particular therapeutic tradition or dogma. In sum, the five major healing traditions continued to flourish, despite the changes of colonialism and looming independence, adapting according to the changing needs of the residents of the city.

Chapter 8. Conclusion.

In order to break away from the established medical historiography of Accra, which has silenced the story of non-Western healing methods and exaggerated the successes of colonial medicine, this dissertation has shown how it has been therapeutic pluralism, rather than the ascent of medicine, that has characterized the story of healing in Accra of the past 300 years. Five distinct traditions of healing emerged and perpetuated themselves in the city (including African-derived healing traditions, European-derived medicine, Christian faith-healing, Islamic healing, and market medicines), and each of these traditions have maintained a clear semblance with their past iterations in terms of their ideas, practices, material cultures and spatial conceptions. Though each tradition was forced to adapt to dramatic political, economic and social changes that occurred over three centuries, no hegemonic regime of healing emerged, nor were any therapeutic alternatives displaced.

By proving the durability of therapeutic pluralism in Accra, this dissertation bears out Steven Feierman's claim that Africans have a "long-standing" tendency to mix and match therapeutic options.¹ It also offers a way around the "European imposition and indigenous response" paradigm that, as Nancy Rose Hunt so poignantly stated, has impeded understandings of cultural mixing by reducing African history to a clash of cultures during the so-called "colonial encounter."² As stated in the introduction, choosing plurality over parsimony runs counter to the historian's instinct, but in this case it has served to reveal the significance of heretofore marginalized healing traditions, offering a window on the actions of myriad patients and practitioners. Just as Karen Flint chronicled the interactions of Zulu, Indian and European healing traditions in Southern Africa, this study has traced the

¹ Feierman, "African Therapeutic Systems," 277.

simultaneous developments of multiple traditions, watching their fortunes ebb and flow, demonstrating how patients tolerated and moved between traditions, showing how they knitted them together to create a pluralistic healing culture in one urban centre. Rather than narrowing the investigation by relying on the colonial archive and a medical metanarrative, this dissertation has been informed by the Ga aphorism of *bela tamo jarawolo* -- the belief that one must shop a sickness around in order to find an appropriate set of treatments.

The presence of therapeutic pluralism in Accra is largely silent in the three major textual accounts of medicine on the Gold Coast because the authors were so wedded to the notion that scientific medicine was destined to eliminate other methods of healing. The universal efficacy of European-derived healing was implicit in their work, as was the belief that African notions of health and healing would eventually dwindle away. This did not happen. Although colonial medicine did experience a dramatic surge in demand starting in the 1920s, the growth of the medical infrastructure occurred in parallel with the diversification of West African therapies, the emergence of Christian faith-healing congregations, the arrival of Muslim migrants with new healing ideas and practices, and an expansion in the culture of self-medication with herbal remedies, patent medicines and pharmaceuticals. Within this pluralistic context, colonial medicine can no longer be privileged as the most significant healing trend in the history of Accra. Moreover, we must clearly break from the teleological assumptions of medical progress in order to take into account the rich variety of therapeutic traditions that have flourished in Accra.

This chapter contains three sections. The first offers some conclusions about the nature of therapeutic pluralism in Accra, and some reasons why it was sustained over the course of three hundred years. The second is a summary of each therapeutic tradition, highlighting the

² Hunt, *Colonial Lexicon*, 323.

factors that allowed for the emergence and sustenance of diverse ideas and practices about healing within the social and cultural milieu of Accra. The third section is an epilogue that addresses the rapid changes that have occurred in the late 20th and early 21st centuries, as Accra had made the transition from colonial capital to African megalopolis. As a coda, this section will list some of the opportunities and challenges that the healing traditions are likely to face in the urban spaces of Accra in the 21st century

Section 1. The Tendencies and Contingencies of Therapeutic Pluralism in Accra.

Although this dissertation has traced the parallel development of five different traditions of healing in one urban space over a period of 300 years, it cannot claim to offer an essential cause for the sustenance of pluralistic healing. As a commercial and political capital over the long *durée*, the residents of Accra have not been beholden to one universal historical force or participated in one overweening narrative. In fact, there is no particular reason why the residents of Accra managed to sustain therapeutic pluralism. Rather, a series of historical events, propelled forward largely by the ingenuity of Africans living in Accra, but also by the activities of people from other parts of Africa and around the world, created the space for distinct therapeutic traditions to coexist in the city. As the historical context of being a patient or a healer in Accra changed, the attitudes, dispositions, and behaviours of patients and healers changed too. Thus, the goal of this project was not to construct yet another parsimonious narrative based on a clichéd model of patient behaviour, but rather, to splinter the former master plotline of medical progress into tangents that more closely reflect the diverse experiences of patients.

Nonetheless, some analytical frameworks have been deployed in this dissertation in order to reveal the social forces that have asserted control over therapeutic decision making

over the course of time in Accra. This section will summarize four ways in which we can explain the ongoing patient demand for multiple healing options, including: the social function of therapy management groups, the search for curative efficacy, the restricting forces of colonial medical power, and the aspirational forces of social distinction. Each of these analytical perspectives can be used to understand patient behavior in the past in the context of Accra, but we must also note that their explanatory power also contains the danger of reductionism. As such, they have been used contingently, as a means of investigating particular historical circumstances, rather than of establishing broad schema for patient behavior.

The first of these models is that of the therapy management group, drawn from the work of Steven Feierman and John Janzen. The archetypical therapy management group embarks on a so-called “quest for therapy,” from multiple sources, leading to “healer hopping,”³ between different healing traditions. The tendency of patients in Accra to form therapy management groups borne out by several pieces of evidence in this dissertation, including: in the second chapter, the quote by Jean Barbot that described patients on the Gold Coast dismissing healers who were unable to help them; the court records used in the third chapter, which describe patients moving between healers; the case of Olivia in the fourth chapter, who sought help from both an African healer and a European-trained physician; the accounts of Cicely Williams in the fourth chapter, a physician who attempted to make accommodations for women who patronized African healers as well as colonial doctors; and the seventh chapter, where interviews conducted by Ione Acquah’s survey

³ Waltraud Ernst. *Plural Medicine, Tradition and Modernity, 1800-2000* (New York: Routledge, 2002), 2. Waltraud Ernst points out that it is easier to understand where the authority to heal is derived from by following the actions of patients, or what he calls the “view from below.” As Janzen noted, patients often move between healers in an attempt to find cures for all of the aspects (bodily, social and spiritual) of an illness.

teams clearly demonstrated movement between healing traditions. By drawing these sources together we are able to assert that, over hundreds of years, the people of Accra have been mixing therapies in order to improve their chances of achieving bodily and spiritual health. Nonetheless, we cannot essentialise this behavior as typical to the residents of Accra because these patients were not automatons, seeking merely to achieve a stasis of health. Some patients found themselves beholden to African healing authorities, as in the case of Ga women, whose rites of fertility were overseen by the Naa Ede Oyeadu shrine before it was suppressed in 1905, or in the case of the men who participated in the Hauka cult. Other patients, particularly employees of the colonial government or British firms, were obliged to attend colonial hospitals because they were under a form of surveillance that required them to seek care within the colonial medical system. Christians and Muslims would have felt a duty to follow their pastors or mallams, respectively, as they sought care in ways that showed their religious devotion. Still others opted out of healing systems altogether by purchasing herbs or medicines, based on their own self-diagnosis, and based on their own personalized regime of therapy. In sum, though a tendency to “healer hop” can be understood as a theme within the history of healing in Accra, it cannot be turned into a model for patient behavior writ large -- there were other historical forces at work that influenced which therapeutic pathway a patient chose to travel down.

One might also expect the story of healing in Accra to have been dictated by causal factors related to the efficacy of each type of therapy. According to this model, patients would sample multiple forms of therapy until they found one that proved efficacious in curing their ills. Embedded within the notion of efficacy is the assumption that certain types of healing would be better at dealing with certain types of maladies. For instance, the affliction of a venereal disease might easily be cured by a physician, while the affliction of

witchcraft might be best handled by an African healer. As the evidence shows, efficacy has indeed played a role in the way that patients have chosen their therapies. Patients clearly expressed demand for arsenicals, sulphur drugs and penicillin because they were efficacious in healing illnesses like gonorrhoea and syphilis. And patients sought help from new deities like Tigare to thwart what they perceived as the rising threat of witchcraft. Efficacy, according to the patient's perception, was a significant factor in therapeutic choice, and likely contributed to the success of colonial medicine in treating bodily illness and non-European therapies in treating spiritual maladies.

