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Sanitation and Public Hygiene in the Gold Coast (Ghana) from the Late 19th Century to 1950

Akwasi Kwarteng Amoako-Gyampah

201090802

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Supervised by Professor Natasha Erlank

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Dedication

To Nana Akwasi Amoako-Gyampah (father), Maame Akua Semwaah (mother) and
my son, Kofi Amoako-Gyampah Kwarteng



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Abstract

European narratives before the 19th century represented the Gold Coast littoral as insanitary, insalubrious and the abode of diseases that killed swiftly. Such narratives grouped the Gold Coast among West African territories that acquired the dubious reputation as the “White man’s grave”, and informed colonial efforts at sanitary reforms during the late 19th century and beyond. Nonetheless, sanitation remained an enduring challenge throughout the colonial period. Curiously, the historiography on the social history of medicine and public health has largely silenced the question of sanitation. Where it is raised, it is treated as background information to explicate a specific health phenomenon. There is, thus, no comprehensive research on the history of sanitation. This study contributes to the historiography by addressing this lacuna. By focusing on the late 19th century to 1950, this research examines the management of sanitation and public hygiene, situating the analysis within the broader context of power and control to tease out its implications for public health.

Colonial measures deployed in managing sanitation and public hygiene in the Gold Coast included the use of legislative and regulatory instruments, the provision of sanitary amenities (including, public latrines, public dustbins, incinerators, potable water, etcetera.), surveillance techniques – mainly sanitary inspection and home visits, and educational prophylactic measures such as the teaching of hygiene in schools, public lectures, and the organisation of health weeks, etcetera. Other measures targeted mainly the materiality of malaria in public spaces and included segregation, drainage construction, swamp and lagoon reclamation, larvicide application and weed control. Furthermore, the colonial administration targeted the sanitary regulation of public and dwelling spaces through town planning. Additionally, the government extended control over bakeries, public eateries, market spaces, and slaughterhouses ostensibly to ensure that food items exposed for sale to the public adhered to hygienic standards.

Although these measures manifestly targeted sanitation and public hygiene in various forms, they produced something else. They provided avenues through which the colonial administration could reorder public spaces, reorient African practices in domestic and public spaces, recast the habits and attitudes of the African population and manipulate their desires towards Euro-Western conceptions of what constituted

appropriate sanitary and hygienic practices and behaviours. Thus, the management of sanitation provided the means through which the colonial administration could assert some form of European cultural hegemony, with an intent to “civilise/modernise” a supposedly primitive population, as well as achieve some form of social control. Paradoxically, colonial attitudes towards sanitation and public hygiene remained lackadaisical, the general refrain being the lack of funds and personnel to execute sanitary reforms. This attitude to some extent, fractured the “modernising” and “control” intents that were implicit in measures targeting sanitary reforms.



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Acronyms

| | |
|--------|---|
| ADH | Assistant Director of Health |
| ADMS | Assistant Director of Medical Services |
| BOA | British Online Archives |
| CBH | Central Board of Health |
| CMO | Chief Medical Officer |
| DC | District Commissioner |
| DDSS | Deputy Director, Sanitary Services |
| DDHS | Deputy Director, Health Services |
| DHS | Director of Health Services |
| DMS | Director, Medical Services |
| DMSS | Deputy Director, Sanitary Services |
| GCLMCW | Gold Coast League for Maternal and Child Welfare |
| GCMD | Gold Coast Medical Department |
| GGC | Government of the Gold Coast |
| IAMCG | Inter-Allied Malaria Control Group |
| JSO | Junior Sanitary Officer |
| KPHB | Kumasi Public Health Board |
| LHB | Local Health Board |
| LSTM | Liverpool School of Tropical Medicine |
| NJO | Native Jurisdiction Ordinance |
| PMO | Principal Medical Officer |
| PRAAD | Public Records and Archives Administration Department |
| RSI | Royal Sanitary Institute |
| SSO | Senior Sanitary Officer |

Chapter One

Introduction

In 1872, Governor Pope Hennessey noted, that “the Gold Coast, was the most filthy and apparently neglected place” he “had ever seen under anything like a civilised government.”¹ Towns along the Gold Coast littoral were described as lacking basic sanitary facilities and, just as in other colonised territories in Africa, sanitary and health conditions were perceived as generally appalling.²³ As a result, irrespective of the true state of conditions, the British viewed sanitation as a major challenge when they declared the coastal region of the Gold Coast a crown colony in 1874. The colonisation of the Gold Coast explicitly incorporated the export of colonial ideas about sanitation, sanitary practices and hygiene codes. What happened subsequently forms the heart of this thesis.

The earliest attempt at sanitary reforms in the Gold Coast, began in the late 1870s when colonial policy dictated that they were necessary to reduce the loss of European lives.⁴ In 1878, the first public health law, *Towns, Police, and Public Health Ordinance* was passed. A little over two decades later, this ordinance was repealed and replaced with the *Public Health Ordinance* of 1892. Sanitation was central to the ordinance. It empowered the governor to demolish dilapidated buildings, while the colonial surveyor was mandated to ensure the clearing and draining of streets. The law also permitted the imposition of fines on those who committed public nuisance by way of littering or keeping insanitary environment.⁵ *The Native Jurisdiction Ordinance* which was passed in 1883 also empowered chiefs with the support of District Commissioners and medical officers to enforce sanitation bye-laws. Chiefs were

¹ Quoted in Gale, ‘The Struggle against Diseases in the Gold Coast’, 186–87.

² Stephen Kojo Addae, *The Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960* (Edinburgh; Durham USA: Durham Academic Press, 1997); Gale, ‘The Struggle against Diseases in the Gold Coast’.

³ Thomas S Gale, ‘The Struggle against Disease in the Gold Coast: Early Attempts at Urban Sanitary Reform’, *Transactions of the Historical Society of Ghana*, New Series, 16, no. 2 (1995): 185–203.

⁴ Ibid.

⁵ William Brandford Griffith, *Ordinances of the Gold Coast, Vol. II* (London: Stevens and Sons, 1898).

authorised to impose fines on persons who infringed sanitary regulations in localities where District Commissioners and medical officers were not available.⁶

In 1909, the Sanitary Branch of the Medical Department was established and was given the mandate to scrutinise all projects bearing on sanitation and public hygiene before they could be implemented. After 1910, further sanitary reforms were made. One important reform was the intensification of sanitary inspection and the consequent training of sanitary inspectors. The colonial government also initiated measures towards the maintenance of clean and spacious neighbourhoods, provision public toilet facilities, and supply of pipe-borne water. Other measures focused on the laying-out along sanitary lines towns and villages that were described as poorly planned, the proscription of home burials and the imposition of cemetery interment, and the provision and regulation of market spaces and slaughterhouses, as well as the regulation of bakeries and public eateries. Despite the centrality of the management of sanitation and public hygiene to discourses on public health, scholars who have studied the social history of health and medicine in the Gold Coast, have not given it the needed attention. This work will address this gap.

The problem underpinning this research, thus, concerns the management of sanitation and public hygiene in the Gold Coast. What I seek to do is to historicise the management of sanitation and public hygiene within the broader context of power and control and tease out its broader implication for public health. The central question I seek to investigate is: how did the management of sanitation and public hygiene and the discourses it engendered help the colonial administration to achieve its public health objectives? To answer this key question, the following related questions will be interrogated: what were the objectives of the colonial administration in relation to sanitation and hygiene? What strategies did colonial governments employ to achieve environmental sanitation and public hygiene? To what extent did these strategies work or not work and what accounted for the successes or failures? How did the local population react to sanitary regulations and the association between medical and political control which they implied? To what extent did the colonial administration

⁶ William Brandford Griffith, *Ordinances of the Gold Coast, Vol. I* (London: Stevens and Sons, 1898).

envisage sanitation and hygiene measures as tools for modernising the Gold Coast Colony?

The management of sanitation and hygiene and the entire public health administration were intimately connected with the overall administration of the Gold Coast. It is, therefore, important, by way of preliminary to sketch briefly, the basic administrative divisions. At the beginning of the 20th century, the entire landmass of what is today's Ghana was under British colonial rule.⁷ For ease of administration, the Gold Coast was divided into three administrative units. These were the Colony, sometimes referred to as the colony proper (comprising towns and villages in the southern littoral and some interior settlements), Asante, (in the centre and farther inland) and the Northern Territories (in the far north). After World War I, Britain gained control over German Togoland as Trust Colony and joined the southern part to the colony proper while the northern part was administered as part of the Northern Territories.

Accra was the capital and administrative seat where the Governor resided. Asante and the Northern Territories were administered by Chief Commissioners who reported directly to the Governor. The administrative units were further divided into Provinces and Districts. These provinces and districts were headed by Provincial and District Commissioners respectively. District Commissioners reported to the Provincial Commissioners, and Provincial Commissioners, to the Chief Commissioners. In this dissertation, unless otherwise stated, most geographical references will be based on these administrative units.

⁷ The history of the colonisation of Ghana has been extensively documented and it is therefore not necessary to repeat it here. For a good summary, see Roger Gocking, *The History of Ghana* (West Port, Connecticut: Greenwood Press, 2005).

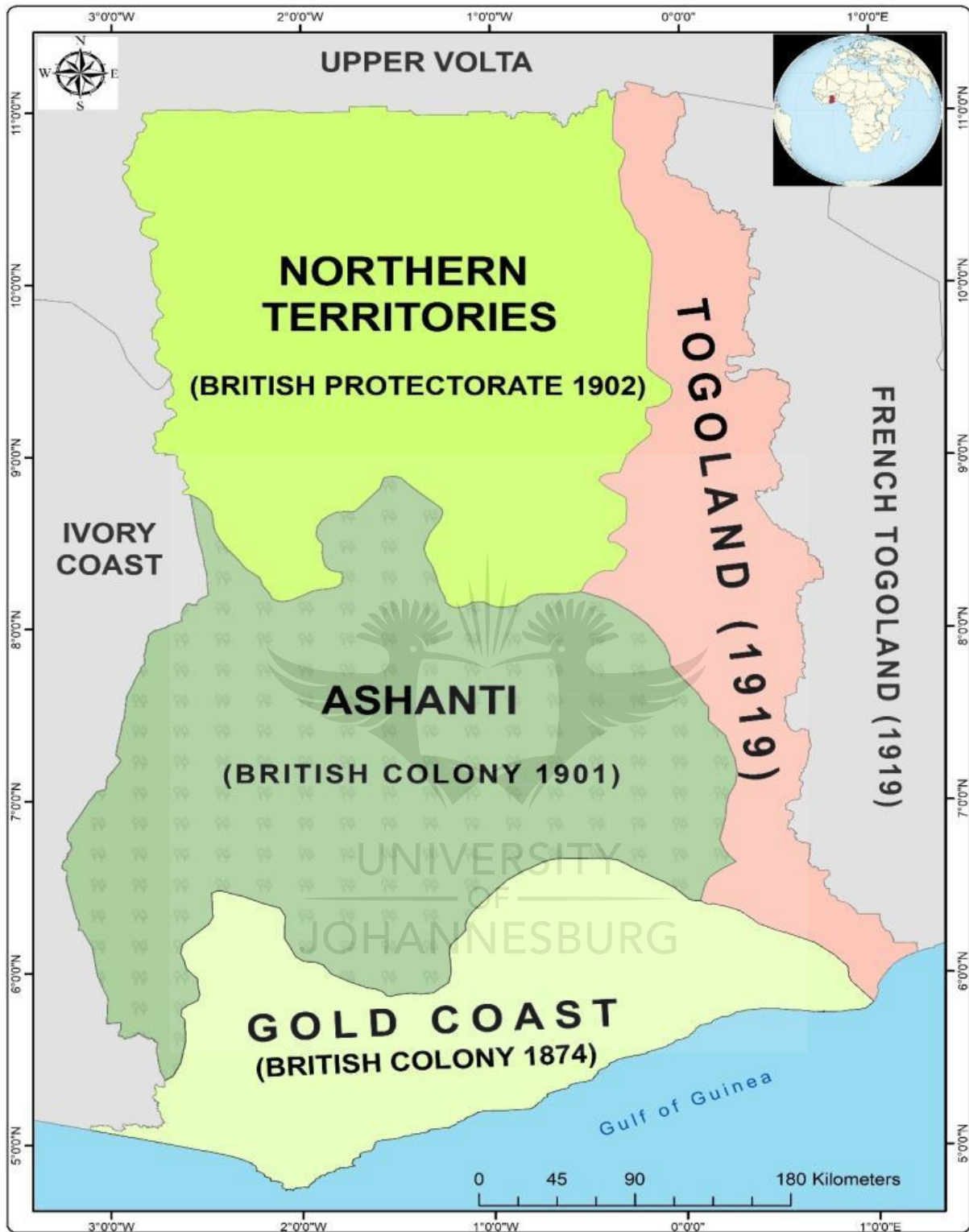


Figure 1: Map showing the Administrative division of the Gold Coast. Source: Author's adaptation.

Contextual Perspectives

From the late nineteenth century, and escalating until the Second World War, hygiene came to be a personal and political imperative and mission, a noun which spawned ever-more adjectives which connected bodily and personal to larger governmental projects: Sex hygiene, domestic hygiene, social hygiene, national hygiene, international hygiene and more. Hygiene was something which people could and did do to themselves and to each other: It was a practice. But it also had a significance greater than oneself. Victorian culture made 'cleanliness' into subjectivity, a practice which shaped one's soul.⁸

This quote reflects the preoccupation with sanitation and hygiene practices that characterised Victorian Britain and other Western European countries during the late 19th century and for most of the 20th century.⁹ Victorian Britain's recognition as the birthplace of the industrial revolution did also bestow on its cities the dubious reputation of the industrial world's most crowded, congested and disease-ridden.¹⁰ Victorian cities expanded massively during the 19th century as working-class migrants thronged to urban areas in search of employment. The resulting deplorable sanitary conditions prompted sanitary reforms during the mid-1800s.¹¹ It was these sanitary reforms which formed the crux of the zealot pursuit of hygienic principles imposed by the state which the above quotation encapsulates. As Alison Bashford has argued, hygiene came to signal a pressing need for purifying an ever-present contaminating threat as well as the "primary means of signification by which threats were specified, and internal weaknesses managed."¹²

Medical research and changes in aetiological thought also influenced the obsession with sanitation and hygiene in Victorian Britain. Before the late 19th century, the most widely accepted aetiological thought was the miasmatic theory which held that communicable diseases arose from foul air produced by decaying organic

⁸ Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (Palgrave Macmillan, 2004), 4–5.

⁹ See for example, Zdatny's account of hygiene in France. Steven Zdatny, 'The French Hygiene Offensive of the 1950s: A Critical Moment in the History of Manners', *The Journal of Modern History* 84, no. 4 (December 2012): 897–932.

¹⁰ Ambe J. Njoh, *Urban Planning and Public Health in Africa: Historical, Theoretical and Practical Dimensions of a Continent's Water and Sanitation Problematic* (Farnham, Surrey: Ashgate, 2012), 8–9.

¹¹ see George Rosen, *A History of Public Health*, revised expanded edition (Johns Hopkins University Press, 2015); Alan Petersen and Deborah Lupton, *The New Public Health: Health and Self in the Age of Risk* (London: Sage, 1996).

¹² Bashford, *Imperial Hygiene*, 5.

substances. By the early 19th century, this theory had been modified. The new version emphasised poor sanitation as the cause of atmospheric conditions that caused epidemics. The remedy advocated, therefore, was environmental cleanliness. However, during the late 19th century, with progress in bacteriological and parasitological research, this medical opinion slowly began to change.

The findings of Louis Pasteur, Robert Koch and William Gorgas, Ronald Ross and Patrick Manson, cumulatively revolutionised scientific understanding of the causes and spread of life-threatening diseases.¹³ Their research established that bacteria and parasites were the causative organisms of disease transmission rather than atmospheric conditions. Henceforth, human beings were seen as vectors of diseases and therefore personal hygiene was advocated. The advances in medical knowledge also clearly demonstrated the link between disease and environment and provided arguments for the scientific basis of environmental control that seemed to offer possibilities for controlling diseases.¹⁴

While this knowledge resulted in the acceptance of the germ theory of disease and the promotion of scientific health measures in Britain and other parts of Europe, it also facilitated the penetration of colonial rule into the interior of the West African littoral and other tropical environments.¹⁵ A significant development during this period was the discovery of the mosquito as the vector for the transmission of malaria and yellow fever; the two diseases that earned most parts of West Africa the dubious reputation as the “White Man’s grave.”¹⁶ The discovery of the tsetse fly as the bearer of the trypanosome that caused trypanosomiasis was also a great relief to the colonialist. These diseases were invariably traced to insanitary environmental conditions, but also, to human agency.