But perceived efficacy from the perspective of the patient is not the same as clinically-determined efficacy. For instance, in chapter 2, when European sailors abandoned their ship's surgeons for African healers, we might argue that they did this because African healers were more efficacious. However, we do not know exactly what illnesses the sailors had, what African medicines they received on shore, or what their recovery rate was. The lack of clinical evidence makes it impossible to demonstrate the clinical efficacy of African medicines. Similarly, the demand for inoculation with Haffkine's prophylactic for bubonic plague in 1908 could be explained by the clinical efficacy of conferring immunity, but it might also be said that the colonial inoculation station was congruent with local therapies of ritual inoculant scratches on the skin, and that a social tipping point was reached in the city where everyone simply had to participate in the campaign. It is hard to imagine the panicked residents of the city sitting back and assessing the efficacy of an imported prophylactic in a clinical manner without intimate knowledge of the causal frameworks of scientific medicine.

The centuries-long battle against malaria is another storyline that, at first glance, should bulwark the significance of efficacy as a driving force of therapeutic decision making -- after all, it should be relatively easy to demonstrate how colonial medical interventions

against malaria would have won over patients gradually, starting with the provision of cinchona bark, then gaining efficacy with sanitation measures, and finally triumphing with the provision of low-cost chloroquine via the colonial post office. However, historical epidemiology requires solid data about rates of infection, morbidity, mortality, and recovery - data that were simply not available in a reliable form with respect to malaria, which was known only by symptoms of fever before the twentieth century. And though cinchona and chloroquine may have been efficacious checks on the disease, we do not have any data showing when and to what degree these drugs were used as cures for malaria, nor have we ever had any strong data about the use of local herbal antimalarials. Moreover, the availability of imported antimalarials happened to coincide with changes to the urban environment of Accra that made it a haven for mosquito larvae, a factor that likely increased malaria rates in the city. All of these qualifications make it difficult draw conclusions about progressive acceptance of therapeutic regimes based on clinical efficacy. Thus, rather than making assertions about how clinical efficacy revealed the superiority of certain therapeutic options, this dissertation has highlighted the perceived efficacy of different sorts of therapies, and in doing so, has shown how they contributed to a plurality of healing traditions in Accra.

It is also tempting to lean on the Foucauldian concept of biopower in order to offer a causal relationship between the growth of colonial medical power and control over the bodies of the subject population of the Gold Coast. During the 1920s, the legitimacy of the colonial state was predicated on increasing the size and vitality of the colonial workforce, a project that required the recruitment of African sanitary officials, African doctors and nurses, international researchers, and British experts in maternal care. The colonial state was also able to use its various appendages (such as the police, courts, and legislators, and British

commercial enterprises) to guarantee a supply of patients to colonial medical institutions. The brief period of martial law during the Second World War was the height of ascendant biopower, as the Allied forces endeavored to eradicate malaria from Accra to ensure the safe passage of aircraft and war materiel through the city. After independence, the Africanization of the colonial medical system became a key component of the new Ghanaian identity, as the CPP government appropriated biopower as a justification for its program of development. In fact, having demonstrated the alignment of medical and colonial power, we can now argue that the very project of colonialism depended on the medicalization of the colonial subject.

However, practically speaking, there were many gaps in the expansion of colonial medical authority, mostly due to underfunding, but sometimes due to sheer lack of interest in the health of the colonized. Though the colonial government was able to build suburbs for white residents and control the movement in and out of the European “reservation,” the residents of Ussher Town and James Town stood firm, protesting and rioting when sanitary officials attempted to demolish and restructure their city. Though the anti-malaria campaign of the Second World War might represent the apex of biopower in Accra, it quickly petered out after the war, as funding evaporated and the engineering of the Korle waterway was discontinued. Indeed, if biopower in Accra was truly robust, it might have manifested itself in a police state that eliminated competing healing regimes by demolishing shrines and restricting the sale of medicines in the marketplace. But as we have seen, the Gold Coast government relied on Ga chiefs and head priests as allies during crises in the city, and during the 80 years that Accra was the capital of the Gold Coast Colony, only one Ga shrine was suppressed. Moreover, there is evidence to suggest that colonial doctors were unable to regulate the behavior and movement of their patients in and out of hospitals, and many

accounts of patients moving between doctors and non-Western healing practitioners. If the success of biopower is to be measured via its control of colonized bodies, there were definitely moments when colonial medicine rose to prominence, and almost took on the role of medical hegemony, but these moments were brief. In the long term, the colonial medical state failed to assert hegemony over the patient population of Accra.

Another way that one might explain the development of pluralistic healing in Accra is by locating patterns of social differentiation whereby individuals aligned themselves with particular ethnic, religious or social groups during their quests for therapy. From this perspective, patients actively constructs their social status via their therapeutic choices. Participating in Ga healing, for instance, has always been a means of distinguishing oneself as an active member of the Ga ethnic group. In particular, being involved in the rituals of the harvest festival of Homowo has been a means of participating in the social healing activities coordinated by the priests of the major shrines and their associated spirit mediums. In the 19th century, becoming Christian involved detaching oneself from Ga rituals and presumably any trappings of religion associated with healing. By joining the Christian community of the Osu Salem, a patient asserted their piety and commitment to a healing culture that included religious faith in the Lord and cultural acceptance of surgical techniques imported from Europe. In the 20th century, Christian healing became faith-healing, as thousands followed pastors who promised to channel the Holy Spirit into their lives as an invigorating force. Similarly, being Muslim in Accra might include visiting the *wanzamai*, *Mallams*, *Alufas*, or *Alhajis*, experts who were able to transmute the word of God in the form of Arabic script into protective amulets or slate wash.

Using the motivating factors of distinction, one can argue that one reason for the success of colonial medicine in Accra is that the residents of the city understood that visiting clinics

and hospitals differentiated them from African culture and associated them with the wealth and modernity of the British Empire. After the racist regulations of the West African Medical Service were abandoned in the 1920s, the sons of the wealthy African elites began to find their way into the upper echelons of colonial society by taking medical degrees in the UK and finding posts within the colonial medical system. Nurses, dispensers and medical technicians also found that the colonial medical system offered them opportunities for professional advancement, as well as newfound cultural capital that connected them to a colonial world of golf, tennis, royalty, and colonial balls. Patients too could align themselves with the prestige of colonial medicine by attending hospitals and clinics and by choosing to put their faith in European-derived medicines. In sum, the aspirations of a patient, as a person fully embedded within Accra society, are as important to the story of healing in the city as the metanarrative of medical progress.

However, though we can locate patterns of distinction embedded in specific healing cultures in Accra, patients seemed to readily move between them. Like biopower, the forces of distinction were never so well developed as to entirely define the identity of residents of Accra. Sick persons evaded ethnic, religious and class restrictions by playing the role of sufferer in multiple ways, participating in Homowo, attending Korle Bu, joining a new Christian faith-healing church, visiting an Alhaji, or openly declaring their trust in a patent medicine. For residents of Accra, the decisions that they made about healing themselves were often related to their economic class, religious faith, and cultural identity, but the boundaries between these social fields were porous, and patients code-switched between therapeutic milieus in order to conduct their quests for therapy.

In conclusion, there was no invisible hand guiding therapeutic pluralism in Accra -- historical change in the healing culture of Accra has been determined by the plurality of

small acts taken by patients and their caregivers in their choice of therapies, and the plurality of innovations made by healers in an effort to attract patients. Therefore, rather than seeking out a single explanatory factor to explain pluralistic healing, this dissertation has offered four approaches that can be used in conjunction, over the long term, to account for the sustenance of pluralistic healing in Accra. Each of these models for understanding patient behavior and the responses of healers can explain some elements of change within the healing culture of Accra, but none of them can entirely account for the diversity of aetiologies, practices, material cultures, and spacings related to disease and healing. Only when they are combined can they offer a richer understanding of the lived experiences of patients, including their diversity of cultural and religious beliefs, their struggle to assert political autonomy, their calculated aims to submit to the most efficacious therapy, their desire to express social aspirations, and their wishes to assert control over the treatment of their own body.

Section 2. The Five Healing Traditions at Independence.

The story of the healing in Accra begins in the late 17th century, at time when the city was primarily Ga, with small groups of immigrants from around the Gold Coast and West Africa. Capturing the diversity and dynamism of healing practices at this time is a difficult task given the limits of the sources, but the accounts we do have provide evidence of a rich lexicon of disease aetiology within the Ga language (which incorporated healing ideas from other ethnic groups), a diversity of practices ranging from herbalism (if we recall Isert's list of medicinal plants) to consecrated objects (if we recall Noyte's "curio cabinet"), and notions of healthy and unhealthy spaces (determined by the welling up of spiritual nodes marked as *ototui*). For many centuries, African healing was pluralistic because it meant seeking help

from priests, spirit mediums and herbalists, the experts who were able to harness the powers of the material and spiritual worlds to heal.

The survival of a pluralistic African healing tradition was not a foregone conclusion. The turmoil of the collapse of Ayawaso, the threat of invasion by the Asante, and the political pressure placed on the residents of the city under British colonial rule, all posed a threat to the survival of Ga and other African healing traditions. But by starting with the diversity of healing concepts in the Ga language, this dissertation has shown that practitioners employing the traditions of African healing have constantly adapted to historical circumstances, starting with Ga healers in the 17th century, and ending with a plurality of African healers in the 20th century. And it is also important to note that there were many instances where the residents of the city stood their cultural ground against incursions by the medically-minded colonial government. By objecting to poll taxes for the Town Council, by protesting against sanitary projects, by resisting the demolition campaign during the plague epidemic, and by protesting against the spraying of Korle Lagoon, the residents of the city declared their rights to control changes within the capital city while at the same time creating spaces of tolerance for other African-derived healing traditions, including priests of migrant deities like Dentu, Tigare and Tongo, soothsayers from Dahomey, and many others.

European-derived healing traditions also have a long history on the Gold Coast, but, as in the case of African forms of healing, it was never a foregone conclusion that the medical practices of Europeans would survive in Accra. For two hundred years, surgeons were minor players in the city because they lacked the skills needed to heal people in the African tropics, and they themselves died at an astonishingly high rate. In fact, European sailors and soldiers often sought healing with Africans when they realized that ships surgeons could not

cure tropical diseases. It was not until the 20th century that European-derived medicine was able to attract patients in Accra. This change was partly due to efficacy. In the case of specific medicines for specific needs, such as chloroquine for malaria and bismuth silicate for yaws, European physicians were able to bask in the glory of providing genuine silver bullet cures. The curative power of European medicine further increased with the arrival of sulfa drugs and penicillin. But these medicines targeted only specific illnesses, and they arrived relatively late in the story of European medicine in Accra. The forces of biopower (which linked colonial medicine to the workings of the colonial state) and the forces of distinction (which aligned class status with European medical practices) also played a role in establishing colonial medicine as a distinct healing alternative in the city. In colonial Accra, being a patient within the colonial medical system was rarely a freely made choice. Some patients probably attended hospitals or visited clinics because it was the expected behaviour of someone in the employ of a European firm, the colonial government, or the army. In the case of a traumatic injury, the hospital was also a place to which you might be sent -- by a boss, by a sergeant, by a judge, or by a police officer. But gradually, seeing a doctor also became a type of social behavior, a performance undertaken to align oneself with modern colonial society. By the 1920s, when the structures of racial segregation were gradually dismantled, African-born physicians, nurses and dispensers began to take the reins of colonial medical power, putting African patients at greater ease within colonial institutions, and signaling the end of white domination of European-derived medical practices. By the 1950s, after a long and winding road of adaptation to the urban African culture of Accra, medicine was endorsed by a new generation of African elites as the official healing regime of the new state of Ghana.

As a sister to curative medicine, the story of sanitation became a significant corollary to the rise of colonial medicine in Accra. In the 19th and early 20th centuries, the British colonial government hoped to sanitize the city of Accra in order to create a safe environment for white officials and a salubrious workplace for the African employees. However, the intentions of the sanitation section of the Gold Coast Medical Department was widely regarded with suspicion by the residents of the city -- the more power sanitary officials were given, the more likely they were to expropriate land, demolish houses, and exert outright control over the bodies of the colonized. Consecutive attempts by the Medical Department to alter the urban core of Accra during the late 19th and early 20th centuries were resisted by the residents of Accra. In response, the British retreated spatially from the urban core, to a “European Reservation,” situated a mosquito flight away central Accra. In 1908, a brief but vigorous anti-plague campaign demonstrated the extent to which British medical officials would go in order to ensure that the port cities of the British Empire were plague free, but this was only a temporary intervention. It was only in the 1920s that the Sanitation Department was able to assert medical notions of health on the subject population of the city, this time via sanitary reforms that operated in unison with the courts and the police. The forces of sanitary biopower were further heightened during the Second World War, when the colonial government, the British armed forces, and the US air force exerted unprecedented control over the inhabitants of the city. But it must also be said that sanitary reforms were almost always met with resistance. Even during crises like the bubonic plague epidemic of 1908 and Second World War, the residents of Accra protested against forced removals and demolition of houses, using legal means or violence when necessary. Moreover, the budgets dedicated to sanitation measures were never large enough to impose sweeping changes over the medical landscape of the city. With the exception of

the European residential areas of the city, sanitation never became an essential component of colonial rule.

The strongest assertion of colonial medical control in Accra came in the realm of maternal and infant care. After the colonial government suppressed the shine of Naa Ede Oyeadu in 1906, it was able to replace it with infant welfare clinics and a training centre for midwives at the Princess Marie Louise Hospital. After this point, the rules of getting pregnant, having babies, and raising children were no longer exclusively set by the religious authority of a local goddesses. Rather, they were being dictated more and more by Women Medical Officers at Korle Bu, by nurses at infant welfare clinics, and by the judges of the baby show during Health Week. Women of elite families were particularly interested in raising babies according to the new rules of so-called mothercraft, but women from many ethnic, religious and class backgrounds showed interest in these new trends in childcare, by attending well-baby clinics and buying imported foods like tinned milk. But even the victory of this particular subset of colonial medicine, maternal and infant care, must be qualified. We are lucky to have accounts by a progressive doctor like Cicely Williams, who was willing to admit that her patients continued to visit African healers for fertility aids and for consecrated devices to protect their children, suggesting that colonial infant and maternal care might have simply been another option for women within the pluralistic therapeutic environment of Accra.

In parallel to the rise of colonial medicine in Accra was a great awakening of interest in Christian faith-healing. Starting from an enclave in Osu, where Basel Missionaries from Europe built a community of followers in 1827, the understanding that healing power could be found within the forces of the Holy Trinity began to emerge. The Christian community in Accra struggled to expand due to the rapid death of European missionaries in the tropical

environment, but the 1866 translation of the Bible into Ga offered a new lexicon of Christian healing. When Johannes Zimmerman, Carl Christian Reindorf and the other members of the Basel Mission offered Ga-speakers translations of the omniscient power of God, the cleansing virtues of the blood of Jesus Christ, and the healing breath the Holy Spirit, they introduced an entirely new set of conceptions about health and healing. However, these religious healing resources were never exploited by white missionaries. In fact, the Basel missionaries intended to build European-derived medical facilities for their congregation, but they were unable to find the personnel to staff them. Only the occasional church member, such as Carl Christian Reindorf, was able to match missionary fervor with knowledge of European surgical techniques, and even Reindorf used African herbalism in conjunction with his European-derived healing knowledge. Control over the provision of European medical care was eventually taken up by the Gold Coast Government rather than local churches, and when the Basel Mission was incorporated into the Presbyterian Church in 1917, aspirations to align the protestant faith with medical practices faded away. None of the so-called mainline churches built hospitals, nor did they incorporate faith-healing ceremonies into their liturgy.