¹³ William Beinart and Lotte Hughes, *Environment and Empire*, 1 edition (Oxford: Oxford University Press, 2009); David Killingray, “A New Imperial Disease’: The Influenza Pandemic of 1918-9 and Its Impact on the British Empire,” *Caribbean Quarterly*, 2003, 30–49.

¹⁴ Beinart and Hughes, *Environment and Empire*.

¹⁵ Virginia Berridge, Martin Gorsky, and Alex Mold, *Public Health in History*, 1 edition (Maidenhead: Open University Press, 2011); Raymond E. Dumett, ‘The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898 - 1910’, *African Historical Studies* 1, no. 2 (1968): 153–97.

¹⁶ see Philip D. Curtin, “The End of the ‘White Man’s Grave’? Nineteenth-Century Mortality in West Africa,” *Journal of Interdisciplinary History* 21, no. 1 (1990): 63; Philip D. Curtin, “‘The White Man’s Grave’: Image and Reality, 1780-1850,” *The Journal of British Studies* 1, no. 1 (1961): 94–110.

After the discovery of the germ theory, there was a renewed emphasis on the necessity for sanitised environment and personal cleanliness. This, naturally, led to a belief in preventive health and ultimately found expression in colonial policy. Historically, Europe and the West benefitted from taking advantage of the germ theory to press sanitary and public health reforms. It was, therefore, not surprising that contemporary European scientific ideas about the link between environment, disease and health were exported to Africa and Asia and applied in policy decisions bearing on public health.

During the late 19th century when colonial rule was formally imposed in Africa, colonial administrators viewed Africans as lacking in knowledge about sanitation and hygiene. The African environment, especially, the coastal regions were described before and during the 19th century as an area “inhabited by savages, rife with horrible diseases which killed swiftly.”¹⁷ Colonial officials and European medical ‘experts’ tended to blame the social customs and habits of Africans as contributing to the diseased environment and the spread of diseases.¹⁸ The colonial state, therefore, sought to intervene to control the spread of diseases and, most importantly, to protect the health of Europeans.

State intervention in controlling diseases took various forms and had a profound impact on the health of Africans and the colonial environment. Indeed, state intervention became the vehicle through which colonial subjects practically experienced political and social control.¹⁹ Initial disease control measures often appeared in the form of sanitation and hygiene policies and ordinances with a focus on prevention. In most parts of British West Africa, for example, the Sanitary Department was created during the first decade of the 20th century to promote environmental sanitation, hygiene and public health. Among its functions, the Sanitary Department was mandated to conduct inspections in homes and in communities to ensure that people complied with statutory rules and norms on sanitation and public

¹⁷ Addae, *The Evolution of Modern Medicine in a Developing Country*, 18.

¹⁸ Timothy Burke, *Lifebuoy Men, Lux Women: Commodification, Consumption, and Cleanliness in Modern Zimbabwe* (Duke University Press, 1996).

¹⁹ Beinart and Hughes, *Environment and Empire*; David K. Patterson and Gerald Hartwig W., ‘The Disease Factor: An Introductory Overview’, in *Disease in African History: An Introductory Survey and Case Studies*, Duke University Centre for Commonwealth and Comparative Studies 4 (Durham, N. C.: Duke University Press, 1978), 3–24.

health. The essence was to ensure public hygiene and a sanitised environment and ultimately prevent disease outbreaks. Without a doubt, Britain's attitude towards sanitation and hygiene had a profound influence on her colonial public health policies, and the Gold Coast being a model British colony in sub-Saharan Africa was a focal point for the implementation of the policies.

Conceptual Considerations

Sanitation, Hygiene and Public Health: Context and Provenance

In this section, I review the concepts of sanitation and hygiene, how they have been linked to disease aetiology and in what ways they have been central to discourses on public health from a Euro-Western perspective. This is necessary because, as I show in subsequent chapters, colonial discourses on sanitation, hygiene and public health in the Gold Coast were partly conditioned and shaped by Euro-Western aetiological thoughts of the late 19th and early 20th centuries. I also review how pre-colonial African societies conceptualised health and what measures they adopted to maintain community health.

The terms sanitation and hygiene are difficult to define. Claire Hooker has, for instance, argued that during the 20th century scholars including sociologist and historians used the term "sanitary" in derogatory ways because they often contrasted "modern' bacteriological public health with 'older', 'sanitarian' cleansing practices and mistaken miasmatic theories."²⁰ Hooker's assertion implies that what constituted sanitary practices in Euro-Western aetiological thought during the 20th century was markedly different from what sanitation meant to people in preceding centuries.

For example, David Armstrong defines sanitary science as a mid-19th century practice which identified the spaces of bodies as distinct from the environment.²¹ For Armstrong, 19th century sanitary practices were concerned mainly with the "socially-constructed natural environment" such as "buildings, dwellings and habitations."²² He

²⁰ Claire Hooker, "Sanitary Failure and Risk Pasteurisation, Immunisation and the Logics of Prevention," in *Contagion: Historical and Cultural Studies*, ed. Alison Bashford and Claire Hooker (London: New York: Routledge, 2001), 130.

²¹ David Armstrong, 'Public Health Spaces and the Fabrication of Identity', *Sociology* 27, no. 3 (1 August 1993): 401.

²² *Ibid.*, 396.

argues that by its preoccupation sanitary science delineated a boundary that “marked the separation of the space of the body from the space of geography,” and in doing so, established the physical environment as exterior to the body.²³ Thus, to maintain the public health, 20th century sanitary science focused on policing the boundary between the body and the physical environment and “its regime of hygiene developed as the monitoring of matter which crossed between these two great spaces, especially in its manifestation as dirt.”²⁴ Nonetheless, Armstrong contends that the beginning of the 20th century marked a shift towards an era in sanitary science that emphasised personal hygiene whose features were practices that concentrated on the spaces between bodies.²⁵

Lupton and Petersen, on the other hand, defines sanitation to include a range of environmental and social policies that characterised the emergence of bacteriology during the late 19th century, which they argue, re-oriented public health ideology and practice to focus on “narrow, individuated, microbe-hunting policies.”²⁶ Nancy Tomes corroborates Lupton and Petersen when she notes that even though the germ theory of disease was initially integrated into established frameworks of sanitation its centrality diminished in favour of ‘individuated microbe-hunting public health in the 1920s.’²⁷ From these definitions, it can be inferred that Armstrong, Lupton and Petersen, as well as Tomes, discount incipient sanitary practices in societies preceding the 19th century.

Providing a much-nuanced definition, Claire Hooker states that:

Sanitation has...come to refer above all to the classic practices of the mid-nineteenth century British Public Health (sewerage and water purification systems, garbage removal and nuisance acts, poor law reforms), to a public health characterised by broad environmental and social reforms as opposed to the control of individual.²⁸

²³ Ibid.

²⁴ Ibid.

²⁵ Ibid., 396–401.

²⁶ As cited in Hooker, ‘Sanitary Failure and Risk Pasteurisation’, 131.

²⁷ see *ibid.*

²⁸ Ibid.

She notes further that, “saturated in moral implications, it preceded and was differentiated, though not banished, from its modern scientific form.”²⁹ It will be seen from Hooker’s definition that even while emphasising mid-19th century sanitary practices, she does acknowledge the imprint of the past on so-called mid-19th century scientism that characterised sanitation and sanitary practices. For this study, Hooker’s definition is most useful.

The term hygiene, on the other hand, is used as a referent for health practices through which sanitation is produced. It is broadly implicated in the complexity of the social values and sentiments of societies and may relate to issues about privacy, intimacy, neatness, social prestige, and convenience.³⁰ Dorothy Porter contends that hygiene was an ancient philosophy of health which became commonly practised in Britain from the 18th century and beyond.³¹ According to Foucault, the notion of hygiene connotes “rule(s) of life and a form of preventive medicine which emerged during the 18th century as “a regime of health for the population.” Foucault notes that the programme of hygiene adopted varying authoritarian medical interventions and controls that focused *inter alia* on the surveillance and control of urban spaces which were deemed to “constitute the most dangerous environment of the population.”³² The significance of the idea of hygiene increased during the first half of the 19th century as it was seen to provide a potential solution to the devastating epidemics that confronted most European societies. Claire Hooker notes that hygiene emerged as a major technique of “social government” in Europe during the 19th and 20th centuries as governments adopted measures such as garbage and night soil removal, provision of ventilation devices in houses, and limited industrial waste.³³

Thus, Hooker contends that the 19th and early 20th centuries could well represent the “hygienic era”. She argues that the miasmatic theory of disease fed the environmental focus of techniques of hygiene and was shaped and conditioned by an

²⁹ Ibid.

³⁰ Sjaak van der Geest, “Hygiene and Sanitation: Medical, Social and Psychological Concerns,” *CMAJ: Canadian Medical Association Journal* 187, no. 17 (November 17, 2015): 1313–14.

³¹ Dorothy Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times* (London; New York: Routledge, 1999).

³² Michel Foucault, ‘The Politics of Health in the Eighteenth Century’, in *The Foucault Reader*, ed. Paul Rabinow (New York: Pantheon Books, 1984), 282.

³³ Claire Hooker, “Hygiene - Hygiene and Public Health, 1700–1945,” accessed May 5, 2017, <http://science.jrank.org/pages/9722/Hygiene-Hygiene-Public-Health-1700-1945.html>.

increasing obsession with personal cleanliness which was steeply influenced by an 18th century French aristocratic mannerly culture. A culture that emphasised a kind of hygienic regime that was distinct “from its predecessors by its cleansing rituals, from nose-blowing to bathing.”³⁴ For most of the 20th century, in Europe, “hygiene became a duty and a responsibility that individuals owed the state.”³⁵ Alison Bashford argues that, everywhere, concerns over hygiene resulted in the creation of institutions and public health practices that helped considerably to reduce mortality and produced what seemed acceptable to many, “a desirable order, cleanliness and safety.”³⁶ This position is reinforced by Deborah Lupton who argues that hygiene, cleanliness and dirt became intimately linked with notions concerning societal order and control.³⁷

The notions of sanitation and hygiene have been historically variable, and so have their meanings. However, whatever way they were understood, they informed aetiological thoughts and the evolution of principles towards the protection of both individual and community health as well as the maintenance of social order in most societies. Dorothy Porter, writing on public health in Europe from ancient to modern times have demonstrated that, concerned with the need to protect both individual and community health the elite and nobility in ancient societies were guided by the principles of sanitation and hygiene in the creation of healthy settlements. She argues that incipient forms of sanitary engineering in ancient civilisations were practical expressions of the concern for the well-being of “the ideal community and of a self-governing elite.”³⁸ George Rosen’s account of health-related problems in ancient human settlements, on the other hand, has provided evidence of sanitary arrangements in societies in the Indus Valley in India, Egypt, and in ancient Greece, to suggest that these ancient societies took the question of sanitation and hygiene seriously in their efforts to deal with disease outbreaks.³⁹

However, these incipient concerns with sanitation and hygiene in ancient societies were justified not only on material basis but also, on spiritual grounds. Porter writes that in ancient societies in Europe, several measures that were adopted to

³⁴ Ibid., 1.

³⁵ Bashford, *Imperial Hygiene*, 21.

³⁶ Ibid., 6.

³⁷ Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body*, 3 edition (SAGE Publications Ltd, 2012).

³⁸ Porter, *Health, Civilization, and the State*, 10.

³⁹ Rosen, *A History of Public Health*.

prevent diseases and secure individual and community health were often imbued with spiritual symbolism even if they were products of rational thought.⁴⁰ Thus, ancient protocols of health and cleanliness, along with relics of sanitary engineering maintained an inextricable link between notions of cleanliness and godliness.⁴¹ As Rosen has illustrated, in ancient societies such as the Egyptians, Mesopotamians, Hebrews and Incas, the maintenance of clean environment and personal appearance was not based so much on health considerations, but rather on the need to be pure in the sight of the gods.⁴² Porter notes that even in 13th century Europe, methods of personal and public hygiene were often integrated into schemes that were geared not only toward disease prevention and the avoidance of sickness but also, the maintenance of a salubrious spiritual and physical environment.⁴³ It is perhaps this conflation of spiritual and material concerns which characterised sanitation and hygiene measures in ancient societies that explains why scholars like Armstrong, Lupton and Petersen, and Tomes delimit their definitions of sanitation to 19th century sanitary practices.

As scientific knowledge improved, and more information became available regarding the source of, and means of disease transmission, sanitary beliefs and hygienic practices were also altered. Put differently, new knowledge that led to better understanding of the environment, aetiology and the maintenance of health refocused sanitary concerns and its concomitant hygienic codes. For instance, beliefs and practices that were considered to conform to sanitary and hygienic standards during the middle ages in parts of Europe were considered repulsive during the 19th century. An example was the controversy over the health benefits of water to the human body.⁴⁴

According to William Cohen during the 16th and 17th centuries, “immersing the body in water was long thought to be dangerous rather than salubrious, because of fears of waterborne plague and contagion penetrating the body.”⁴⁵ The understanding was that keeping the body healthy required closing the body’s orifices by applying skin

⁴⁰ Porter, *Health, Civilization, and the State*, 10.

⁴¹ Ibid.

⁴² Rosen, *A History of Public Health*.

⁴³ Porter, *Health, Civilization, and the State*, 26.

⁴⁴ see Zdatny, ‘The French Hygiene Offensive of the 1950s’.

⁴⁵ William Cohen A., ‘Introduction: Locating Filth’, in *Filth, Dirt, Disgust and Modern Life*, ed. William Cohen A. and Ryan Johnson (Minneapolis; London: University of Minnesota Press, 2005), xviii.

coatings (in the case of children) or by wearing tightly-knit clothing which prevented the entry of unwholesome air into the surface of the body. Water was perceived to have weakening effects on the skin. Such assumptions about the permeability of the body and the consequent sanitary and hygienic codes that were enacted to protect the body against diseases were fed by the prevalence of epidemics and the environmental determinist view of disease causation which was the orthodoxy throughout the middle ages until the emergence of the scientific model of medicine.⁴⁶

However, within the context of a clearer understanding of the physiology of the human body and a shift in attitude towards dirt during the latter part of the 18th century, washing the body in water in most parts of Europe became, once again, important to the idea of cleanliness.⁴⁷ Deborah Lupton argues that the equation of the body with a machine during the 18th century brought with it a new understanding of the usefulness of water to the body. Water was now seen to have properties that could strengthen the body, stimulate circulation, and provide the body with firmness.⁴⁸ Opening the orifices of the body, rather than keeping them closed to free the skin by removing dirt was now emphasised. Lupton notes that “with the scientific discovery of microbes in the late 18th century, external signs of cleanliness were no longer considered sufficient. These theories were legitimised by science; washing was seen to rid the body of microbes and release it from the danger of rotting matter.”⁴⁹ During this period, what mattered was the quality of air which became the significant marker of cleanliness and healthfulness, and sanitation was thus equated with getting rid of bad odour, both of individuals and places.⁵⁰

As new knowledge developed and the link between sanitation, hygiene and the maintenance of health became clearer, much attention became focused on the dangerous disease of large populations. However, it was the increasing growth in urban population concomitant with industrialisation in 19th century Europe, which having led to overcrowding, unremitting squalor and outbreaks of epidemics, that lent

⁴⁶ Lupton, *Medicine as Culture*; Matthew Gandy, *The Fabric of Space: Water, Modernity, and the Urban Imagination* (Cambridge: The MIT Press, 2014), 13.

⁴⁷ Gandy, *The Fabric of Space*, 13.

⁴⁸ Lupton, *Medicine as Culture*, 35.