But when Christian revival movements swept through Nigeria, the Western Gold Coast, and the Ashanti Region, new churches dedicated to using the Holy Trinity to heal bodily and spiritual illnesses began to pop up in Accra. By the 1950s, dozens of splinter churches, mostly led by individual pastors, garnered followings in the urban core of Accra, where outdoor services and ad-hoc healing ministries filled the empty spaces and buildings of Ussher Town and James Town. These were not Christian hospitals per se -- the sick and spiritually needy could already seek medical care from herbalists or doctors. Rather, they were assemblies that encouraged a pure faith in the healing power of the supreme deity.

Some of the churches, such as the Musama Disco Christo Church, even forbade their followers to take any sort of medicine (African or European), because to do so would demonstrate a lack of faith in the healing power of God. In particular, the new churches of the Christian revival offered cures for afflictions such as barrenness (a traditional illness of concern in Accra) and witchcraft (an affliction that was perceived to be on the rise in Accra in the twentieth century). Though we cannot quantify efficacy in the faith-healing practices of the pastors of Accra, its prominence was indicative of demand by patients in Accra for healing within a Christian idiom that would cure both bodily and spiritual ailments, and it would become increasingly important in the city in the postcolonial period. By the 1950s, almost 5000 people attended the new churches of Accra. By the 1980s, they would number in the hundreds of thousands.

Demand for Islamic forms of healing also grew as the Muslim population of the city began to increase in the 19th century. The first Muslims in the city of Accra were so-called Hausa migrants from Nigeria, who were later followed by Brazilian Muslims returning to Africa to settle and trade in Accra. These enclaves maintained their own systems of healing, which included herbal medicines as well as Quranic medicines that drew their power from the word of God rendered in Arabic script. The moderate Tijaniya order, to which the Muslims of Accra belonged, allowed for the presence of a class of healers known as the *wanzamai*, who offered services such as barbering, circumcision, ritual scarifications, as well as herbal remedies and Quranic apotropaics. There is precious little evidence to show the impact of their work in Accra, but parallel findings indicate that amulets bearing Arabic script were prominent around the Gold Coast, and so it is easy to see why the residents of Accra might have patronized *wanzamai* for objects health or protection.

Yoruba Muslim practitioners (who were also known as “Hausa” in Accra) were the next generation of healers with practices associated with Islam to arrive in Accra. With Hausa Islamic healing culture came categories of *Mallams*, *Alufas*, and *Alhajis*, practitioners who offered a broad set of curative and protective medicines -- everything from herbal concoctions to fabricated objects filled with Quranic script. These healers thrived within a moderate Islamic community where the Muslim community, and the rest of the public, were open to the combination of Quranic therapies, herbal medicines, and local apotropaics. The immigrant communities of the city were also supplemented by Ga converts, a slowly growing subsection of the Muslim population. As the Muslim community became more integrated into society, residing in the same communities as Christians and followers of Ga and Akan religions, and worshipping at mosques built in Ussher Town, it is easy to see how non-Muslim patients with a pluralistic outlook on healing might have sought out aid from Muslim healers.

Related to the story of Islamic healing are the social conditions faced by Muslim migrants. Each new wave of Muslims in Accra found themselves to be outsiders within a Ga majority community, and they were compelled to organize themselves either along religious lines or within ethnic communities. Many came to the city as subjects of the British Empire, in the form of soldiers in the West Africa Regiment or the Hausa Constabulary, or as labourers in the employ of the Gold Coast Government or the Accra Municipality. Others scratched out a living in the most menial of jobs, scavenging and trading to get by in marketplaces of the city. Many of these migrants were required to attend the colonial hospitals in Accra when they were sick, and some were even recruited unwittingly for medical experiments. Springing forth from this marginalized community was an innovative version of the *Hauka* cult, comprised mostly of followers from the ethnic groups from the

Northern Territories and the French West African Department of Niger. In a dramatic expression of subaltern status, the *Hauka* grotesquely represented colonial officials (such as the governor, the general, and the physician's wife) as oppressive and savage figures, in combination with a diversity of spirits from the Muslim world. The *Hauka* cult demonstrated clearly the psychological effects of marginal status within a colonial urban setting, and showed how colonial medicine was perceived as an apparatus of colonial power.

The last healing tradition addressed in this dissertation is that of the market for medicinal products. The residents of Accra had been healing themselves with local herbs as home remedies for generations, and it is likely that people have traded medicinal herbs around the region of the Gold Coast for centuries. As routes of oceanic exchange expanded to Asia, and then across the Atlantic, Accra became home to a wealth of both imported and indigenized herbs. The trans-oceanic transmission of herbal knowledge of medicinal flora had flows that we might refer to as subaltern. Dozens of plants and herbs that were not indigenous to Africa appear in the historical record by the late 18th century but we have no way to trace who brought them or how they arrived on the Gold Coast. This pattern of exchange was not entirely open, as key items like cinchona bark were never indigenized in West Africa, but during the era of the transatlantic slave trade, the *materia medica* of the residents of Accra was likely supplemented by trade in American imports, including medicinal roots like sarsaparilla. In the 19th century, proprietary medicines fabricated in Britain, Europe and the USA began to find their way to Accra in the medicine kits of Europeans, and then into the marketplaces of the towns along the Gold Coast. Dozens of new medicines, like quinine powder, Chlorodyne and Warburg's Tincture found their way to Accra by the end of the 19th century, offering new ways to cure illnesses like malaria. These

medicines were brought to Accra by white government officials and merchants, but they soon became obtainable to Africans by mail order or in the marketplace.

In the 20th century, the number of medicines available expanded rapidly, and some were given local meanings within the broader community. Atwood Bitters, for instance, was a purgative that became a fertility medicine, a transition that is not surprising considering the demand for fertility and fecundity medicines in Accra over the past centuries. After the Second World War, the advertising for patent medicines changed, as producers realized that they had a specific market in Africa that required localised marketing schemes. Rather than being a subsidiary market that supplemented sales in the metropole, Accra and other West African communities had become essential to the sales of some patent medicines.

Advertisers tried to build demand by connecting their products to concepts like vigour, vitality, and productivity, creating archetypes of the happy and healthy colonial worker. At independence, the number of patent medicines and pharmaceuticals available in Accra continued to increase, and the cash economy of self-medication with pills or bottled remedies became increasingly important to maintaining one's health in the city.

Though evidence of the coexistence and interaction of this plurality of healing traditions is largely absent from medical histories and anthropologies of the Ga, by looking at a diversity of source materials over three centuries, the trend is clear -- starting with the multi-stranded aetiological framework of the Ga healing lexicon, and building over the centuries to include five major traditions of healing, the residents of Accra have sustained a culture that tolerates, and even welcomes, new healing ideas, practices, and material cultures. The presence of diversity over the long *durée* compels us to abandon the search for singularity inherent in the logic of Ockham's razor, and to accept that no a single tradition can offer a parsimonious explanation of the history of healing in Accra. Even when powerful forces,

like the colonial state or the armed forces, clearly favoured a singular healing option, the patients of the city kept up demand for the others, sharing the burden of their sickness amongst many healers in a search for a cure. The next section will provide a sketch of how this culture of pluralistic healing has been maintained up to the present day, and offer some insight into the future of healing in Accra.

Section 3. Epilogue: Therapeutic Pluralism in Postcolonial Accra.

The chronology of this dissertation ends in 1957, which is in some ways an artificial finishing point in the story of healing in Accra. The transition from colony to nation was a momentous event in Ghana and around Africa, but the five therapeutic traditions chronicled in this dissertation remained vibrant within the new capital of Ghana. The trends that emerged in the middle of the 20th century, such as growing demand for medical services, growing interest in Christian faith-healing churches, and an expanding Muslim population, did not wane in the postcolonial period. Though each major healing tradition in Accra is different today due to the circumstances of history that they have encountered over the past 300 years, they remain recognizable as pathways to health, each consisting of a collection of ideas, practices, material cultures and senses of space. However, the tumultuous era of independence does deserve its own treatment as a separate era in the history of healing because of some significant historiographical, demographic, political, religious and economic changes in Accra. This section will serve as an epilogue by discussing some of the challenges in tracing patterns of change in patient behavior and the provision of healing services in postcolonial Accra, and by suggesting some new areas of research that emerged during the late 20th and early 21st century.