⁴⁹ *Ibid.*

⁵⁰ see Alain Corbin, *The Foul and the Fragrant: Odor and the French Social Imagination*, Reprint edition (Harvard University Press, 1988); see Cohen, “Introduction: Locating Filth.”

a sense of urgency, which eventually led to a medico-administrative knowledge that focused on the urban poor.⁵¹ For instance, during the 19th century when faced with a scourge of infant mortality, cholera outbreaks and high incidence of typhus amongst the economically vulnerable population, Britain was compelled to seriously consider the provision of clean water necessary for domestic chores and the maintenance of domestic hygiene to its urban poor.⁵² At the same time, Britain was forced to initiate environmental and preventive medical reforms which targeted the urban poor to mitigate disease outbreaks. Spearheaded by new bearers of a professionalised hygienic ideology – medical officers of health – these reforms had a profound effect on domestic consciousness which helped to minimise apathy towards infectious disease and encouraged new hygienic and sanitation practices within the home.⁵³

Edwin Chadwick, an English social reformer and civil servant who was one of the key advocates of sanitary reforms in Britain during the 19th century championed the implementation of what he called “the sanitary idea”. This idea emphasised the formation of a public health authority to assume responsibility for ensuring the provision of drainage, cleansing, paving, potable water as well as sanitary regulations to manage dwellings, nuisances and offensive trades.⁵⁴ Chadwick’s sanitary idea was premised on the belief that disease was caused by filth and that disease could be prevented by constructing civil engineering works that provided sewage and drainage as well as clean water.⁵⁵

These mid-19th century sanitary reforms in Britain were adopted throughout Western Europe and other Western countries. Faced with similar urban conditions as those in Britain, most cities in Europe and the Western world launched campaigns during the mid-19th century and beyond to regulate cleanliness and dirt.⁵⁶ However, the nineteenth-century European campaigns to prevent diseases and rid cities of filth became a proxy for state intervention and regulation of individual bodies and

⁵¹ Petersen and Lupton, *The New Public Health*, 91–93; Rosen, *A History of Public Health* Chapter VI.

⁵² Porter, *Health, Civilization, and the State*, 78.

⁵³ Ibid.

⁵⁴ see Pratik Chakrabarti, *Medicine and Empire, 1600-1960* (Basingstoke: Palgrave MacMillan, 2014).

⁵⁵ Porter, *Health, Civilization, and the State*, 78; John V. Pickstone, ‘Dearth, Dirt and Fever Epidemics: Rewriting the History of the British “Public Health”, 1780-1850’, in *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, ed. Terence Ranger and Paul Slack (New York: Cambridge University Press, 1992), 125–48.

⁵⁶ see Rosen, *A History of Public Health*; Njoh, *Urban Planning and Public Health in Africa*.

freedoms, especially, the bodies of the urban poor. Again, it allowed the bourgeois class to create new forms of identity. Cohen observes that the bourgeois in most parts of Europe relentlessly appropriated the notions of filthiness and stench, captured in public health discourses to justify the need for surveillance and control of the poor and the working class as they, the bourgeois class positioned themselves as the 'clean other'.⁵⁷

Cohen states, thus:

The great nineteenth-century campaigns to eradicate disease and cleanse the cities of their filth were at once vast improvements and often violently discriminatory; as the monumental installation of metropolitan sanitation systems, the regulation of food and water quality, and campaigns against contagious diseases dovetailed with the increasing state regulation of individuals' bodies and freedoms, the disenfranchised – the poor, women, foreigners – suffered first and worst.⁵⁸

Public health discourses during the 19th century and the early part of the 20th century was moralistic and judgemental preferring to draw binaries between dangerous and safe populations. As Petersen and Lupton argue, public health discourses in Britain, Australia, and Northern America represented slum areas in industrial cities like London, Manchester, Sydney, San Francisco and New York as dangerous not only because of their unremitting insanitary conditions, but because of the proletariat and the urban poor (and in the case of Australia and Northern America, the ethnic minority) who inhabited these areas. Such people were presented as “contagious” and the spaces they inhabited as “breeding grounds of filth and squalor.” The urban poor and ethnic minorities were “constructed” as “bestial, incapable of self-regulation while the bourgeoisie was positioned as the neutral observers of their degradation.”⁵⁹

Public health reformers of the 19th century and beyond believed that apart from the spread of infectious diseases, overcrowding could result in high risk of non-infectious diseases, increased crime, mental illness and other social vices. To deal with overcrowding, filth, squalor, pollution, among other insanitary conditions, some public health reformers proposed the creation of ideal communities “in which all

⁵⁷ Cohen, 'Introduction: Locating Filth', xx.

⁵⁸ Ibid.

⁵⁹ Petersen and Lupton, *The New Public Health*, 92.

houses” were to enjoy “natural ventilation, sunlight and gardens.” Gardens and parks, notes Petersen and Lupton, were reckoned to be the “lungs of cities and towns” supplying fresh air to resuscitate wearied urban dwellers.⁶⁰

The latter part of the 19th century and the beginning of the 20th century was a watershed moment for the discourse on sanitation and hygiene. Sanitary reform was translated into social movements that were fed by political and economic imperatives. The idea of state or political medicine was highly advocated. Porter notes that “Sanitary reform and state medicine” were now underscored by “a belief in the environmental determinants of disease, the remedy for which was political intervention followed by bureaucratic measures of administration for regulating the health of communities.”⁶¹ Yet, the period also witnessed a surge in research in bacteriology which was expected to feed into public health work, both as a diagnostic tool and as a method for tracing the mode of disease transmission. And this significantly altered the environmental model of disease prevention that was underscored by the sanitary idea of Chadwick.⁶²

One of the greatest discoveries of bacteriological research was that the greatest agent for spreading diseases was the human carrier. This discovery implied that the individual could no longer be regarded as an isolated health unit, but rather as the bearer of the social relations of health and illness. This understanding refocused procedures of disease control from emphasis on the environment to the individual as the vector of transmission. Thus, the mode of disease transmission became the new focus of disease prevention and this shaped further, ideas on sanitation and hygiene. The argument for disease prevention, now, entailed dealing with filth not only in the external urban environment but also with insanitation and unhygienic practices within dwellings, factories and other public spaces. The understanding gained from bacteriological research did not, however, diminish the significance of the previous miasmatic theory of aetiology entirely. Rather, it broadened the scope of what comprised the environment of disease – to embrace both the physical environment and the social behaviour of individuals.⁶³

⁶⁰ Ibid., 93.

⁶¹ Porter, *Health, Civilization, and the State*, 164.

⁶² see Porter, *Health, Civilization, and the State*.

⁶³ see *ibid.*

These notions of sanitation and hygiene discussed above are useful to the present study because European ideas on hygiene and sanitation were transported to, and imposed on Africa, sometimes in their most perverted, repressive and racialised forms, as colonial rule made inroads on the continent. Stated differently, European notions of sanitation and hygiene found expression in colonial medical and health policies, even if they were not directed towards the same end as in Europe. As Njoh argues, the philosophy that underpinned colonial sanitation and hygiene policies in Africa were distinct from what prevailed in Europe. He contends that whereas in Britain, for example, sanitary reforms were anchored on the utilitarian principle of the greatest good for the majority, in Africa, colonial administrators were concerned with the health of Europeans at the expense of the African majority. And where sanitary and health services were extended to Africans it was only because that was necessary to prevent the spread of diseases to Europeans living in the colonies, or to facilitate the reproduction of labour for the colonial economy.⁶⁴

Health in Pre-colonial Africa

Like other societies in different parts of the world, African societies had standards of personal and community cleanliness before their contact with Europeans.⁶⁵ And while some early European travellers to Africa hastily discounted and passed disparaging remarks about the sanitary and health status of coastal settlements, others linked such insanitary conditions to the influence of so-called European “civilisation”. Molony-Kimberly, a European colonial official observed in the 1880s that sanitation in the West African littoral where European “civilisation” had influenced people’s habits was far inferior compared to the interior towns where Europeans were yet to make contact and whose indigenous ways of maintaining sanitation and hygiene remained intact.⁶⁶

In most pre-colonial African societies, the maintenance of hygiene and sanitation in public spaces such as markets, the chief’s court, banks of river bodies, footpaths, among others, were the responsibility of the entire community. Special days were set aside when all persons in the community, except invalids, were required to

⁶⁴ Njoh, *Urban Planning and Public Health in Africa*, 8.

⁶⁵ Patterson and Hartwig, ‘The Disease Factor: An Introductory Overview’.

⁶⁶ Cited in T. S Gale, ‘Official Medical Policy in British West Africa’ (University of London, School of Oriental and African Studies, 1972), 48.

participate in the sanitary upkeep of their community. It was the practice, also, in most African societies for community members to collect rubbish and burn it in designated places every morning.⁶⁷ The organisation and distribution of such sanitary tasks was the responsibility of the ruling class.⁶⁸ According to Casely Hayford in pre-European Gold Coast, headmen of villages supervised women who were responsible for keeping their homes and their portion of the neighbourhood clean, as men cleared the footpath and constructed and maintained communal latrines.⁶⁹ In Asante, there existed an elaborate public service scheme for maintaining sanitation which was headed by a chief who was the occupant of the *Akwanbofofo* stool.⁷⁰

Pre-colonial African societies adopted varied strategies to deal with health-related challenges. To prevent environmental pollution, the ruling elites made laws that criminalised insanitary behaviour. For example, it was forbidden in most African societies to defecate or dump waste near river bodies or any source of water – and there were several of such taboos that regulated sanitation and hygiene in African societies. In times of epidemic outbreaks, ruling elites in pre-colonial African societies took stringent measures such as curtailing peoples' movement, prohibiting public gatherings and conjugal relations and any other activity that was reckoned to be conducive to promoting human contact.⁷¹ Donna Maier writes that the Asante of present-day Ghana, for example, made border arrangements that prevented infected persons in the event of an epidemic outbreak, from entering Kumase, the Asante capital.⁷²

The medico-religious nature of pre-colonial African health systems fed sanitary and hygiene practices, and this was not different from what prevailed in ancient Euro-Western societies. In Pre-colonial Zimbabwe, for example, the fear of witch-craft informed many of their sanitary and hygienic practices – and these were aimed mainly to protect people from evil influences. As Burke notes, people concealed faeces, urine

⁶⁷ Njoh, *Urban Planning and Public Health in Africa*.

⁶⁸ Ambe J. Njoh, "Ideology and Public Health Elements of Human Settlement Policies in Sub-Sahara Africa," *Cities* 26 (2009): 9–18.

⁶⁹ J. E. Casely Hayford, *Gold Coast Native Institutions: With Thoughts upon a Healthy Imperial Policy for the Gold Coast and Ashanti* (Frank Cass & Co. Ltd., 1970).

⁷⁰ see Donna Maier, 'Nineteenth-Century Asante Medical Practices', *Comparative Studies in Society and History* 21, no. 01 (1979): 63–81. More on this in the next chapter.

⁷¹ Gloria Waite, 'Public Health in Pre-Colonial East-Central Africa', *Soc. Sci. Med.* 24, no. 3 (1987): 197–208.

⁷² Maier, 'Nineteenth Century Asante'.

and other secretions not only because they were seen to be pollutants, but also, because of the belief that witches could deploy them to cause harm to individuals from whom such secretions emanated.⁷³ Important festivals and rituals in most pre-colonial African societies also had hygienic rules or practices connected to them. For example, the *bragoro* initiation (female nubility rites) of the Akan of Ghana featured rules regarding washing and presentation of the body.⁷⁴ Similarly, the annual *Odwira* (cleansing) festival of the Akan as the name suggests, among other things, related to purifying, sanctifying, and cleansing the communities of both spiritual and physical contamination.⁷⁵

Apart from keeping their environments clean, in pre-colonial African societies, people also paid attention to personal hygiene. Writing in 1874, Marcus Allen, a surgeon and an adventurer, made this remark of the Fante of the Gold Coast. “The expression of countenance in the Fante is far from agreeable, in both men and women, their teeth are beautifully white and regular, and they pay much attention to cleaning them after every meal; and sometimes but not frequently, a girl may be met with whose features are decidedly pretty.” He noted further that “...both sexes” were “remarkably clean in their person and habits.”⁷⁶ Such attention to personal hygiene as Marcus Allen observed among the Fante was common among most pre-colonial African Societies.

According to Burke, in pre-colonial southern Africa, people had clearly defined ideas about what “constituted proper physical appearance and personal manners” as well as “clearly defined hygienic rules and codes.”⁷⁷ He noted that it was a common practice among pre-colonial Zimbabweans, for instance, to smear their bodies with a mixture of soil and some kinds of oil. And the hygienic justification of such practices was that it served as a protective coat to keep the body safe from dirt and from cracking and drying.⁷⁸ A similar practice prevailed in pre-colonial Khoikhoi society. Russel Viljoen writes that women and children applied lubricants made of sheep fats, soot, and ashes to their bodies, powdered their hairs with a yellowish “powder, and

⁷³ Burke, *Lifebuoy Men, Lux Women*.

⁷⁴ Peter Sarpong, *Girls' Nubility Rites in Ashanti* (Ghana Pub. Corp., 1977).

⁷⁵ Frank Kwesi Adams, *Odwira and the Gospel: A Study of the Asante Odwira Festival and Its Significance for Christianity in Ghana* (OCMS, 2010).

⁷⁶ Marcus Allen, *The Gold Coast or A Cruise in West African Waters* (London: Hodder and Stoughton, 1874), 23.

⁷⁷ Burke, *Lifebuoy Men, Lux Women*, 24.

⁷⁸ *Ibid.*, 25.

beautified their skins with sweet-smelling herbs”, not just for its aesthetics, but as a means of disease prevention.⁷⁹

Washing the body with water was a regular practice in most pre-colonial African societies. Burke writes that washing the body was a regular part of pre-colonial Zimbabwean hygienic repertoire, which was even made into a ritual affirmation of the conjugal relationship between men and women. He writes: “in some places, wives were expected to attend to the washing of a husband’s face and hands in the morning.”⁸⁰ In some houses, there existed small enclosures, sometimes, partitioned into separate sections that were used by men and women for washing. Children were taught practices of hygiene and manners. They were expected to bath regularly, taught to use the right hand, and general cleanliness; and mothers bathed infants.⁸¹

Donna Maier notes that the regular rainfall pattern in Asante ensured regular bathing amongst the people.⁸² It is evident then, that contrary to claims by some Europeans of the absence of notions of cleanliness in pre-colonial Africa, pre-colonial African societies had a keen awareness of the problems of filth and insanitary conditions, and therefore, devised ingenious hygienic codes and sanitary regulations to deal with it. It would thus seem that it was rather the imposition of European colonial rule with its associated western value systems that supplanted and diminished the pre-eminence of pre-colonial African practices that could conduce to hygiene and sanitation of their towns and villages.

Historiographical Trajectories

Colonialism, Western Medicine and Public Health in Africa

The history of medicine, health and disease in Africa has moved from being a neglected field in the 1970s to a burgeoning scholarly enterprise.⁸³ The range and diversity in the literature have been most impressive and revealing. Generally, two

⁷⁹ Russel Viljoen, ‘Medicine, Health and Medical Practice in Precolonial Khoikhoi Society: An Anthropological-historical Perspective’, *History and Anthropology* 11, no. 4 (January 1999): 518.

⁸⁰ Burke, *Lifebuoy Men, Lux Women*, 29.

⁸¹ *Ibid.*, 29-30.

⁸² Maier, ‘Nineteenth Century Asante’ More on this in the next chapter.