As stated in the introduction, the most practical reason for dividing the study of healing in Accra into colonial and postcolonial eras is the lack of adequate record keeping by the Ghanaian Ministry of Health. In 1981, K. David Patterson stated plainly that data upon which a historian of medicine might evaluate the state of medical care in the new country of Ghana were unreliable.⁴ Addae also laments that “the moment the country became independent the writing and preservation of annual medical reports ceased.”⁵ Though Addae was still able to ingeniously cross-reference several reports to come up with vital statistics for his end year of 1960, the absence of reliable record keeping created a dead end for the statistical analysis of health trends in the second half of the 20th century.⁶ Although Scott did not explicitly state why he chose to close his inquiry into epidemic disease on the Gold Coast in 1960, it must have been because data on instances of disease in the country petered out shortly afterwards. Anticipating a dearth of records with which to reconstruct the disease history of the region, Scott made a prescient call “for an international disease intelligence bureau to be set up in West Africa.”⁷ Unfortunately, no such regional organization was ever founded, and African governments continued to rely on weak World Health Organization data for statistical data about epidemic disease. While the study of healing in Ghana has been ably pursued by anthropologists, such as Patrick Twumasi and

⁴ Patterson, *Health in Colonial Ghana*, 86. As evidence for this assertion, Patterson cites demographers S.K. Gaisie and K.T. Graft-Johnson, who had admitted in 1974 that their demographic analysis of population trends in Ghana were based on “defective and highly unreliable” vital statistics. Samuel K, Gaisie, and K. T. De Graft-Johnson *The Population of Ghana* (Paris: CICRED, 1976), 6.

⁵ Addae, *Evolution of Modern Medicine*, 458.

⁶ Addae, *Evolution of Modern Medicine*, 89.

⁷ Scott, *Epidemic Disease in Ghana*, 200.

Kojo Senah,⁸ no history of medicine in Ghana has been written that effectively covers the postcolonial period.

The absence of a strong historiography of European-derived medical practices makes it difficult to continue a historical inquiry into therapeutic pluralism in Accra after independence. Though one might argue that medical historiography privileges the work of medical officials and professionals and silences other types of therapies, a historian would at least be able to find other healing traditions between the lines of medical documentation, in the same way that the unnamed herbalist appeared in the case of Commey, the fertility specialist Merry Brew emerged in the case of Olivia, and the voice of the healer Afori Atta can be heard in the biographies of Dr. Cicely Williams. Historians of postcolonial Ghana can still work with journalistic accounts, biographies, and oral interviews, but without the balancing weight of scientific medical inquiry and the history of medical professionals, it is difficult to paint a full picture of the healing culture of the city in the postcolonial period.

Another compelling reason to end this dissertation at independence is because of the astounding growth in the population of Accra. In 1954, 200,000 people were living in the city and it was growing rapidly. By 1964 the population was 350,000 and twenty years later it had reached over one million people. Ever since, growth has been exponential and the city is now estimated to be populated by almost four million people.⁹ Though the Ga population of the city was also growing rapidly during this time, it could not keep up with the influx of newcomers. In 1948, the Gas made up only 52% of the population, and though we do not have census data for 1957, it is safe to assume that they were the minority in the city by

⁸ Twumasi, "Colonialism and International Health," 147-51; Twumasi, *Medical Systems*; Senah, *Money Be Man*.

⁹ Acquah, *Accra Survey*, 31; Accra Metropolitan Assembly. *MCE's message*, accessed March 1, 2011, http://www.ama.ghanadistricts.gov.gh/?arrow=dce&_=3. The Chief Executive of the

independence.¹⁰ Today, Ga speakers make up only 30% of the total population of Accra. Immigration, in particular from Akan-speaking parts of Ghana, was the biggest contributor to the decline of Ga influence in Accra in the postcolonial period. In fact, one might argue that Accra is largely an Akan city today, because Fante, Asante and Akwapim migrants and their descendants make up 40% of the urban population, and because Twi is arguably the most widely spoken language in the city. The Ewe-speakers are also significant, making up 18% of the population.¹¹ Other smaller groups of Africans, Lebanese/Syrian, Chinese, European and other population fragments make up the rest of the population of the city, amounting to less than 10% of the population.¹² Unreported residents probably number in the hundreds of thousands, and are likely made up mostly of migrants from West Africa.

Though Accra is still the capital of the Ga ethnic group, Ga chiefs have lost their ability to guide the development of the city, and Ga healers have lost the exclusive authority to exclusively define states of health amongst patients and within Ga society as a whole.¹³ Though Homowo is still a significant event in Ussher Town and James Town, it is very difficult for the priests to impose a ban on drumming (music and noise making) throughout the metropolis, and the power of the chiefs and priests has diminished outside the urban

Accra Metropolitan Assembly, estimated that approximately three million people live in Accra while about one million visit the city for business each day.

¹⁰ The population breakdown by ethnicity of a total of 129,065 was: 1. Ga, 66,619 (52%), 2. Ewe, 14,343 (11%), 3. Fanti, 6,696 (5%), 4. Nigerian (south), 6,109 (5%), 5. Hausa, 4,407 (3%), 6. Adangme, 3,642 (3%), 7 Akwapim, 2,878 (2%), 8. Kwahu, 2,623 (2%), 9. Zabarima, 2,282 (2%), 10. Asante, 2,163 (2%). See Acquah, *Accra Survey*, 176.

¹¹ Government of Ghana. Greater Accra, accessed October 21, 2014, <http://www.ghana.gov.gh/index.php/about-ghana/regions/greater-accra>.

¹² Government of Ghana. Greater Accra, accessed October 21, 2014, <http://www.ghana.gov.gh/index.php/about-ghana/regions/greater-accra>.

¹³ John Parker has argued that Ga chiefs had already lost substantial control over the city by 1920. By the 1960s, they no longer maintained hereditary rights to political representation on the Accra City Council (reorganized as the Accra Metropolitan Assembly in 1993. Parker, *Making the Town*, xix-xx; Accra Metropolitan Assembly, Background, accessed March 1, 2011, <http://ama.gov.gh/ama/page/5103/background>.

core. And though the city is now home to other African healers, revisiting the internal pluralism within the healing systems of the city would require the extensive collection of oral histories of patients and healers -- a project that would require teams of researchers and substantial funding.

One might also argue that the population explosion has created a new, precarious, sanitary situation for the people of Accra in terms of sewer disposal, waste water dispersal, and the supply of fresh water. Like most cities in West Africa, Accra has no sewer system,¹⁴ and raw sewage is still dumped by the truckload into the Atlantic Ocean at Korle Gonno. The water supply in the city is also a major source of concern because water mains first laid by the British are leaking and the piped water supply is irregular. In most parts of the city, water for washing is delivered inefficiently via water trucks, which pump water from the Weija Dam. Most drinking water is sold in 500ml plastic sachets, an unsafe form of packaging that has recently been implicated in spreading cholera, causing over 3000 cases of illness and dozens of deaths in 2011.¹⁵ The environmental damage caused by plastic sachets is also a concern, because they wash into drains and clog the local waterways, which exacerbates flooding in the city. Waste water management is also a major problem, one that is associated with the ill-health of the sacred Korle Lagoon. In 2002, the \$89 million dollar Korle Lagoon Restoration Project began work dredging the waterway and building a pumping station to try to flush contaminated water from the lagoon. The project was completed in 2008, but it remains to be seen whether the pumps will be able to handle the human waste emanating from the squatter community of Agbobloshie and the volume of

¹⁴ Addae, *Evolution of Modern Medicine*, 140. In the early 1970s, the Israeli government offered to build a sewer system as a form of bilateral aid to Ghana, a project which was quickly abandoned when President Busia sided with the Arab nations during the Yom Kippur War.

¹⁵ Ghana News Agency, "Greater Accra Leads Cholera Infection," accessed March 24, 2011, <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=205482>.

garbage floating downstream from Kwame Nkrumah Circle.¹⁶ The resistance to sanitary reforms of the Accra Metropolitan Assembly by squatters at Agbobloshie is uncannily similar to the resistance by Ga chiefs and priests to the sanitary reforms of the British colonial regime; several half-hearted and incomplete attempts have been made to evict them but they remain in the location today.¹⁷ These are just a few of the tangents of the larger story of postcolonial sanitation, a story which has links to the colonial era and the anti-malaria campaign of the Second World War, but one that has become a much more complicated issue as Accra has become a major metropolis.

The population explosion has also changed the disease environment of Accra. Malaria, carried by mosquitoes that breed in the alleys, ditches, and rubbish piles around the city, has never abated, and the burden of treating malaria cases has been largely carried by government health services. For example, in the 1970s, the cost of imported antimalarial pharmaceuticals was almost equivalent to the wages and salaries of all of the employees of the Ghanaian Ministry of Health,¹⁸ and today malaria accounts for almost half of all illnesses

¹⁶ Interview, Korle Wulomo, February 3, 2005; Interview, Korle Wulomo, February 16, 2005; Marie Huchzermeyer and Aly Karam, *Informal Settlements: a Perpetual Challenge?* (Cape Town: UCT Press, 2006), 191-94.

¹⁷ Squatters in Agbobloshie have sought legal means at staving off eviction. See Centre For Public Interest Law, "Housing Rights and Forced Eviction Cases, Issa Iddi Abass V Accra Metropolitan Authority (Ama) & Another," accessed March 4, 2011, <http://www.cepil.org.gh/courtcases.htm>; Joyonline. "Comment: Tale of Two evictions," accessed March 4, 2011, <http://news.myjoyonline.com/features/200909/35022.asp>

¹⁸ A. Barnett, A.L. Creese and E.C. Ayivor, "The Economics of Pharmaceutical Policy in Ghana," *International Journal of Health Services: Planning, Administration, Evaluation* 10, no. 3 (1980), 480. Additionally, Barnett points out that the association by patients of injections with quick cures has led to increased costs, as injections are more expensive to give than antimalarials and antibiotics in pill or syrup form (485-88). In other words, the extent of the so-called bum-punching during the colonial era appears to have firmly connected injections to magic bullet cures.

reported at outpatient facilities in the city.¹⁹ New diseases have also arrived in the city in the postcolonial era, including cholera (mentioned above) and HIV/AIDS. The social changes wrought by the spread of HIV/AIDS have been treated in sociological and epidemiological studies of the illness, but a more comprehensive history of the impact of the disease on urban life and the therapies of Ga and other African healers over three decades needs to be written.²⁰ Moreover, Accra has increasingly become a place that suffers from the so-called “double burden” of disease where endemic diseases like malaria and typhoid fever flourish at the same time as diseases of affluence such as obesity, diabetes, hypertension and heart disease.²¹ Also looming in the future is the threat of an Ebola outbreak. Though nurses and doctors are trained to handle such outbreaks, they may be left to manage with very limited resources if international aid is funneled exclusively towards Guinea, Sierra Leone and Liberia. In sum, understanding the health dimensions of the explosion of the urban population, in terms of healing practices, sanitation, and new

¹⁹ J. Songsore and G McGranahan, "Environment, Wealth and Health: Towards an Analysis of Intra-Urban Differentials within the Greater Accra Metropolitan Area, Ghana," *Environment and Urbanization* 5, no. 2 (1993), 11.

²⁰ Joseph Oppong has suggested that the AIDS rate in Accra is lower than in some rural areas of Ghana because urban residents are more sexually empowered than poorer rural residents, though this is an area that requires more research. Joseph R. Oppong, "A Vulnerability Interpretation of the Geography of HIV/AIDS in Ghana, 1986-1995," *Professional Geographer* 50, no. 4 (November, 1998), 437-448. Alfred Neequaye has suggested that ritual scarification might cause infection because the razors used to make incisions are not sterilized. See Alfred R. Neequaye et al., "Factors That Could Influence the Spread of AIDS in Ghana, West Africa: Knowledge of AIDS, Sexual Behavior, Prostitution, and Traditional Medical Practices," *J AIDS Journal of Acquired Immune Deficiency Syndromes* 4, no. 9 (September, 1991).

²¹ Agyei-Mensah & De-Graft, "Epidemiological Transition"; R.B Duda and other scientists have found that high blood pressure is a significant health risk and cause of death in Accra for both men and women, while A.G. Amoah has found that obesity rates are rising in the city, especially for women. R.B.Duda et al., "Results of the Women's Health Study of Accra: assessment of blood pressure in urban women," *International Journal of Cardiology* (April 12, 2007), 115-22; A.G. Amoah, "Obesity in adult residents of Accra, Ghana," *Ethnicity and Disease* 13, no 2 (Summer, 2003), 97-101.



Figure 8.1 Kwame Nkrumah Visiting Korle Bu Hospital. Circa, 1954. Though the provision of medical care at Korle Bu continued regardless of whether doctors and nurses were black or white, the transition of political power to the hands of the new citizens of Ghana meant that Africans working at the institution were able to advance to the highest ranks of administration, completely appropriating the levers of power at the institution. *Source: Korle Bu Hospital: Golden Jubilee Souvenir.* (Advent Publishing, Accra. 1973).

diseases, would require a multi-disciplinary approach that is well beyond the scope of this dissertation.

Another major reason for ending this dissertation at independence is that the political context of healing changed when the CPP formed the first government of the new country of Ghana.²² Though doctors, nurses, dispensers and technicians continued their duties as places like Korle Bu as they had before, the transition to home rule was significant because it marked a point where Ghanaians had fully appropriated colonial power, including a national medical system. The photo of Kwame Nkrumah (Figure 8.1.), strolling through the halls of Korle Bu in 1954, as the nurses look pensively at one another, speaks volumes about the transition of political power at the institution, even if the manner in which medical care was provided did not radically change. In the 1960s, the Ministry of Health funded the expansion of the in-patient wards at Korle Bu to 1,000 beds, increased educational facilities for doctors, nurses and dispensers, and provided medicines for free at all of its clinics and hospitals.²³ In the immediate independence era, no effort was made to generate a new type of African healing service for the new citizens of Ghana. Rather, Ghanaian politicians, bureaucrats, and medical professionals simply appropriated the levers of medical power from their colonial predecessors.

However, at the same time that the Ghanaian government committed itself to medicine as a national project, it weakened the medical system with limited budgets, outdated equipment, and political instability.²⁴ Stephen Addae, who ends his history of medicine in

²² In 1955, the British administrators who held the positions of Chief Medical Officer and Deputy Chief Medical Officer took leave from their positions with the intention of retirement. Dr. Eustace Akwei became CMO and Dr. R.H.O Bannerman Deputy CMO. Their positions were not officially held until 1957. Addae, *Evolution of Modern Medicine*, 218.

²³ Addae, *Evolution of Modern Medicine*, 92-93, 291-92; T. M. Kodwo Mercer, "The Gold Coast Development Programme," *African Affairs* 55, no. 218 (January, 1956), 27-32.

²⁴ Addae, *Evolution of Modern Medicine*, 97.

Ghana in 1960, sketched out some preliminary findings about postcolonial medical care in Ghana that showed weak growth in the medical infrastructure, weak gains in out-patient and in-patient care, and a very weak performance in preventative medicine.²⁵ The most tenuous link in the provision public health care was a severe lack of Ghanaian doctors. In the 1950s, Kwame Nkrumah envisioned a health system comprised of Ghanaian doctors and nurses trained exclusively by fellow Ghanaians,²⁶ but due to limited budgets and political rivalries between funders in the UK and the USA, Korle Bu did not become a teaching hospital until 1963, and even then, it struggled to provide a full set of courses. It was not until 1969 that the first students of the Ghana Medical School graduated,²⁷ only to find themselves in a destabilized country that had suffered through a coup d'etat and the collapse of cocoa prices. The Ghanaian-trained physicians who would inherit the Ghana Health Services were forced to deal with the disruptions caused by the coup years of the 1960s and 1970s which led to a freeze in funding and a retreat to a "cash and carry" fee-based public system by the 1980s.²⁸ Many physicians simply left the country to seek opportunities abroad and a "brain drain" set in (one that became, according to Addae, an "exodus" by the end of the 1980s).²⁹ The Government of Ghana, wracked by political instability and low commodity prices, simply

²⁵ Addae, *Evolution of Modern Medicine*, 456-480.