⁸³ In a bibliographic essay in 1974 David Patterson lamented the dearth of literature on African medical history and since then, there has been significant strides in the historiography of African medical and health history. K. David Patterson, ‘Disease and Medicine in African History: A Bibliographical Essay’, *History in Africa* 1 (1974): 141–48.

broad tendencies have emerged from existing studies. Critics mostly radical scholars have tended to argue that the practice of colonial medicine (biomedicine) in Africa operated as a form of cultural imperialism through which Europeans introduced new beliefs and values which in the first instance competed with African beliefs and values, but eventually undermined and supplanted them. Yet, there are others, predominantly, liberal scholars, who see the practice of colonial medicine in Africa as a triumph for Africans – having brought about positive change that has enabled Africans to enter the scientific age, enjoying improved health and well-being.⁸⁴

Some of the earlier studies examined the role of western medicine in direct relation with the colonial conquest of Africa. Studies in this direction have produced rich and varied arguments. Some scholars have tended to tout the triumphalist role that the suppression of malaria and the consequent drop in European mortality rates played in the colonisation of Africa. To such scholars, European colonisation of Africa could not have been possible without, first the conquest of malaria – the main killer of Europeans in Africa. Philip Curtin, for example, argues that the discovery of quinine as prophylaxis for malaria and related medical reforms during the 19th century was fundamental to the success of the European colonial enterprise.⁸⁵ He wrote that:

While the medical reforms were not a direct cause of the later scramble for Africa, they were clearly a technological leap forward. As such, they were necessarily an important permissive factor. Whatever other influences were at play in the second half of the nineteenth century, the history of tropical Africa would certainly have been very different if European mortality had continued at the old rate.⁸⁶

Daniel R. Headrick corroborates Curtin's argument. He suggests that the scientific production of Cinchona, which made the mass production of quinine possible was crucial in the European colonisation of Africa and other tropical territories.⁸⁷ However, Pratik Chakrabarti cautions that we must be careful not to overstate a direct "cause and effect relationship between medicine and colonisation." He argues that in the case of French imperial exploits in 19th century Africa, for example, the use of

⁸⁴ see David Baronov, *The African Transformation of Western Medicine and the Dynamics of Global Cultural Exchange*, 1 edition (Temple University Press, 2008) This review is selective and suggestive, not exhaustive.

⁸⁵ Philip D. Curtin, "The White Man's Grave: Image and Reality, 1780-1850," *The Journal of British Studies* 1, no. 1 (1961): 94–110.

⁸⁶ *Ibid.*, 110.

⁸⁷ Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*, 1 edition (Oxford University Press, 1981).

quinine and a decline in mortality was of little consequence. He maintains that the French rarely used quinine as prophylactic until the early 20th century, and French death rates were high throughout the 19th century. Nonetheless, the French empire expanded in Africa. He explains that what was crucial in the French colonial exploits was not “medical advancement” but rather their superior military organisation, their “strategies and arms.” He asserts that well-organised and well-resourced European-led armies could execute “successful conquests while keeping French battlefield deaths low.”⁸⁸

The social history of specific diseases and the politics of prevention have also received significant attention. Pratik Chakrabarti has noted that earlier accounts of the role of science, technology and medicine in Africa have been portrayed in a manner that is triumphalist. He asserts that earlier writers extolled the successes of western medicine in reducing the prevalence of malaria, cholera, leprosy, sleeping sickness and plague which afflicted the continent. Such narratives according to Chakrabarti present the introduction of modern hospital, dispensaries and laboratories into colonised territories as a benign gift of European colonialism.⁸⁹ Recent scholarly accounts, however, have discounted such claims arguing that western medicine “was in fact, not a benign force for good.”⁹⁰ Rather than extenuating the burden of disease, colonial rule and its disruptive proclivities exacerbated it.

Writing on the prevalence of smallpox in early colonial Kenya, Marc. H. Dawson has, for instance, illustrated how changes in the socio-economic structure of colonial Kenya impacted on the dynamics of the spread and control of the disease. He argues that whereas the disease occurred infrequently and reached occasional and epidemic proportions during periods of ecological stress in pre-colonial Kenya, it became endemic during the colonial period because of socio-economic change, even though its occurrence in epidemic forms became less frequent.⁹¹ Following the same line of reasoning, Dawson demonstrates how British colonial rule created an ideal

⁸⁸ Pratik Chakrabarti, *Medicine and Empire: 1600-1960* (Basingstoke: Palgrave Macmillan, 2014), 127–29.

⁸⁹ Chakrabarti, *Medicine and Empire, 1600-1960*.

⁹⁰ Ryan Johnson, ‘Historiography of Medicine in British Colonial Africa’, *Global South SEPHIS E-Magazine*, 2010, 22.

⁹¹ Marc Dawson H., “Socio-Economic Change and Disease: Small Pox in Colonial Kenya, 1880-1920,” in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John M. Janzen (Berkeley. Los Angeles. London: University of California Press, 1992), 90–103.

environment for the spread of communicable disease in a manner that was unprecedented in early colonial Kenya. He shows how famine engendered mass population movement resulting in many devastating epidemics including dysentery, influenza and smallpox – the consequence of which, was high mortality and a concomitant decline in population.⁹² Dawson's observations sync with David Patterson and Gerald Hartwig's paradoxical suggestion that European colonial imposition on Africa may have come with the knowledge and practice of modern preventive and curative medicine, but it also impacted profoundly on the health of Africans and conditioned the disease environment of the colonial period and beyond.⁹³

Maryinez Lyons's study of the social history of trypanosomiasis in the Belgian Congo (Zaire) reveals how the social unrest and disruptions caused by the Belgian conquest of Northern Congo impacted on the prevalence of the disease. She underscores the blatant exploitation of human and natural resources to show how the relationship between Africans and their environment was altered and the concomitant changes to the epidemiological patterns in the Congo which it begot. She argues among other things that the physical and psychological trauma which Africans experienced because of the unhealthy conditions under which they were forced to mine gold and collect rubber weakened their resistance to the disease and conditioned the prevalence and transmission of the diseases. The measures formulated by the colonial administration to fight the disease were ineffective, and exacerbated the situation, resulting in heavy mortality rates. In a similar vein, repressive control measures such as the compulsory relocation of entire communities, and the forceful administering of ineffective medication, she argues, resulted in an intrusive and disorderly manipulation of the Belgian people.⁹⁴ The significance of Lyons work lies in her ability to draw out the wider implications of her research for the study of disease in African history.

⁹² Marc H Dawson, 'Disease and Population Decline of the Kikuyu of Kenya, 1890 - 1925', in *African Historical Demography*, vol. II (Seminar held in the Centre for African Studies, University of Edinburgh, Edinburgh, Scotland: Centre of African Studies, University of Edinburgh, 1981), 121–38.

⁹³ Patterson and Hartwig, 'The Disease Factor: An Introductory Overview'.

⁹⁴ Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940*, Cambridge History of Medicine (Cambridge: New York: Cambridge University Press, 1992) see also; Tanya Weinstein, review of *Review of The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940*, by Maryinez Lyons, *The International Journal of African Historical Studies* 26, no. 3 (1993): 645–47.

Dealing with the same disease but in a different colonial setting, Kirk Aden Hoppe adopts a political ecology perspective to show how competing views on the control of sleeping sickness in Southern Uganda between colonial administrators and medical scientist were articulated. While colonial administrators sought to build a profit-motivated logic into plans for exterminating the disease, he argues, medical opinion emphasised scientific research and intervention unhindered by profit imperatives. He contends that the control of sleeping sickness in colonial Uganda created an ideological platform for the “articulation of colonial visions of African environments.” In the end, the position of the Ugandans’ in their environment, their responses and resistance to colonial plans for dealing with the disease interlaced with the competing interests of the British colonial administration and conditioned how these visions played out. The inter-connectedness between British science, environmental intervention, and colonisation, he argues, played out in the colonial strategies for dealing with sleeping sickness in Uganda. These comprised forceful removals, deliberate relocations, and strategic clearings which ignited an enduring process of land dispossession spanning 1906 to 1962.⁹⁵

Colonial administrations’ attitude towards disease prevalence and prevention in Africa were often interlaced with political expediency and sometimes wilful neglect of the socio-economic conditions that sustained the persistence of diseases amongst the African population. In a study of the history tuberculosis in South Africa Randall Packard argues, mindful of the imprint of racial prejudice on policies formulated to deal with the disease, that the ineffectiveness of the government’s curative efforts stemmed from the wilful neglect to improve the poor socio-economic conditions of Blacks. These conditions included poor sanitation, overcrowded mining compounds, poor health facilities and low wages.⁹⁶

In a remarkably comprehensive study, Myron Echenberg provides an in-depth appraisal of the impact of, and the responses of the colonial government and the

⁹⁵ Kirk Arden Hoppe, ‘Lords of the Fly: Colonial Visions and Revisions of African Sleeping-Sickness Environments on Ugandan Lake Victoria, 1906-61’, *Africa* 67, no. 1 (1997): 86–105.

⁹⁶ Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (University of California Press, 1989) see also; Randall M. Packard, “Industrialisation, Rural Poverty in Tuberculosis in South Africa, 1850-1950,” in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John M. Janzen (Berkeley. Los Angeles. London: University of California Press, 1992), 104–30; Randall M. Packard, “The ‘Healthy Reserve’ and the ‘Dressed Native’: Discourses on Black Health and the Language of Legitimation in South Africa,” *American Ethnologist* 16, no. 4 (1989): 686–703.

African population to the outbreaks of bubonic plague in colonial Sènègal between 1914 and 1945. Part of his argument is that the French response to the disease was anchored on political expediency and was targeted primarily at diffusing the smouldering discontent among the African population. He notes that the French misdiagnosed the causes of the plague by attributing it to perceived insanitary conditions of the African population. Subsequently, the creation of segregated settlements to contain the African population, instead of attacking the vectors of the disease proved largely ineffective and resulted in high mortality.⁹⁷

The social determinants of health and healing and the social cost of production in relation to health and colonialism in Africa has received significant attention from scholars. The pioneering scholar in this endeavour is Steven Feierman. In a rather long article, Feierman situates the evolution of health in Africa in the broader 'story of social change'. His approach is premised on the conviction that "the political and economic forces which shaped the continent's history also established the framework within which patterns of diagnosis and treatment, health and disease, emerged."⁹⁸ It is suggestive from his approach that one cannot begin to understand the development of health in Africa without a perceptive appreciation of the politico-economic dynamics that have influenced developments on the continent. Feierman's approach writes Ryan Johnson, "demonstrates that diseases and sicknesses were not natural conditions of Africa and Africans." The colonial state, Ryan Johnson argues, through its engagement in development projects and "eradication programmes transferred the social cost of these projects – in this case, heavier burdens of disease – onto the most vulnerable populations, mainly women, children and rural inhabitants' in Africa."⁹⁹

Other studies have examined the significance of cultural processes in relation to western medicine and colonial rule. An influential work in this field is Megan Vaughan's *Curing their Ills*. Vaughan builds on Sander Gilman's study on the medical construction of difference and on Michel Foucault's conceptualising of power/knowledge to analyse how western medicine as a 'cultural system constructed

⁹⁷ Myron J. Echenberg, *Black Death, White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914-1945* (Heinemann, 2002).

⁹⁸ Steven Feierman, 'Struggles for Control: The Social Roots of Health and Healing in Modern Africa', *African Studies Review* 28, no. 2/3 (June 1985): 73.

⁹⁹ Johnson, 'Historiography of Medicine in British Colonial Africa', 23.

the African in both racial and gendered forms.¹⁰⁰ Focusing mainly on Central and Eastern Africa, Vaughan argues that colonial medicine and its allied disciplines were pivotal in constructing an objectified African who, in the eyes of Europeans, represented an object of knowledge. She also asserts that colonial medicine was deployed to create an elaborate system of categorisation which was integral to the operation of colonial power.¹⁰¹

Other Africanist scholars have explored the link between medical knowledge and urban planning in colonial Africa. An influential work in this field is Philip Curtin's *Medical knowledge and urban planning in tropical Africa*. In this work, Curtin shows how medicalised discourse on sanitation and a misinformed conception of the 'diseased African' borne out of racial prejudice and imperial pomposity was used to justify the creation of segregated residential patterns. Curtin, however, argues that the idea of segregation was imported from British-India where during the 1860s the British purposefully kept their physical distance from the Native Indians, thereby creating a pattern of racially divided urban settlements.¹⁰² John W. Cell, has, however, countered Curtin's narrative. Cell argues that even though the British developed racially segregated housing in India, the underpinning reason before 1900 was not on medical grounds. He posits that the justification of segregation as a prophylactic against malaria emerged in West Africa in the 1900s and was a completely new idea which had no connection to India. He contends that it was only after medically-conceived segregation had been applied in West Africa was it proposed in India.¹⁰³

Nonetheless, the extent of success in implementing segregation in British West Africa differed markedly from one colony to another and depended largely on individual colonial administrators as well as the local circumstances.¹⁰⁴ Njoh attributes the varying degree of success in implementing residential segregation in colonial Africa to the

¹⁰⁰ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness*, 1 edition (Stanford, Calif.: Stanford University Press, 1991), 7.

¹⁰¹ Vaughan, *Curing Their Ills*.

¹⁰² Philip D. Curtin, 'Medical Knowledge and Urban Planning in Tropical Africa', *The American Historical Review* 90, no. 3 (June 1985): 594.

¹⁰³ John W. Cell, 'Anglo-Indian Medical Theory and the Origins of Segregation in West Africa', *The American Historical Review* 91, no. 2 (1986): 307–35.

¹⁰⁴ see Curtin, 'Medical Knowledge and Urban Planning in Tropical Africa'.

potential socio-politico-economic crisis that could have resulted and the better perception of local colonial administrators of such potential dangers.¹⁰⁵

Odile Georg has compared British and French approaches to urban planning and segregation in Freetown and Conakry. He argued that irrespective of their specific historical context, both cities experienced segregation that was anchored on racial prejudice and justified on hygienic grounds.¹⁰⁶ Focusing on the prevalence of yellow fever in Saint-Louis-du-Sènegal, Kalala Ngalamulume examines how French colonial administrators addressed the challenges presented by the outbreaks of yellow fever epidemics. He argues that the colonial administration's perception that the disease was caused by insanitary conditions and their construction of African habits as a causative of filth resulted in the pathologisation of the African population and subsequently, the creation of urban segregation practices which separated European residents from Africans.¹⁰⁷

In an earlier work, Leo Spitzer investigated how the discovery of the aetiology of malaria in the late 19th century and contemporary scientific explanation of disease causation resulted in the creation of segregated settlements in Sierra Leone, and consequently, altered the hitherto harmonious co-existence of Europeans and Africans.¹⁰⁸ Stephen Frenkel and John Western, however, connects the creation of segregated settlements in Sierra Leone to the pervasive racial prejudice of the period.¹⁰⁹ In doing so, they discount the role of the discovery of the malaria vector as key to segregation. A similar theme running through these studies, however, is that racial prejudice and medical discourse conjoined to inform residential segregation in colonial urban Africa, in both French and British colonies. This was not unusual. French colonial administrators, as Njoh argues, drew inspiration from the medical and

¹⁰⁵ Njoh, *Urban Planning and Public Health in Africa*, 47.

¹⁰⁶ Odile Georg, 'From Hill Station (Freetown) to Downtown Conakry (First Ward): Comparing French and British Approaches to Segregation in Colonial Cities at the Beginning of the Twentieth Century', *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines* 32, no. 1 (1998): 1–31.

¹⁰⁷ Kalala Ngalamulume, 'Keeping the City Totally Clean: Yellow Fever and the Politics of Prevention in Colonial Saint-Louis-Du-Sènegal, 1850–1914', *The Journal of African History* 45, no. 02 (2004): 183–202.

¹⁰⁸ Leo Spitzer, 'The Mosquito and Segregation in Sierra Leone', *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines* 2, no. 1 (1968): 49–61.

¹⁰⁹ Stephen Frenkel and John Western, "Pretext or Prophylaxis? Racial Segregation and Malarial Mosquitoes in a British Tropical Colony: Sierra Leone," *Annals of the Association of American Geographers* 78, no. 2 (1988): 211–28.

health policies and experiments of British colonial administrators.¹¹⁰ To that extent, French and British colonial health policies, largely converged.

Despite this impressive scholarship, little scholarly attention has been paid to the management of sanitation and hygiene – a central theme in health and disease – and its broader implication for public health and colonial governance in general. Scholars who have studied sanitation have treated it merely as a public health means designed, to borrow Alison Bashford's words, "as part of systems and cultures of race management."¹¹¹ Maynard Swanson, for example, has demonstrated how sanitation was used as a social metaphor to justify the need for racial segregation in the Cape Colony in South Africa between 1900 and 1909 during the outbreak of the bubonic plague.¹¹² This is what he conceptualised as the "sanitation syndrome."