²⁶ Addae, *Evolution of Modern Medicine*, 289; Additionally, a suggestion that the Central Investigation Bureau of the United States was involved in funding of a medical school in Ghana is a subplot that has been addressed by Stephen Addae but has never been fully investigated. Addae, *Evolution of Modern Medicine*, 285-88.

²⁷ Addae, *Evolution of Modern Medicine*, 293.

²⁸ In 1985, a user fee system was implemented by the NDC government as a means of accounting for the dispensing of drugs and services at Ministry of Health facilities. When government supplied medicine became less affordable it led, in most cases, to a drop of attendance at government medical facilities. See C. J. Waddington & K. A. Enyimayew, "A price to pay: The impact of user charges in ashanti-akim district, Ghana," *The International Journal of Health Planning and Management*, 4, no.1 (January/March, 2006), 17-47; W. K. Asenso-Okyere et al., "Cost recovery in Ghana: are there any changes in health seeking behavior?," *Health Policy and Planning*, 13, no. 2 (1988), 181-188.

²⁹ Addae, *Evolution of Modern Medicine*, 457.

could not match the rapid growth of the National Health Service in the UK. Despite the valiant efforts of Ghanaian medical administrators, doctors, nurses and technical staff, the medical system stagnated.³⁰

While struggling to maintain the Ghanaian state health care system, the Government of Ghana also made efforts to Africanize healing in the country.³¹ Inspired by Maoist health reforms in China, Nkrumah hired Mensah Dapaah (a scientist who had studied healing at the Akonedede shrine at Larteh in the Akwapim Hills) in 1963 to form the Ghana Psychic and Traditional Healers Association.³² The organization was intended to become a body that would certify traditional healers with professional licenses and support the production of herbal medical products as substitutes for imported pharmaceuticals, but it seems to have collapsed when Nkrumah was deposed in 1966.³³ The only concrete outcome of this was

³⁰ Addae, *Evolution of Modern Medicine*, 194. The heroic struggle to maintain and improve the medical infrastructure of Ghana during an era of political and financial instability deserves its own treatment as a separate historical topic. A significant part of this story would be efforts to conduct research within a crumbling medical system -- as doctors and scientists continued to do in the Ghana Medical Journal, which was founded in 1958.

³¹ These included the *Brachott Committee Report on Professionalization of African Medicine* (Accra: Government of Ghana, Ministry of Health, 1961) and the *Easmon Report* (Accra: Government of Ghana, Ministry of Health, 1966). See K. Mensah-Dapaah, "Traditional healing," *Ghana Journal of Science* 21 (1968), 16-21; Murray Last and G L. Chavunduka, *The Professionalisation of African Medicine*. International African seminars, new ser., no. 1 (Manchester: Manchester University Press in association with the International African Institute, 1986), 132-3.

³² Twumasi and Warren, "The Professionalisation of Indigenous Medicine," 122; Helga Fink stated in 1990 that two parallel organizations emerged in the early 1960s with deceptively similar names -- the "Ghana Psychic and Traditional Healers Association" and the "Ghana Psychic and Traditional Healing Association" -- a situation that created confusion about registration and licensing amongst healers in Ghana. Fink, *Religion, Disease and Healing*, 38.

³³ The Ghana Psychic and Traditional Healers Association still exists nominally under the sole leadership (and membership) of faith healer, Reverend Dr. Henry Joshua Tetteh, in Mamprobi, Accra. After the collapse of this organisation, there was no subsequent attempt to form an umbrella association of healers, but in 1974, General Acheampong set up the Centre for Scientific Research into Plant Medicine at Mampong which collected herbal remedies for scientific analysis, and is still operating today. Twumasi and Warren, "The Professionalisation of Indigenous Medicine," 121-23; Senah, *Money Be Man*, 66-67; E. Evans-

Mampong Centre for Herbal Medicine in 1975, which partnered with the World Health Organization in the 1980s and today sells over 30 different herbal products.³⁴ State supported herbal commodification gradually became private-sector herbal product differentiation, and by the 21st century, local bottled herbal remedies, manufactured in many parts of Ghana, were widely available in Accra. In fact, in some cases herbal medicines in commodity form have become the first option for healing specific diseases -- an inversion of the patient priorities stated by Ione Acquah in 1958.³⁵ Familiarity with the recipes, the lower prices of the products, and the wide availability of bottled herbals seem to be the cause of the rise in their popularity, but the drive to Africanize health care (as a repeating trope that reverberates back to the Society of Herbalists) deserves its own treatment as a uniquely postcolonial topic.

A fourth reason why the postcolonial period deserves separate historical treatment is that it was a time of tremendous religious revival in Accra. There are very few people in Accra today are not associated in some way with either a Christian church or with the Muslim faith, a dramatic change from the 19th century, when there were fewer than a thousand Christians and Muslims in the city combined. Today, Accra is predominantly Christian, at 83%. There are still substantial Catholic, Presbyterian, Methodist and Anglican congregations in the city, but the overwhelming majority of Christians are so-called “Charismatics,” adherents to the

Anfom, *Traditional Medicine in Ghana: Practice, Problems and Prospects* (Accra: Academy of Arts and Sciences, 1986), 42.

³⁴ Interview, Kingsley Kumi, October, 2002. For a more recent defence of the potential of herbal medicine in Ghana see Kofi Akosah-Sarpong, “The Herbalization of Korle Bu,” Ghanaweb.com, accessed January 25, 2004, <http://www.ghanaweb.com/GhanaHomePage/features/artikel.php?ID=50539>. Darko, “Ghanaian Indigenous Health Practices,” 50.

³⁵ J. Royall, “David Ofori-Adjei Building Bridges for Health Care and Research in Ghana,” *The Lancet Infectious Diseases* 3, no. 4 (April 2003), 254.

sort of faith-healing churches that emerged in the 1940s and 1950s in Accra.³⁶ The Nazarite Healing Home and the Musama Disco Christi Church, two of the original faith-healing congregations, are still in existence but are of negligible significance today. Other churches have emerged as individual pastors have split with either the mainline congregations or prior faith-healing congregations, and have garnered thousands of followers through their oratory skills and with the help of sophisticated advertising campaigns and auxiliary print and audio publishing companies. The influence of this new type of prosperity gospel and its attendant structures of faith-healing has been partially chronicled by scholars like Birgit Meyer, Rijk Van Dijk, and Paul Gifford,³⁷ who have addressed the changes in the city wrought by major churches like Winners Chapel, Lighthouse International and the Central Gospel Church. The story of Lighthouse International, for example, would be an essential component of the postcolonial faith-healing story because it was founded by a physician who worked at Korle Bu Teaching Hospital, Dr. Dag Heward Mills, and its headquarters are just south of Guggisberg Avenue in Korle Gonno. Also significant are new types of healers that do not have attachments to major congregations, operating independently as so-called *awoyoo*, spiritualists who heal bodies and families by casting out witches.³⁸ This revolution in Christian worship is part of a postcolonial healing landscape that is too rich and diverse to

³⁶ Greater Accra. <http://www.ghanadistricts.com/region/?r=1&sa=7044>

³⁷ Gifford, *Ghana's New Christianity*; Birgit Meyer, "Make a Complete Break with the past: Memory and Post-Colonial Modernity in Ghanaian Pentecostalist Discourse," *Journal of Religion in Africa* 28, Fasc. 3 (August, 1998), 316-49; Rijk A. Van Dijk, "Localisation, Ghanaian Pentecostalism and the Stranger's Beauty in Botswana," *Africa: Journal of the International African Institute*, 73, no. 4 (2003), 560-83; Rijk A. Van Dijk, "From Camp to Encompassment: Discourses of Transsubjectivity in the Ghanaian Pentecostal Diaspora," *Journal of Religion in Africa* 27, Fasc. 2 (May, 1997), 135-59

³⁸ Interview, Abednego Agoe Bortey, August 6, 2003; Interview, Rahel Roye, June 17, 2003; in a case study of mental health in Ghana, Kristine Krause discusses the struggles between medical, Christian and traditional diagnoses of schizophrenia. The refashioning of local spirits like Mami Wata as Christian demons and the processes of exorcism as healing in Ghana today require further study. Krause, "Double Face of Subjectivity," 54-71.

be covered in this dissertation, and deserves its own account that can connect it with changing notions of African subjectivity and global Christian modernity.

Muslims are still a minority compared to the Christian community, making up approximately 10% of the urban population.³⁹ The Muslim community is poised to grow as more and more migrants from northern communities make Accra their home, and as an increasing amount of funding is put forward for new mosques in Central Accra, and in outlying areas like Nima, Kanda and Madina. Along with the many practices mentioned in Acquah's *Accra Survey*, geomancy and numerology are currently practiced in the city, in particular in suburbs like Nima and Kanda, where Muslim immigrants from northern Ghana and the surrounding French-speaking countries tend to congregate.⁴⁰ What remains to be studied is how the many influences of healing practice, from Hausa traditions, Yoruba traditions, Nigerian traditions, Lebanese and Syrian traditions, have mixed, or perhaps diverged, in the city.

The story of the marketing, sale and consumption of commodified medical products, in particular antibiotics and antimalarials imported from Europe, will also be a vital part of the story of changing medical ideas and practices in Accra in the postcolonial period and the 21st century. The Ghana Health Services have, like all national health services around the world, become increasingly dependent on the quick fixes for epidemic and endemic illness. For instance, by the 1980s, the importation of pharmaceuticals made up 75-80 percent of operating budget of Korle Bu hospital, indicating how much Ghanaian biomedicine had become reliant on the curative values of imported drugs.⁴¹ But to restrict our investigations to the dependency of the Ghana Health Services on drug supplies misses the fact that most

³⁹ <http://www.ghanadistricts.com/region/?r=1&sa=7044>

⁴⁰ Interview, Mustapha Dowuona, June 12, 2003.

⁴¹ A. Barnett et. al., "economics of pharmaceutical policy."

medicines, whether herbal, patent or pharmaceutical, are used beyond the oversight of physicians. Kodjo Senah has offered evidence from Bortianor (a Ga village outside Accra) that demonstrates how the proliferation of pharmaceuticals has turned health into “transactionable goods” in a way that makes a patient beholden to market rates for medicines.⁴² Other studies of consumption patterns have shown how patients have used commodified medical products as a means of distinguishing themselves as part of upwardly mobile social classes in the 20th century.⁴³ The space within which to investigate this phenomenon in Accra would be the Okaishie section of the Makola Market, a warehousing area that grew in the late 20th century to become an entrepot of every imaginable sort of pharmaceutical and patent medicine, including imports from China, India and Nigeria, and increasingly, locally made generics.⁴⁴ But tracking the marketing and consumption of these packaged imported medicines remedies, and the ways that people define their identity according to their regimes of self-medication, would require an extensive oral history project

⁴² Senah, *Money Be Man*, 204; Bernhard Beirlich has also observed the rise of cash payments and the expansion of the market for medical commodities in Northern Ghana. See Bernhard Bierlich, “Sacrifice, Plants, and Western Pharmaceuticals: Money and Health Care in Northern Ghana,” *Medical Anthropology Quarterly*, New Series, 13, no. 3. (Sept., 1999), 316-337; Peter Ventvogel has pointed out that Akan-speakers in Ghana at the end of the 20th century were “using natural explanations of disease more often than supernatural explanations” leading to the pre-eminence of pharmaceutical or herbal cures. See Peter Ventvogel, *Whiteman’s Things: Training and detrainning healers in Ghana* (Amsterdam: Het Spinhuis, 1996), 20.

⁴³ van der Geest & Whyte, “The Charm of Medicines,” 348-50; Whyte, *Questioning Misfortune*; Senah, *Money Be Man*.

⁴⁴ Interview, Auntie Charlotte, June 18, 2007; Interview, Mabel Taylor, May 23, 2006. Makola Market now stands just north of the old Selwyn Market, which was demolished by the AFRC under Jerry John Rawlings in 1979. It has been suggested that the etymology of Makola is Yoruba meaning “lucky child,” a reference to the labour of children in the market, who were thought to bring good luck to the stalls. The Nigerian roots of the word speaks to the diversity of traders in Accra during the 20th century. Calus Von Brazi, “Controversy Unlimited: The Nigerian “Re-invasion” Of Ghana,” *Ghana Web News*, accessed September 14, 2009, <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=168530>.

that would gather information from chemists working at large medical institutions, itinerant vendors of off-the-shelf products, and herbalists in the city. Such a project would require its own funding, as well as clear ethical and research guidelines.

Another problem is that herbal remedies, dubious bottled panaceas, pharmaceuticals and counterfeit drugs all share the same space at market stalls in Accra today.⁴⁵ While many reliable local herbals have been vetted by the Ghana Standards Board in Ghana or the Centre for Scientific Research into Plant Medicine, they share the market with many other unregulated products that claim to cure everything from epilepsy to Ebola, and that may be mixtures of herbs and pharmaceuticals.⁴⁶ Counterfeit pharmaceuticals are also a problem. The Ghanaian government has been tracing the sources of counterfeit medical products over the past few decades, and has recently prohibited medical imports from neighboring countries in West Africa such as Nigeria and Togo.⁴⁷ However, a quick walk around Okaishie Market indicates that fake medicines from around West Africa and from China are still finding their way into Accra.⁴⁸ The “Destination Inspection” program, initiated in 2010 by the Ghana Standards Board, seeks to halt the importation of high risk goods at the ports and borders, but since controlling the distribution and consumption of medicines in Ghana

Drug companies like Aryton are now listing on the Ghana Stock Exchange and generic drug producers like Ernest Chemists play a major role in distributing pharmaceuticals in the city.

⁴⁵ Senah, *Money Be Man*, 8-9.

⁴⁶ Myjoyonline.com, “Ghanaian Prophet claims he has Ebola cure,” September 17, 2014, accessed October 28, 2014, <http://www.myjoyonline.com/news/2014/September-17th/ghanaian-prophet-claims-he-has-ebola-cure.php>; Emelia Ennin Abbey, “2 Arrested for producing ‘Waist & Power’ concoctions, GraphicOnline July 15, 2014, accessed October 28, 2014, <http://graphic.com.gh/news/general-news/27082-2-arrested-for-producing-waist-power-concoctions.html>.

⁴⁷ Kofi Akosah-Sarpong, “The drugs that kill by default,” *West Africa* (November 21-28, 1988), 2185; S. Ogoh Alubo, “Death for Sale: A Study of Drug Poisoning and Deaths in Nigeria,” *Social Science and Medicine*, 38, no. 1 (1994), 97-103.

⁴⁸ For example, during a series of visits to Makola in 2007 I was able to acquire Nigerian products from street vendors, and Chinese medicines brought to Ghana through the Port of Lome.

has never before been attempted, regulating the traditionally open market in medicines in a place known for its deep-seated therapeutic pluralism may prove elusive.⁴⁹

Any academic work on healing in Accra will have to reckon with a plurality of conceptions about disease aetiology, healing practices, material culture, and healthy/unhealthy spaces. Rather than granting discursive authority to a singular system, scholars will have to explain how healing knowledge is distributed amongst a plurality of changing traditions, and demonstrate how patients make therapeutic choices in their quests to be healed. Accounting for therapeutic pluralism will be difficult because it will require a multidisciplinary approach to gathering and analysing data related to various traditions, but it is necessary if the lived experiences of the residents of Accra are to be represented faithfully. As the metanarrative of medical progress gives way to a recognition of therapeutic pluralism, it is hoped that we can gain new insights about the lives of patients and healers, and their anxieties and aspirations, as they struggle to fight disease and stay healthy in a globally-connected, 21st century, African metropolis.

⁴⁹ Ghana Standards Board. *Destination Inspection Programme*, accessed March 21, 2011, (<http://www.gsb.gov.gh/site/pdf/Destination%20Inspection%20Programme.pdf>).

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