Swanson follows this thread of investigation to show how the discourse on sanitation conjoined with political and economic forces to influence debates on racial segregation in Durban during the late 19th century and the early part of the 20th century.¹¹³ Along similar lines, Harriet Deacon, examining racial segregation in institutional settings in the Cape discussed how scientific and medical discourses bearing partly on sanitation was used as the basis to justify the need for racial segregation in two government institutions in Cape Town.¹¹⁴ Similarly, Godwin R. Murunga, drawing on the prevalence of bubonic plague, has examined the link between racialised discourse on sanitation and the creation of segregated settlements in colonial Nairobi. He demonstrated the shift in discourse from Nairobi as an unhealthy site for human settlement to an emphasis on unsanitary population whose

¹¹⁰ Njoh, *Urban Planning and Public Health in Africa* see also; A. J. Njoh, 'Colonial Philosophies, Urban Space, and Racial Segregation in British and French Colonial Africa', *Journal of Black Studies* 38, no. 4 (19 March 2007): 579–99. .

¹¹¹ Bashford, *Imperial Hygiene*, 2.

¹¹² Maynard W. Swanson, 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900–1909', *The Journal of African History* 18, no. 03 (1977): 387–410.

¹¹³ Maynard W. Swanson, "'The Asiatic Menace": Creating Segregation in Durban, 1870-1900', *The International Journal of African Historical Studies* 16, no. 3 (1983): 401.

¹¹⁴ Harriet Deacon, 'Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town', *Journal of Southern African Studies* 22, no. 2 (1996): 287–308.

lifestyle was reckoned as the cause of sanitary problems, providing the basis for European settlers to demand segregation.¹¹⁵

Marc Epprecht, drawing on local debates concerning the creation of an African location in Pietermaritzburg, has questioned the analytical utility of the “sanitation syndrome.”¹¹⁶ He argues that it obscures rather than clarifies and, therefore, relying on it may undermine a nuanced understanding of “complex struggles of the past.”¹¹⁷ For example, he demonstrates that white fear of contagion from Africans as the basis for creating segregated settlements was not important in the Pietermaritzburg case. What was critical, he argues, were Africans’ own concerns for their health and morals, scientifically informed assessments by public health officials, and white anxieties about African elites’ political ambitions.¹¹⁸ For Epprecht, therefore, relying on the “sanitation syndrome” could potentially oversimplify the health and sanitation challenge that confronted African cities. It could also, he contends, exaggerate the improbity of public health officials and the deficiency in the science they relied upon. Africans’ agency and their participation in the construction of the “sanitation syndrome” for their own diverse ends, as demonstrated in Pietermaritzburg, might therefore be overlooked.

Epprecht is, however, not the only one who departs from Swanson’s line of argumentation. Stephen Sparks, for example, while acknowledging the role of racial prejudice in the management of sanitation, gives considerable attention to the politics of public health in South Durban from the mid-19th century to about the third decade of the 20th century. He investigates how municipal administrators sought to use public health issues (sanitation and hygiene) as a tool to exert greater control over South Durban.¹¹⁹ The significance of Sparks’ contribution is that it draws out the political dynamic to public health issues. In a similar vein, Festus Cole’s study of the provision of sanitary services in colonial Sierra Leone, while mindful of the race question, considers the interplay between the limited availability of medical personnel and the

¹¹⁵ Godwin R. Murunga, “Inherently Unhygienic Races: Plague and the Origins of Settler Dominance in Nairobi, 1899 -1907,” in *African Urban Spaces in Historical Perspective*, ed. Steven J. Salm and Toyin Falola (Rochester, NY: Rochester University Press, 2005), 98–130.

¹¹⁶ Marc Epprecht, “The Native Village Debate in Pietermaritzburg, 1848-1925: Revisiting the “Sanitation Syndrome”, *Journal of African History* 58, no. 2 (2017): 259-83.

¹¹⁷ *Ibid.*, 262.

¹¹⁸ *Ibid.*, 283.

¹¹⁹ Stephen Sparks, “Playing with Public Health: The Search for Control in South Durban, 1860 - 1932,” *Journal of Natal and Zulu History* 20 (2002): 1–28.

strained economic conditions during World War I – as the key determinants that shaped and conditioned the direction of sanitation and public health policies. The exclusion of African physicians from the West African Medical Service (WAMS), because of racial prejudice and the imperial pomposity of the colonial administrators, was secondary and merely served to complicate the health situation in Sierra Leone.¹²⁰

An exceptional contribution to this scholarship is the work of Timothy Burke. In examining the commodity culture of Post-World War II Zimbabwe with emphasis on cosmetic products, Burke dedicates his first two chapters to examine the discourse around sanitation and hygiene, making occasional references to other parts of Southern Africa. His emphasis, however, was to show how these discourses around hygiene and sanitation created a platform for the commodification of hygiene products – such as toiletries during the 1940s – a development which according to him catapulted Zimbabwe into the ambit of global capitalism.¹²¹ Taking together, these wide-ranging historiography on colonial medicine, disease, health and public health in Africa provides formidable background information and suggestive hints on how analysis of sanitation and hygiene as a unit of study should proceed.

Health, Disease and Medicine in Ghana: The Historiographical Void

The historiography of Ghana has been hugely biased towards its political history, even though recent scholarship has seen a reorientation leading to impressive contributions from social historians. No serious scholarly work existed on the history of health, disease, and medicine until the 20th century. David Scott, an epidemiologist to the Ministry of health during the 1950s, was the first to have written what can be reckoned as a historical study of health and disease on colonial and post-colonial Ghana. His study, covering the period 1901 to 1960 was essentially the chronicling of what he called “the natural history of different epidemic diseases in Ghana” focusing on the prevalence of seven different epidemic diseases during the period.¹²² Indicative of his preoccupation, he failed to situate the work within the broader context of colonial policy and any discussion on sanitation sits outside the core of his analysis. His work,

¹²⁰ Festus Cole, ‘Sanitation, Disease and Public Health in Sierra Leone, 1895-1922: Case Failure of British Colonial Health Policy’, *The Journal of Imperial and Commonwealth History* 43, no. 2 (2015): 238–66.

¹²¹ Burke, *Lifebuoy Men, Lux Women*.

¹²² David Scott, *Epidemic Disease in Ghana, 1901-1960*, London; First Edition (Oxford University Press, 1965).

nonetheless, provides useful insights into the epidemiology of the diseases he covered and provides useful background information for researchers interested in public health history.

Patterson's study of disease and socio-economic change in the Gold Coast addresses a significant gap in the shortcomings in Scott's study. Patterson traced the history of British colonial health efforts from 1900-1955.¹²³ Drawing mainly from archival documents and situating his analysis within the broad framework of colonial policy and socio-economic change, he provides an assessment of the demographic implication of British medical and sanitary efforts in the Gold Coast. He also provides brief accounts of the aetiology, transmission, and pathology of some of the diseases that he examined. Nonetheless, useful topics such as the management of sanitation and hygiene which require full treatments are dealt with only to the extent that they provide background information. Indeed, Patterson admits that his work is only an initial synthesis of the relationship between European colonial rule and African health, and therefore, calls attention to the need for comprehensive treatment of other related topics.¹²⁴

The most ambitious contribution to the historiography is the work of Stephen Addae. Addae's study of Western medicine in Ghana, details not only the status of health and disease, but also provides an examination of the evolution of health policy, the provision of health services such as sanitation, laboratory services, training and research as well as the development of health institutions from the late 19th century to the late 20th century.¹²⁵ The usefulness of Addae's work lies not only in the insights it provides and its broad coverage but also in how it opens up new opportunities for further research.

Apart from these general surveys, few studies have examined health in urban areas and mining towns. Patterson's study of urban health, using colonial Accra as case study details the various health challenges that confronted the city and the effectiveness or otherwise of the measures that the colonial administrators employed

¹²³ David K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955* (Waltham, Mass: African Studies Assn, 1981).

¹²⁴ *Ibid.*, ix.

¹²⁵ Addae, *The Evolution of Modern Medicine in a Developing Country*.

to solve them.¹²⁶ Along similar lines, Thomas Gale has examined early attempts at fighting disease in the Gold Coast through sanitary reforms in urban centres. He argued that the early colonial period typified an era of basic decisions on public health reform. Subsequently, no significant accomplishments were made in urban sanitary reforms mainly due to the lack of interest exhibited by the colonial administration.¹²⁷

Examining disease and mortality in two mining towns, Obuasi and Tarkwa, Raymond Dumett considers the attitudes of mine managers and the colonial government towards health challenges in these mining enclaves. He illustrates how mine managers pursued policies that improved the health of European mine officials while the health of Africans was treated only as a subject of secondary concern. The only period when the health of African mineworkers received attention was during the 1930s – a period when more Africans had attained technical and supervisory positions in the mines – and a loss of such skilled workers threatened the profit imperative of the mine managers and the colonial state.¹²⁸

Jonathan Roberts has examined the combined effort of the colonial administration and American military forces during World War II to eradicate malaria in Accra through sanitary engineering and biomedical experiments. He contrasts official account of the anti-malaria campaign with the oral recollections of the event to determine the extent to which it resonated with the people of Accra.¹²⁹ He argued that despite the history of resistance to previous attempts in dealing with the unhealthiness of African urban spaces in Accra, there was no concerted opposition to this anti-malaria campaign. He thus suggests that the campaign offered the rare opportunity for medical experts and technocrats to use Accra as a laboratory for testing the transmission of diseases through what he termed “the so-called African bloodstream.” However, the project failed because of the inability of the British administrators to finance the scheme after American support was withdrawn after the end of the war.

¹²⁶ David K. Patterson, ‘Health in Urban Ghana: The Case of Accra 1900-1940’, *Soc. Sci. Med.* 13, no. B (1979): 251–68.

¹²⁷ Gale, ‘The Struggle against Diseases in the Gold Coast’.

¹²⁸ Raymond Dumett, “Disease and Mortality among Gold Miners of Ghana: Colonial Government and Mining Company Attitudes and Policies, 1900-1938,” *Soc. Sci. Med.* 37, no. 2 (1993): 213–32.

¹²⁹ Jonathan Roberts, “Korle and the Mosquito: Histories and Memories of the Anti-Malaria Campaign in Accra, 1942–5,” *The Journal of African History* 51, no. 03 (2010): 343–365.

Put together, these studies seem to agree that early attempts at improving health conditions and controlling diseases in urban Gold Coast were largely unsuccessful, due partly, to the lackadaisical attitude of the colonial government towards the health of the Africans. Therefore, the only time the health of Africans was seriously considered was when it had the potential to benefit the exploitative colonial scheme.

The history of specific diseases, their demographic and ecological impact, and the role of various actors in fighting epidemic outbreaks have received some attention. Writing on the outbreak of the influenza epidemic of 1918/1919 in the Gold Coast, Patterson investigated the spread of the disease and examined the responses of the colonial government as well as the general population to the outbreak. He argued that the disease represented the “worst short-term demographic disaster in the history of the Gold Coast”, killing over a hundred thousand people in less than six months, largely because of the ineffective measures adopted by the colonial government to fight the disease.¹³⁰ The health implications of the opening up of the interior of the Gold Coast to the rest of the country through the provision of railway network and the political ramifications of disease control measures were the focus of James W. Brown’s study of the outbreak of disease in early colonial Asante. Brown demonstrated that while the railroad network exposed Asante to outbreaks of the bubonic plague epidemic, the committed responses of the colonial administrators and their health officials helped to contain the disease.¹³¹

However, Patterson’s study of onchocerciasis in the Northern Territories of the Gold Coast illustrates that the colonial medical authorities were slow to identify the prevalence of the disease – a development which led to large-scale blindness in the region.¹³² Whereas Patterson’s works allow us to appreciate the demographic and ecological consequences of epidemic and endemic diseases in the Gold Coast,

¹³⁰ K. David Patterson, “The Influenza Epidemic of 1918–19 in the Gold Coast,” *The Journal of African History* 24, no. 04 (1983): 502.

¹³¹ James Brown W., ‘Increased Intercommunication and Epidemic Disease in Early Colonial Ashanti’, in *Disease in African History: An Introductory Survey and Case Studies*, ed. David Patterson K. and Gerald Hartwig W., Duke University Centre for Commonwealth and Comparative Studies 4 (Durham, N. C.: Duke University Press, 1978), 180–206.

¹³² David K. Patterson, ‘River Blindness in Northern Ghana, 1900-50’, in *Disease in African History: An Introductory Survey and Case Studies*, ed. David K. Patterson and Gerald Hartwig W., Duke University Centre for Commonwealth and Comparative Studies 4 (Durham, N. C.: Duke University Press, 1978), 88–117.

Brown's contribution illuminates the effectiveness of political responses to disease outbreaks. In a recent study, Ryan Johnson has inserted the role of "intermediaries and subordinates" in the history of public health in the Gold Coast by illustrating how the agency of local rulers and interpreters in colonial Accra was crucial in fighting the outbreak of the bubonic plague epidemic in 1908.¹³³

To this growing historiography have been added some few recent PhD dissertations focusing on different aspects of the history of disease and health.¹³⁴ Samuel Adu-Gyamfi's dissertation deals with the impact of colonial administration on indigenous medical practices as well as indigenous approaches to disease prevention in Kumase, the capital of the Asante. He illustrates how the colonial administration using their expert knowledge on nutrition and disease prevention used legislation to influence the customs and practices of the Asante, ensuring that disease transfer was minimised.¹³⁵ Sylvester Gundona, focusing on the politics that underpinned the colonial administration's approach to treating leprosy as a colonial disease demonstrates the self-serving nature of and the shifts in colonial public health policy.¹³⁶

Nana Akua Amponsah examined the attempt by the British colonial government to medicalise and politicise female reproductive behaviour in colonial Ghana. Drawing on Foucault's concept of biopower, she analysed how the British colonial administration sought to use the provision of infant and maternal welfare services as well as western mid-wifery education to reconstruct the reproductive behaviours of women in colonial Ghana.¹³⁷ Jonathan Roberts's dissertation investigated the simultaneous development of five therapeutic traditions in Accra, viz: traditional African healing practices, indigenised Islamic therapies, Christian faith healing, biomedical therapies and self-medication. His work challenges hegemonic

¹³³ Ryan Johnson, 'Mantsemei, Interpreters and the Successful Eradication of Plague: The 1908 Plague Epidemic in Colonial Accra', in *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960*, ed. Amna Khalid (New York and London: Routledge, 2012), 135–53.

¹³⁴ There could be more, but these are the ones that I am aware of.

¹³⁵ Samuel Adu-Gyamfi, "A Historical Study of the Impact of Colonial Rule on Indigenous Medical Practices in Asante: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumase, 1902-1957" (Faculty of Social Sciences, College of Art and Social Sciences, Kwame Nkrumah University of Science and Technology, 2010).

¹³⁶ Sylvester Gundona, "Coping with This Scourge: The State, Leprosy, and the Politics of Public Health in Colonial Ghana, 1900- Mid 1950s" (University of Texas, 2015).

¹³⁷ Nana Akua Amponsah, 'Colonising the Womb: Women, Midwifery, and the State in Colonial Ghana' (University of Texas, 2011).

historiographic positions that presents single-dimensional narratives of healing practices that favour European trained physicians and undermines African traditional healing practitioners.¹³⁸

Together, these works have generated insightful debates and arguments. Most of the earlier scholars who studied the history of disease and health either in colonial or post-colonial Ghana, except Thomas Gale, seem to suggest that the impact of western medical intervention was generally positive and that it benefited the African population than Britain and its imperial institutions. Gundona's recent study, however, contradicts the dominant position. He argued that the burden of British colonial health policy was not necessarily to improve the disease ecology, but rather the African was viewed as a tool in the hands of schemers whose primary aim was to make profits from the diseased environment. He contends that the British were much interested in using Africans as research objects to develop biomedicine and create a market for the later distribution of "western medication". Whatever, the interpretative paradigms, these works together provides a rich context to situate a study of the management of sanitation and public hygiene. Despite the depth of these studies, however, the question of the management of sanitation and public hygiene has not been sufficiently studied. This dissertation contributes to the historiography in this area.

Theoretical Perspectives

I draw critical theoretical insights from the works of Michel Foucault, especially, his notion of biopower to analyse some of the questions raised in this study. Recognised as the theorist of power, Foucault has studied the shifts in European history from the exercise of sovereign power in premodern societies to the appearance of a new form of power during the 18th century and beyond. Foucault writes that at the turn of the 17th century the power to "take life or let live" which characterised sovereign power gradually gave way to another kind of power which aimed to "foster life or disallow it to the point of death."¹³⁹ Subsequently, the modern state became increasingly invested with the convergence of power and human existence. And increasingly, health started

¹³⁸ Jonathan Roberts, 'Sharing the Burden of Sickness: A History of Healing in Accra, Gold Coast, 1677 to 1957' (Dalhousie University, 2015), <https://dalspace.library.dal.ca/handle/10222/56339>.

¹³⁹ Michel Foucault, *The History of Sexuality, Vol. 1: An Introduction*, trans. Robert Hurley, Reissue edition (New York: Vintage, 1990), 138.

to assume greater significance in the conceptions of power and political discourses bearing on the utility of the body to economic processes.

Foucault notes that the emergence of this new form of power was co-incidental, yet central to the emergence of capitalist proclivities – which could not have been sustained “without the controlled insertions of bodies into the machinery of production and the adjustment of the phenomena of population to economic process.”¹⁴⁰ Foucault writes that:

... This political investment of the body is bound up, in accordance with complex reciprocal relations, with its economic use; it is largely as a force of production that the body is invested with relations of power and domination; but, on the other hand, its constitution as labour power is possible only if it is caught up with a system of subjection (in which need is also a political instrument meticulously prepared, calculated and used); the body becomes a useful force only if it is both productive and a subjected body.¹⁴¹

What Foucault is implying is that for economic reasons (i.e. maintaining a productive labour force), the state became increasingly invested in “regulating, moderating, and overseeing the health of its citizens in various distinct realms.”¹⁴²

This exercise of power over the body by the state is what Foucault characterised as *biopower* – by which he meant the state’s exercise of power over the body not only as political subjects but also, as biological entities.¹⁴³ According to Foucault, biopower operates at two distinct, yet mutually reinforcing levels. The first is what he refers to as *anatomo-politics*. *Anatomo-politics* focuses on the disciplining of the individual human body with an aim to maximise its abilities, extract its forces, simultaneously increase its “usefulness and its docility” and merge it into an efficient production system.¹⁴⁴ The other dimension concerns the control of the entire population – what he calls *biopolitics*. It focuses on regulating health indicators such as birth and death rates, procreation, quality of life and the conditions that can cause

¹⁴⁰ Ibid., 140–41.

¹⁴¹ Michel Foucault, *Discipline & Punish: The Birth of the Prison*, trans. Allan Sheridan, 2nd Edition (New York: Vintage Books, 1995), 25–26.

¹⁴² Jeremy Youde, *Biopolitical Surveillance and Public Health in International Politics* (New York: Palgrave Macmillan, 2010), 17.

¹⁴³ Foucault, *The History of Sexuality, Vol. 1* see also; Youde, *Biopolitical Surveillance and Public Health in International Politics*.

¹⁴⁴ Foucault, *The History of Sexuality, Vol. 1*, 139.

them to change.¹⁴⁵ Simply put, biopower targeted the “individual body” through disciplinary techniques, “and the social body through government of the population.”¹⁴⁶

New forms of disciplinary techniques accompanied the emergence of biopower. The state, writes Youde, no longer had to rely on its overt ability to force changes, rather ‘it sought to flex its power through standardising human existence.’¹⁴⁷ “Techniques to control the individual body,” writes Padovan, “were integrated into biopolitical techniques that sought to control the standardised multitude of bodies...”¹⁴⁸ Foucault notes that:

...the rudiments of anatomo-politics and biopolitics, created in the eighteenth century as *techniques* of power present at every level of the social body and utilised by very diverse institutions (the family and the army, schools and the police, individual medicine and the administration of collective bodies), operated in the sphere of economic process, their development, and the forces working to sustain them. They also acted as factors of segregation and social hierarchisation, exerting their influence on the respective forces of both these movements, guaranteeing relations of domination and effects of hegemony.¹⁴⁹

What is being implied by Foucault is that the modern state sought through biopolitical techniques to create economically efficient, but politically docile subjects.

Biopolitics, when it was first applied in Western Europe during the nineteenth century, sought to bring about urban reforms as reformers hoped to improve the health of cities, cleanse them of filth, and improve public health. Youde puts it succinctly:

Improving the society’s health became part of the government’s basic function. Society had to be remade, and it was the state’s responsibility to remake it. The government now had a clear interest in understanding and regulating the health of the social health, and it sought to instil proper health and hygiene habits in each individual “that would improve both the physical and moral health of each individual through public education, family involvement, and by state intervention in the field of the most common social areas of health disease.”¹⁵⁰

There is raging debate among academics regarding the applicability of Foucault’s reflections on power in colonial contexts. Frederick Cooper, has, for

¹⁴⁵ Foucault, *The History of Sexuality*, Vol. 1.

¹⁴⁶ Stephen Legg, *Spaces of Colonialism: Delhi’s Urban Governmentalities* (Blackwell Publishing, 2007), 3.

¹⁴⁷ Youde, *Biopolitical Surveillance and Public Health in International Politics*, 17.

¹⁴⁸ Quote in *Ibid*.

¹⁴⁹ Foucault, *The History of Sexuality*, Vol. 1, 141.

¹⁵⁰ Youde, *Biopolitical Surveillance and Public Health in International Politics*, 21.

example, argued that Foucault's conception of power as "capillary" is difficult to apply in colonial Africa. He posits that power in colonial Africa was "more arterial than capillary – concentrated spatially and socially" and not very useful outside such domains.¹⁵¹ Cooper, however, admits that one begins to see in Foucauldian terms a power/knowledge regime during the late colonial period.¹⁵² Vaughan has cautioned that in translating Foucault in colonial Africa, one must acknowledge some significant differences in the knowledge/power regime described by Foucault and that of colonial power. She argues that colonial states were less modern, but rather very repressive and that medical power/knowledge was not key to colonial control as it was in modern European states. Again, Vaughan questions the extent to which colonial power focused on individuals – rather she posits that colonial power focused on "group classification" and "generalised about an already pathological colonial other" rather than acquiring "detailed medical knowledge" as was done in Europe. Colonial capitalism she argues was less modern but more extractive and therefore, resulted in uneven development.¹⁵³

Thus, as Legg using the example of colonial India observed:

Biopolitically, the *colonial* state sought knowledge about the details of the multiplicity of the peoples within its territory yet refused to finance welfarist interventions that would have improved the lives of subject peoples. That is colonial governmentality was more an art of government than a science. It remained wedded to the apparatuses of regulation rather than security to a model of police rather than one of liberalism.¹⁵⁴

Yet, as Legg has illustrated, colonial societies did not only influence Foucault's conceptualisation of the 'metropole', but also the techniques of power that were applied in Europe were first tested and modified in colonial settings before they were sent back to Europe. To that extent, the making of modern Europe and the construction of colonial subjects in the Foucauldian sense were mutually constitutive.¹⁵⁵ Nonetheless, as Sara Berry has shown, no matter how much colonial administrators

¹⁵¹ Frederick Cooper, 'Conflict and Connection: Rethinking Colonial African History', *The American Historical Review* 99, no. 5 (1994): 1533; Frederick Cooper, *Decolonization and African Society: The Labor Question in French and British Africa*, 1 edition (Cambridge: Cambridge University Press, 1996), 15–16.

¹⁵² Cooper, *Decolonization and African Society*, 16.

¹⁵³ Vaughan, *Curing Their Ills*, 10–12; see also, Legg, *Spaces of Colonialism*, 24.

¹⁵⁴ Legg, *Spaces of Colonialism*, 25. My emphasis.

¹⁵⁵ Stephen Legg, 'Beyond the European Province: Foucault and Postcolonialism', in *Space, Knowledge and Power: Foucault and Geography*, ed. W. Jeremy Crampton and Stuart Elden (England: Ashgate, 2007), 265–66.

desired to create governable subjects, they rarely exercised enough control to accomplish what they sought to do. Part of this related to funding and the agency of the colonised. While the colonial state was invested in reproducing European hegemony, Berry notes it was also limited by its desire to have the colonised fund the cost of their “civilisation.”¹⁵⁶ For Cooper, the colonisers’ hegemonic project created a paradoxical relationship between the colonial administrators and indigenous social structures – albeit unequal and tension-packed – which allowed indigenous elites sometimes to manipulate European hegemonic discourses to pursue their interest.¹⁵⁷ Cooper is here reinforcing the question of the agency of the colonised to illustrate the contradictions in the colonial project, a situation to which Foucault paid little, if any, attention.

In this dissertation, however, I find that many of the governmental measures that were applied in the Gold Coast in the management of sanitation and hygiene reflect the biopolitical techniques that Foucault describes. Governmental concerns with sanitation and public health led to increasing state intervention in the daily lives of ordinary people. Measures such as sanitary surveillance/inspection, the teaching of hygiene in schools, public education on hygiene and sanitation (which included public lectures, the observance of health weeks and health days, etc.), the regulation of public and dwelling spaces through town planning, the introduction and imposition of new knowledge regimes on toileting techniques and habits, refuse disposal, etc. were among the biopolitical techniques that the colonial administration used in managing sanitation and public hygiene. However, I show that these colonial initiatives were self-serving and were tailored towards making the Gold Coast safe for the coloniser than it was about ameliorating the unhealthy conditions for the benefit of the local population. Furthermore, the nature of colonial biopower remained for the most part tangled with coercion and layered with contradictions. Thus, in trying to understand the management of sanitation and hygiene through the theoretical gaze of biopower, I was mindful of its limitations, some of which I draw out in the concluding chapter

¹⁵⁶ Sara Berry, ‘Hegemony on a Shoe-String: Indirect Rule and Access to Agricultural Land’, *Africa: Journal of the International African Institute*, 62, no. 3 (1992): 327-355.

¹⁵⁷ See Cooper, *Decolonization and African Society*.

Sources and Methods

This is a qualitative study that relies extensively on primary archival sources supplemented by secondary materials. I draw on primary documents kept at the Public Records and Archives Administration Department (PRAAD) in Accra. Data in the record class ADM5/1 to ADM5/4, comprising annual departmental reports and specially commissioned reports provided useful information for the writing of this dissertation. I also sourced information from record class CSO11/3 to CSO11/19 as well as CSO14/5. These record classes contain varying information on public health, sanitation and hygiene-related issues in the Gold Coast. The research also benefitted from primary documents stored at the Central Regional archives in Cape Coast and the Asante regional archives in Kumase.

At the Cape Coast archives, record class ADM23/1 and RG1/9 were most useful. They provide varying information on sanitary issues ranging from records of minutes of sanitary committees and provincial health boards, inspection reports, and sanitary reports on towns and villages as well as records on a range of public health issues. In the Kumase archives, health and sanitary related issues were found in the record class ARG1/14 to ARG1/26 as well as ARG2/14. In these record classes, information on native sanitation rules, minutes of meetings of the Kumase Public Health Board, reports of minutes of meetings of sanitary committees in Asante, inspection reports, and general records on public health were found. Annual departmental and general reports and reports of Gold Coast Legislative debates kept at the Africana section of the Balme Library at the University of Ghana, Legon, was also very helpful.

I also used extensively primary records that are hosted on the British Online Archive (BOA). The BOA hosts a range of digitised primary records on about six continents. One-Hundred and thirty-eight documents comprising fifty-six thousand three-hundred and eighty scanned pages are hosted online on the Gold Coast from 1843 to 1957. The records are categorised into eleven different sets comprising, administration, finance, natural resources, judicial and police, transport and public works, commerce, communications and postal services, staff list, miscellaneous and social services. For this work, the records in the social services category were the most useful. This category contains information on educational developments and

medical and sanitary reports. It provides almost complete annual reports on the medical and sanitary department from 1885 to 1954.

In using these official sources generated mainly by the colonial outfit, I have been very attentive to the nature of sources that they are and their limitations. This corpus of primary materials is mostly administrative records and official correspondence written by White colonial officials. The information contained in them, as so often happens, projects their prejudices and idiosyncrasies on the colonised and leave no space for African voices. When African voices are entered in the evidentiary record, they are either reports of African sabotage or sometimes complaints which colonial officials were not ready to entertain. Some of the reports have the imprints of propaganda pieces written to convince the Colonial Office either about improvements in the colony or to justify why some policies or measures were necessary.

Despite these weaknesses, these sources taken together allowed me to examine broad sanitation and public hygiene measures and campaigns, their implementation and challenges, and the thinking, the assumptions, and the attitudes of the people in the colonial outfit who were responsible for initiating and implementing public health measures in the Gold Coast. It also enabled me to interrogate the intent that underpinned the measures that were adopted towards the management of sanitation and public hygiene.

Secondary sources, mainly peer-reviewed journal articles, books, and monographs provided wide-ranging perspectives and insights that enabled me to put some of the issues raised in this dissertation in their proper historical and theoretical context.

Chapter Outlines

Chapter two analyses the health status of the Gold Coast from c'17th century until formal colonisation and the passing of the first public health ordinance in 1878. I interrogate the narratives of European travellers, merchants, soldiers and writers who presented the climate and environment of the Gold Coast littoral as unwholesome and insalubrious, and the people as predisposed to uncleanliness and unhygienic habits. I contrast these linear narratives with other accounts that suggested that in the interior region, people adhered to practical sanitary arrangements and engaged in hygienic

practices and that the environment there was also healthy and salubrious. I, therefore, implicate the presence of the Europeans in towns and settlements along the Gold Coast littoral as a factor that contributed to the depressing sanitary conditions that were presented in European accounts.

In chapter three, I examine the evolution of public health and sanitary administration from the late 19th century to the 1950s. I investigate the contexts that produced the establishment of formal administrative structures, agencies, and agents to administer public health and sanitary reforms. The circumstances leading to the establishment of the Gold Coast Medical Department (GCMD) in 1884, and the devolution of sanitation work to town/municipal councils and native authorities which began in the 1880s and the 1890s are examined. Furthermore, I investigate the conditions that led to the creation of the sanitation branch of the GCMD in 1909 and its allied agencies comprising sanitary committees and health boards. Also, I discuss the recruitment and training of Sanitary Inspectors and Overseers – who executed the mundane daily activities of the sanitary branch.

Chapter four examines the management of excrement, the maintenance of clean streets and neighbourhoods, and the sanitation of rural communities and mining areas. I show in what ways the colonial administration sought to manage dirt in its various forms in different spaces. Starting with the examination of the provision of public toilets, I illustrate that despite claims of insanitary toileting habits of the African population, most of the toilet facilities that the colonial state provided and the methods that were adopted to dispose of night-soil remained largely primitive, inefficient and inadequate to meet the toileting needs of the African population. It is argued that the attempt to maintain clean streets and neighbourhoods, notwithstanding, the provision of insufficient and badly constructed dust-bins, a limited number of incinerators, and the problem of insufficient and inefficient labour to undertake scavenging activities impinged on the efforts to maintain clean environmental conditions in towns and villages. Furthermore, the lukewarm attitude of the colonial state towards the sanitation of rural communities and mining areas led to a situation where rural sanitation remained deplorable for most of the colonial period.

Chapter five investigates the efforts of the colonial state to provide potable water. Beginning with an examination of the water supply situation before 1900. I show

that during the late 19th century, the colonial state concerned itself with providing potable and adequate water supply for European officials while the African population relied mostly on brackish ponds, shallow wells, rivulets and streams for their water supply. And measures to improve the water supply situation before the 20th century remained inefficient and, therefore, could not achieve any significant results. It was after 1910 that the colonial state, initiated processes to provide piped water supply to principal towns and villages starting with Accra and Sekondi in 1911. By 1950 several towns and villages were either being supplied with pipe-borne water or water from wells. Yet, a lot more remained to be done. The principal challenge that impinged on water supply as with other sanitation projects, was finance.

Chapter six examines two broad themes, viz anti-mosquito sanitation and educational prophylaxis. I focus on sanitary segregation, sanitary inspection, drain construction, swamp and lagoon reclamation, the application of larvacides and the removal of weeds as some key anti-mosquito breeding measures. The key educational prophylactic measure concerned the teaching of hygiene both to school children and the adult population. I bring the two themes together to argue that these measures, despite their manifest intention, also had latent motives which were geared towards the reorientation of the practices, habits, manners and attitudes of the African population towards sanitation and hygiene in both the domestic and public sphere. They were meant, among other things, to express and reinforce the notion of European cultural hegemony. In doing so, the colonial state was essentially seeking, through these sanitary measures, to achieve its dubious mandate of 'civilising' a so-called 'primitive' indigenous population. However, I question the degree of success in implementing these measures. I also highlight the logistical and financial challenges that constrained this colonial endeavour as well as African opposition.

In chapter seven, I interrogate the creation of cemeteries, the planning of towns and regulations regarding the construction of dwelling houses. I examine the regulation and control of market spaces, slaughterhouses, bakeries and restaurants. These were presented as measures targeting sanitation and public hygiene, nonetheless, they provided avenues through which the colonial administration could manipulate the desires of the African population to achieve some form of broad social control. Through these measures, the colonial administration sought to impose a

Eurocentric vision of what constituted acceptable sanitary and hygienic manners and practices regarding the use of such spaces. In doing so, the colonial government sought to transform and modernise what were perceived as primitive practices of the African population regarding their understanding and use of such spaces. The appropriation and control of such spaces, also, had some latent economic motivation. However, the implementation of such sanitary initiatives and space control was not always smooth. It presented a conundrum to the colonial administration.

Chapter eight provides a conclusion to the study. It summarises the key issues examined in the dissertation and draw out their implications, relating it to the theoretical framework underpinning the study.



Chapter Two

The Health Status of the Gold Coast before 1878¹

Introduction

This Chapter examines the health status of the Gold Coast before the last three decades of the 19th century. I review European accounts that characterised the climate as insalubrious and its physical environment as unwholesome. I suggest that while there remained formidable health challenges, particularly, in the coastal settlements, the linear narrative that privileges the insanitary conditions and unwholesomeness of the region could be quite misleading. Notwithstanding, the health status of the coastal settlements was deemed dangerous enough to have caused alarming morbidity and mortality amongst European expatriates – a situation that persisted deep into the late 19th century and thus, caused the colonial government to devise mechanisms to improve the situation when the Gold Coast was formally colonised in 1874.

Of Climate, Environment, and Diseases

Early European records are replete with depressing statistics on European mortality and morbidity in the towns/villages in the Gold Coast littoral. Writing between 1678 and 1712, Jean Barbot, a French Calvinist slave trader, who was in the employment of the *Compagnie du Sènegal*, observed that, “out of every ten Whites who arrive on the coast in good health, six fell ill in less than a month, and invariably two or three of them die shortly afterwards.”² Drawing on the records of the Dutch West India Company, Harvey M. Feinberg noted that at least, one of every five Europeans who were employed by the company perished every year on the coast between 1719 and 1760.³ Headrick reckons that two-thirds of all Europeans who landed in the Gold Coast between 1823 and 1827 perished. In 1824 alone, two-hundred and twenty-one out of two-hundred and twenty-four Europeans died on the Gold Coast.

¹ A slightly modified and expanded version of this chapter under the title, “Inherently Diseased and Insanitary? The Health Status of the Gold Coast [Ghana] from the 18th to the late 19th Century” has been published in the *Nordic Journal of African Studies*, Vol. 27 no. 2, November 2018.

² Jean Barbot, *Barbot on Guinea: The Writings of Jean Barbot on West Africa 1678-1712, Vol. II*, ed. Paul Hair, Second 176 (Hakluyt Society, 1992), 575.

³ Harvey M. Feinberg, ‘New Data on European Mortality in West Africa: The Dutch on the Gold Coast, 1719–1760’, *The Journal of African History* 15, no. 03 (1974): 367.

Similarly, between 1830 and 1840, six successive Danish Governors of the Christiansborg perished. It has been suggested that it was partly due to their high mortality that the Danes decided to abandon the Gold Coast and subsequently sold their possessions to the British in 1850.⁴ Raymond Dumett notes that the death of “European officials” was “as high as 75.8 per thousand” between 1881 and 1897 and for Missionaries, traders and miners, mortality rate stood at an average of 81.48 per thousand per year between 1879 and 1888.⁵

The likely causes of death in most of these instances have been attributed to yellow fever or malaria.⁶ Yet, initially, the cause of ill-health and high mortality among the European population was attributed to the insalubrious climatic and environmental conditions and the presence of some noxious air. Willem Bosman, a leading Dutch merchant, and a slave dealer, commenting on the health status of the Gold coast in 1702 attributed the insalubrious nature of the littoral zone to two factors. The first was what he observed as the abrupt transition in temperature – that is the acute heat during daytime and the coolness of the night. This condition according to him, induced in European expatriates’ contrary effects, which caused them to be ill, particularly, those who were not accustomed to withstanding more heat than cold. Secondly, he observed that the several mountains that surrounded the coastal settlements and the valleys in-between them produced, “every morning a thick, stinking, and sulphurous damp or mist”, especially, around waterlogged areas or rivers.⁷

This mist, according to him, was poisonous and it induced an infection that was impossible to escape, which killed Europeans, but not Africans. Bosman observed further that the African population suffered less casualty to this ‘corrupt and infectious air’ and did not suffer “any distempers, because being born in that unhealthy air, and bred up in sloth, and that stench, those things little affect them.”⁸ Bosman’s claim suggests that the African population was immune to the environmental and climatic conditions because of their long association with it.

⁴ Addae, *The Evolution of Modern Medicine in a Developing Country*, 1997, 10.

⁵ Dumett, ‘The Campaign against Malaria’, 115.

⁶ Addae, *The Evolution of Modern Medicine in a Developing Country*; see also, Dumett, “The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898 - 1910.”

⁷ Willem Bosman, *A New and Accurate Description of the Coast of Guinea, Divided into the Gold, the Slave, and the Ivory Coasts* (Sir Alfred Jones, 1705), 105–6.

⁸ Ibid.

Bosman further lamented that some insanitary habits and practices of the African population also contributed to the noxious air, and more broadly, the unhealthy environment. 'The stench of this unwholesome mist' he wrote:

...is very much augmented by the negroes' pernicious custom of laying their fish for five or six days to putrify(sic) before they eat it, and their easing of their bodies around their houses, and all over their towns; and if this odious mixture of noysome(sic) stenches very much affects the state of health here, it is not to be wondered since 'tis next to impossibility, not only for newcomers, but those have long continued here, to preserve themselves extremely from its malign effects.⁹

Bosman's remark, however, requires some qualifications. Firstly, the assertion that fish was kept until rotten before it was consumed is a misrepresentation. It is a misunderstanding of a method by which the people processed and preserved fish for consumption. What Bosman observed was the 'sun-drying' of fish which was a common and simple but effective method of curing fish for preservation. Sun-drying was often done "in combination with salting and/or fermentation." The fish was usually, washed, spread on the ground (on the beach) or mats, and left to dry between three to five days.¹⁰

Secondly, Bosman's suggestion that the African population disregarded any environmental and sanitary precaution seems inaccurate. Sjaak van der Geest has suggested for example, that the Akan – the dominant population along the coast, who Europeans often encountered and wrote about – were often keenly concerned with environmental cleanliness. However, it was, according to him, their method of getting rid of faecal matter which appeared inefficient, leaving them to be confronted with what they might have detested – filth, particularly, faeces.¹¹ It was thus, probably, not correct that the people were giving to deliberate indiscriminate defecation in their townships, but rather, their crude method of disposing of human excreta is what might have created the situation that Bosman observed.

⁹ Ibid.

¹⁰ see R D Pace, W A Plahar, and J Y Lu, 'Status of Traditional Food Preservation Methods for Selected Ghanaian Foods', *Food Reviews International* 5, no. 1 (1989): 1–12.

¹¹ Sjaak Van Der Geest, 'Akan Shit: Getting Rid of Dirt in Ghana', *Anthropology Today* 14, no. 3 (June 1998): 8–12.

Nevertheless, such views expressed by Bosman and others held sway as the standard explanation of the health status of the Gold Coast well beyond the 18th century. About a century later, Joseph Dupuis, an English official corroborated these earlier assertions. Writing in 1820, he noted that, “as regards climate or atmosphere, the Gold Coast and places adjacent to the settlements [on the coast] are more or less known to be unhealthy.”¹² It must, however, be remarked that not every part of the Gold Coast appeared so unwholesome, at least, to some of these European observers. For instance, Dupuis, comparing the coastal regions to the interior, noted that, “...But I will hazard an opinion that the countries inland are infinitely salubrious, the aire (sic) more pure, and the soil less humid and vaporous than at any station on the coast...”¹³

It is obvious that these observations and comments had no scientific basis. Rather, they were fed by the miasmatic theory of disease which was the standard aetiological thought until the bacteriological revolution of the late 19th century supplanted it and diminished its significance. Until then, it was generally held that the bad air of the tropical climates was the cause of malaria – the greatest cause of European mortality in West Africa, and indeed, the word malaria derives from the Italian word for swamp, *mal'aria* – which translates literally as ‘bad air’.

The representation of the Gold Coast climate and environment as unwholesome, and as a place abounding in deadly diseases received high publicity in Europe, causing fear, panic, and psychological traumas amongst future travellers. And in this, other West African territories shared a similar status. Referring generally to the Guinea coast, Henry Meredith wrote in 1812 that the region had gained notoriety in Europe about its fatality to the health of European expatriates.¹⁴ An anecdote Meredith recorded in the same year is revealing:

In 1807, one of His Majesty's ships was ordered to the coast of Guinea; which caused such depression of spirits in the Captain, that he acquainted his particular friends he was bound to a part of the globe, whence he did not expect to return. He made his will, and in other respects arranged his affairs. After

¹² Joseph Dupuis, *Journal of a Residence in Ashantee, Comprising Notes and Researches Relative to the Gold Coast and the Interior of Western Africa*. (London: Henry Colburn, 1824), 84.

¹³ Ibid.

¹⁴ Henry Meredith, *An Account of the Gold Coast of Africa with a Brief History of the African Company* (London: Longman, Hurst, Rees, ORME and Brown, Paternoster Row, 1812), 39.

touching at Goree and Sierra Leone, the ship anchored at Cape Coast. The Captain visited the Governor, dined and slept on shore: on the following day, he complained of being unwell, went on board, took to his bed, and resigned himself to that lowness of spirits which he had given way to on sailing from England; and in a very few days after, was buried on shore.¹⁵

Certainly, what caused the high mortality and morbidity of Europeans in the Gold Coast littoral had little to do with noxious air and the abrupt transitions in temperature or the supposed insalubrity of the climate. Rather, European sojourners to the Gold Coast died from diseases that were endemic to this region. The physical environment of the Gold Coast predisposed it to many diseases that Europeans who visited the region had no immunity and which the barber-surgeons who accompanied them had no skill in treating. As Bosman noted in 1702, European surgeons on the coast were “unskilled physicians” who out of their ignorance endangered the lives of many.¹⁶ Thus, many of the Europeans died of one or another of the common diseases that the Gold Coast was predisposed to, but chiefly from malaria and yellow fever. It is now commonly known that West Africa has been home to the most severe form of malaria [*Plasmodium falciparum*] and yellow fever which is transmitted by the *Anopheles gambiae* and *Aedes aegypti*, respectively, both species of mosquito.¹⁷ And as Patterson notes “malaria was holoendemic throughout the Gold Coast”, emphasising the existence of conditions that facilitated the breeding of the *Anopheles gambiae*.¹⁸

European writers such as Bosman, Pieter de Marees, Henry Meredith, Brodie Cruikshank, Edward Bowdich and Joseph Dupuis, all of them, writing between the 17th and the 19th centuries, variously, recorded contemporary accounts of some of the commonest diseases that they observed in the Gold Coast. Patterson lists the commonest amongst them and they include, ascaris, filaria, hookworms, guinea worm, schistosomiasis, yaws, leprosy, yellow fever, dengue, pneumonia, tropical ulcer, amoebic and bacillary dysentery.¹⁹

¹⁵ Ibid., 39–40.

¹⁶ Bosman, *A New and Accurate Description of the Coast of Guinea, Divided into the Gold, the Slave, and the Ivory Coasts*, 106.

¹⁷ see Emmanuel Kwaku Akyeampong, ‘Disease in West African History’, in *Themes in West Africa’s History*, ed. Emmanuel Kwaku Akyeampong (Oxford: James Currey Publishers, 2006), 186–207.

¹⁸ Patterson, *Health in Colonial Ghana*, 2.

¹⁹ Ibid.

However, while it is true that many parts of the Gold Coast were predisposed to several diseases, it is also true that some diseases were introduced from outside. Patterson notes that the Gold Coast's participation in the long-distance trade that connected sub-Saharan Africa to the Northern Africa, dating as far back as 1200 CE, exposed the people to other diseases of other regions of the African continent which they did not have immunity. But also "the European ships and castles" that lined the Gold Coast littoral from the 15th century onward 'were the foci for the diffusion of diseases like smallpox and syphilis.'²⁰ Significantly, then, the arrival of Europeans during the 15th century further inclined the country to new diseases which complicated the disease ecology.²¹

'Dirty Inhabitants, Squalid Dwellings, and Ugly Townships'

It has been reckoned that the manners, customs, and habits of the African population contributed to the insalubrity of the environment that predisposed the population to diseases. Their buildings were said to be of, generally, low quality, lacking enough ventilation; and their dwellings were described as filthy and full of pungent smells. Pieter de Marees, a Dutch merchant and explorer, and one of the earliest Europeans who wrote a detailed description of West Africa wrote disparagingly of the dwellings in the coastal settlements of Gold Coast. He noted that:

In general, their dwellings or houses are nothing special, being of very poor quality and rather like pigsties. Indeed, I think that in many countries even pigsties are better than the houses and dwellings which some people have here.²²

About eighty years later, Jean Barbot, confirmed de Marees's assertion, noting that:

Generally, their houses are dirty, uncomfortable, and for the most part stinking, particularly, those which have privy huts [*huttes de commodities*], for which great heat causes a very foul air to spread abroad, and this the land wind carries even to the vessels in the roadstead.²³

²⁰ Patterson, *Health in Colonial Ghana*.

²¹ Ibid.

²² Pieter De Marees, *Description and Historical Account of the Gold Kingdom of Guinea (1602)*, trans. A. Van Dantzig and Adam Jones (Oxford University Press, 1987), 75.

²³ Barbot, *Barbot on Guinea*, 511.

About two centuries later, Richard Burton observed that the African population lived in dark, damp, ill-ventilated rooms, sharing space with pieces of decayed fish and meat, scattered everywhere on the ground.²⁴

The coastal towns were described as containing unhealthy features, poorly planned, slovenly, and stinking; and streets, narrow and crooked. de Marees wrote that:

There is nothing especially noteworthy about their towns on the coast, except that they are ugly places and stink like carcasses because of the rubbish which they throw out on the roads in heaps. Indeed, there is always such a stench and such foul air that if the wind blows from the landward side, one can smell the foul air one and half miles out to sea.²⁵

Such narratives continued to pervade European accounts deep into the 19th century. Charles Alexander Gordon, a British Deputy Surgeon-General sent to the Gold Coast in 1847 made similar observations as de Marees. Writing on Cape Coast, he noted that:

The part of the town occupied by the poorer classes consists of houses terribly huddled together, along the opposite faces of what is a deep valley, along which in the rainy season, a considerable torrent runs, and where, during the dry season, all kinds of filth, the most abominable accumulate. From this ravine offshoots extend in various directions among the houses; myriads of frogs domesticate themselves.²⁶

Writing about three years after Gordon, Cruickshank noted that in Cape Coast, “African houses were huddled together in the most crowded manner, and without the slightest regard to light, or air or the convenience of approach.”²⁷ Another contemporary observer, an African, and a staff assistant surgeon in the service of the British West African Forces, Africanus B. Horton, wrote generally of the coastal towns, noting that “the native huts were huddled together, pell-mell, without any plan; there

²⁴ Richard Francis Burton, *Wanderings in West Africa from Liverpool to Fernando Po* (London: Tinsley brothers, 1863), 85, <http://archive.org/details/wanderingsinwest02burtiala>.

²⁵ Marees, *Description and Historical Account*, 75.

²⁶ Sir Charles Alexander Gordon, *Life on the Gold Coast* (Baillière, Tindall, & Cox, 1874), 4.

²⁷ Brodie Cruickshank, *Eighteen Years on the Gold Coast of Africa: Including an Account of the Native Tribes, and Their Intercourse with Europeans* (Hurst and Blackett, 1853), 23.

are scarcely any streets or proper lanes, but as a whole, only crooked by-paths.”²⁸ It was reckoned that almost all the townships along the coast contained swamps and ponds that produced very awful smell and harboured mosquitoes; they had no drainages, no public or private latrines and relied on animals to scavenge their refuse. There was no potable drinking water and most of the people relied on ‘brackish ponds or swamps’ for their water supply.²⁹

Only the parts in the towns that were occupied by European merchants and officials, and rarely some wealthy Africans, were said to be in some good condition. In Cape Coast, Gordon observed that:

In the parts of the town where Europeans merchants or wealthy natives reside, the houses are of a superior kind, being composed of brick, flat-roofed, and well white-washed. The two principal streets are wide like boulevards...³⁰

Even so, Cape Coast was a poor exception. It was, partly, because of its perceived unhealthy environment and insanitary status that the colonial government relocated its headquarters from there to Accra in 1877. Yet, it did not seem that Accra was any better, except for what appeared to be the absence of “swamped land in its immediate neighbourhood.”³¹ Richard Burton wrote in the 1860s that Accra rarely had anything that could be called a street and that the township was dirty, slovenly, and unswept, relying on pigs to scavenge the refuse-strewn walk-ways.³² Indeed, British officials admitted that the township of Accra was badly built, with narrow and crooked streets, and that the inhabitants rarely observed any form of sanitation. Even so, the official view was that Accra was healthier for European residents than other parts of the coast.³³

Be that as it may, the sanitation and health status of the coastal settlements did not improve and by the 1870s, the situation had deteriorated further. Gale writes that

²⁸ James Africanus B. Horton, *Physical and Medical Climate and Meteorology of the West Coast of Africa: With Valuable Hints to Europeans for the Preservation of Health in the Tropics* (London: John Churchil & Sons, 1867), 132, <http://archive.org/details/physicalandmedi00hortgoog>.

²⁹ see Gale, “Official Medical Policy”; James Africanus B. Horton, *Physical and Medical Climate and Meteorology of the West Coast of Africa*; Richard Francis Burton, *Wanderings in West Africa from Liverpool to Fernando Po* (London: Tinsley brothers, 1863), <http://archive.org/details/wanderingsinwest02burtiala>.

³⁰ Gordon, *Life on the Gold Coast*, 4.

³¹ Gale, ‘Official Medical Policy’, 64.

³² Burton, *Wanderings in West Africa from Liverpool to Fernando Po*, 141.

³³ Gale, ‘Official Medical Policy’, 64.

the health status of Cape Coast seemed hopelessly irredeemable to the extent that “No sanitary[sic] work would materially diminish the unhealthiness of the place for Europeans.”³⁴ The mortality though, of the Europeans had begun to decline steadily, but not because of improved sanitation, but rather because of the discovery of quinine as a prophylactic against malaria and its sustained use amongst European expatriates.³⁵ Even so, European mortality on the coast remained relatively high. And British officials hesitated in accepting posting as Governors of the forts and castles that were lined along the southern coast because of its health status.

Dumett writes that following the British expedition against Asante in 1874, in which British soldiers succumbed to diseases rather than fell in battle, three senior British officials declined offers as Governors of the Gold Coast, and justifiably so, because the fourth official who accepted, died few months on arrival, and the cause was malaria.³⁶ There had been no improvement in the settlement patterns of the coastal towns, the towns remained poorly drained, and the swamps remained polluted, open defecation was common and the streets were still strewn with refuse.³⁷ In 1871, Ferdinand Fitzgerald, the London editor of the *African Times*, described Cape Coast as ‘one vast public privy and a dunghill.’³⁸ Before Fitzgerald, Africanus B. Horton had in 1867 lamented that people had been erroneously blaming the death of Europeans on the coast on climate when the real problem was the absence of any form of sanitary system.³⁹ It was on account of some of these scathing criticisms and the recognition by the newly constituted colonial government of its responsibility to provide sanitary amenities as a *sine qua non* for ending the unnecessary loss of European lives that after 1874, concrete attempts were made to contain the insanitary situation.

It must be remarked, however, that how much truth there may be in these European narratives, it is impossible to say. Similarly, there could be a high possibility that most of these accounts were overly exaggerated and others, tainted with

³⁴ Ibid., 62.

³⁵ For information on the relationship between the prophylactic use of quine against malaria and mortality rate of Europeans on the coast, see Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*, 1 edition (Oxford University Press, 1981), 69–70.

³⁶ Dumett, ‘The Campaign against Malaria’, 157.

³⁷ Dumett, “The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898 - 1910”; see also Addae, *The Evolution of Modern Medicine in a Developing Country*.

³⁸ *The African Times*, 24 April 1871, cited in Gale, “Official Medical Policy in British West Africa,” 54.

³⁹ see Gale, ‘Official Medical Policy’.

prejudice. Indeed, in later years, some British colonial officials admitted to the mischief that was intended in sustaining a bad reputation of the Gold Coast. An extract from an 1887 report by Dr C. H. Eyles, the Assistant Colonial Surgeon in charge of Axim, a coastal town located to the western part of the country is revealing:

As I have frequently remarked in my official reports, this Colony is overshadowed by a curse, the curse of a bad name. It would serve no useful purpose 'to waste the time yet ours, in trampling on thistles because they have yielded no figs,' it is useless lamenting the fact that to preserve the monopoly of an extraordinarily lucrative trade, merchants have dammed the place by giving it a bad name, and thus crippled all attempts at developing the resources of the Colony. We can at least serve one useful purpose, we can show that we enjoy no monopoly of anyone peculiarly fatal and malignant disease; that even malaria we cannot claim pre-eminence, for the 'pernicious comatose' form of malarial fever in which after a single paroxysm the patient dies in coma.⁴⁰

In 1912, the Senior Sanitary Officer, Thos C. Rice, quoted Eyles's observation fully and commented that: "There can be no doubt that in the past, officials, as well as merchants, have caballed to keep up the evil reputation of the colony."⁴¹ Notwithstanding these possible exaggerations, and the potential mischief that may have been intended in some of the writings, some of the accounts were nevertheless, probably, fairly correct. What is difficult to admit, however, is whether the descriptions written about the 17th century and beyond could fit the situation before European contact. This is a difficult question and any attempt to answer may be speculative. However, given that these were contemporary accounts, the earliest dating to the early part of the 17th century, almost two centuries after the Europeans arrived on the Gold Coast, the picture painted in the 17th century and beyond cannot be assumed to represent the earliest period. Many of the settlements before European contact were most likely small enough, so that nature's scavengers and the sun were most likely sufficient to dispose their sewerage and refuse.

What is clear, however, which is not accounted for in these European accounts is that most of the squalor which characterised the coastal towns from the 17th century

⁴⁰ Government of the Gold Coast (Hereafter GGC), 'Sanitary and Medical Reports, June 1887', Quarterly (Gold Coast, 1887), 24, British Online Archive, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>. Accessed, 25/6/2017

⁴¹ GGC, "Medical and Sanitary Report for the Year 1912" (London: Waterlow & Sons Limited, Printers, London Wall, 1913), 101, BOA, <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>. Accessed, 25/6/2017

and beyond which the European records so lucidly describe, was itself, partly a function of the arrival and settlement of the Europeans on the coast. The arrival of the Europeans stimulated a steady growth in trade. This development redirected pre-existing trade traffic from trade routes that extended from the interior to the Northern part of the Gold coast and beyond, towards the coast, attracting African newcomers who were enthralled by the commercial exploits of these coastal towns.

The obvious implication of the redirection of trade traffic towards the coast was increased population and expansion of coastal towns. Thus, one of the earliest consequences of European presence on the coast was that by the beginning of the 18th century, about two centuries after their first contact, the initial development of some nascent urbanisation along the coast was beginning to emerge. Writing on 18th century developments of the Gold Coast, Walton Claridge observed that at the beginning of the 18th century:

The seaboard was still divided into practically the same kingdoms as those that existed when the Portuguese settled on the coast; but the centres of trade with Europeans had increased the importance of the coast towns and raised them from the position of tiny fishing villages to that of prosperous trading centres, which either became the capital of their respective kingdoms or rivalled the capital in importance.⁴²

This process continued throughout the 18th century and beyond and as the coastal towns continued to expand, and their populations increased, new fishing villages began to emerge around them. Sanitary challenges accompanied these developments.⁴³ Thus, the effect of trade and the concomitant development of some incipient form of urbanisation had a series of repercussions on the coastal settlements; and the depressing sanitary conditions was intimately connected to these processes.

In the meantime, European merchants and officials on the coast had already begun to exercise some form of authority over the African population residing within the precincts of their forts and castles, from about the eighteenth century which was

⁴² William Walton Claridge, *A History of the Gold Coast and Ashanti from the Earliest Times to the Commencement of the Twentieth Century, Vol. 1* (London: J. Murray, 1915), 115, <http://archive.org/details/historyofgoldcoa00clarrich>.

⁴³ see David Kimble, *A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1925* (Oxford: Oxford University Press, 1963).

solidifying by the nineteenth century.⁴⁴ Yet, they could hardly compel the African population to maintain any form of sanitation. The problem, as noted by David Kimble, was that “the forts tended to over-shadow and depress the power of the chiefs, who yet retained sufficient authority to hamper direct control” by the European administrators.⁴⁵ Thus, the power of the chiefs to compel their people to perform municipal functions like cleaning and sweeping within their communities was somewhat impaired, and this impinged on the management of sanitation in the coastal settlements. And yet, the European administrators were helpless about compelling the people to adhere to ‘proper’ sanitary practices without the support of their chiefs. In the 1850s, Governor Pine admitted to his frustration over the inability to persuade the inhabitants of Cape Coast to clean up and reorganise their township.⁴⁶

Nonetheless, the culpability of European officials to the insanitary conditions was not altogether lost on some observers. Ferdinand Fitzgerald, for example, in 1871, remarked of the European officials as people who could “enjoy their mistresses and drink their brandy and champagne upon a dung heap, provided they may occupy the highest position on the stinking mess.”⁴⁷ This stricture must, however, be qualified. It is doubtful that European officials during this period had the needed funds or the requisite legal backing, which could enable them to provide the kind of sanitary amenities that was necessary to keep the settlements sanitised and healthy.

In pre-European Gold Coast, there seemed to have existed in many parts of the country a system of municipal government that ensured the sanitation of their towns. Casely Hayford wrote that in the pre-European period, “Each important township’ had ‘its sanitary board, arrangements for the carrying out of public works, and other necessary provisions for the due and proper regulations of the internal government of the little community.”⁴⁸ The local chiefs had a Council which comprised

⁴⁴ For example, in 1830, the British crown assumed direct control of their possessions on the Gold Coast and placed it under the governor of Sierra Leone. In 1844, representatives of the crown signed a bond with some prominent chiefs in the coast and in the interior in which the African chiefs ceded some of their judicial powers to the British crown. Before the 1800s, the administration of the forts and castles was handled by the company of merchants – this has been called by some as the period of company rule.

⁴⁵ Kimble, *A Political History of Ghana*, 142.

⁴⁶ Ibid.

⁴⁷ Quoted in Gale, ‘The Struggle against Diseases in the Gold Coast’, 187.

⁴⁸ Hayford, *Gold Coast Native Institutions*, 110.

the various wards of the towns represented by their *Asafuhene*⁴⁹. The chief relied on this Council for such municipal functions as cleaning and clearing of bushes. A description of the functions of the Chief's Council by Cruikshank, as he observed during the 19th century, is instructive:

their duty [chief's council], properly speaking, is to look after the police of the town, to suppress nuisances in the street, to clean the parts and roads in its neighbourhood, and to promulgate the edicts of the chiefs and his counsellors, as well as any other notice which it is necessary to make to the public.⁵⁰

He, however, noted that "...whatever might have been the efficiency of their service on their first appointment, they are now totally worthless. Inefficient as police, and totally regardless of the state of their streets."⁵¹

What Cruikshank was not aware of, was that it was partly, due to the presence of Europeans and their attempts at various points to impose their authority on the African population that had impaired the initiatives of the African chiefs and their Councils in such matters. Casely Hayford lamented that:

The effect of intercourse with Europeans on the part of the people of the coastal towns has been to disorganise their own formal municipal arrangements and to throw them back upon such haphazard provisions as the government has felt inclined to make. It is like the case of the dog in the manger. The Government will do nothing effective, and they neutralise the influence of the native Chiefs who would otherwise carry out necessary sanitary arrangements.⁵²

Some European officials admitted to their negative influence on native authority on the Coast. In 1865, Sir Benjamin Pine appearing before the Parliamentary Select Committee on West Africa admitted that:

⁴⁹ The Asafuhene was the head of the Asafu company. He could be regarded as a Captain-General. The Asafu is essentially a warrior group and it is the term used to refer to all male adults organised for the purpose of war. According to De-Graft Johnson, the term Asafu can also be used in a broader sense to delineate a "socio-politico-military organisation" that has within its ranks, both male and female, including chiefs and other members of the political elite. see J. C. De Graft Johnson, "The Fanti Asafu", *Journal of International African Institute*, Vol. 5, no. 3 (1932), 307-322.

⁵⁰ Cruickshank, *Eighteen Years on the Gold Coast of Africa*, 250.

⁵¹ Ibid.

⁵² Hayford, *Gold Coast Native Institutions*, 111.

the native municipality in Cape Coast does not work at all, but in the interior, where there has been no interference with native government it works very well. They keep their towns in order and clean.⁵³

He explained further that the interior was better managed than the coast because "...the Chief and people on the coast rely upon us and we rely upon them and between the two there is no government at all."⁵⁴

In the interior where there was no sustained contact with Europeans, the situation was different. The Asante were regarded to be favourably disposed to cleanly manners and habits and had sound and practical sanitary arrangements and practices. Thomas Edward Bowdich's account of his visit to Kumase in 1817 is revealing. He noted:

What surprised me most and is not the least of the many circumstances deciding their great superiority over the generality of Negroes, was the discovery that every house had its cloacae, besides the common ones for the lower orders without the town. They were generally situated under a small archway in the most retired angle of the building, but not infrequently up-stairs, within a separate room like a small closet, where the large hollow pillar also assists to support the upper story: the holes are of a small circumference but dug to a surprising depth, and boiling water is daily poured down, which effectually prevents the least offence. The rubbish and offal of each house was burnt every morning at the back of the street, and they were as nice and cleanly in their dwellings as in their persons.⁵⁵

William Hutton, an acting Consul to Asante and an official in the service of the English African Company wrote in 1820 affirming Bowdich's assertion. He stated that:

Mr Bowdich's observations regarding the houses with cloacae, and the general cleanliness of the Ashantees are correct; and there can be no doubt that in the arrangement of their dwellings, they are superior to many of their neighbours.⁵⁶

In the same year, another British Consul, Joseph Dupuis, observed that in Asante,

⁵³ Quoted in Bridglal Pachai, 'An Outline of the History of Municipal Government at Cape Coast', *Transactions of the Historical Society of Ghana* 8 (1965): 132.

⁵⁴ Ibid.

⁵⁵ Thomas Edward Bowdich, *Mission from Cape Coast Castle to Ashantee: With a Descriptive Account of That Kingdom*, New Edition (Griffith & Farran, 1873), 256.

⁵⁶ 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, Longman, Hurst, Rees, Orme, and Brown, 1821), 237, <http://archive.org/details/avoyagetoafrica01huttgoog>.

Both men and women are particularly clean in their persons, the latter washing themselves, and the former being washed by them daily on rising, from head to foot, with warm water and Portuguese soap, using afterwards the vegetable grease or butter which is a fine cosmetic. Their clothes, which are beetled are always scrupulously clean.⁵⁷

It is clear from these accounts that the Asante people maintained a strict regime of sanitation and hygiene which invariably resulted in what has been described as their relatively good health and salubrious environment.⁵⁸ Indeed, the cleaning of “streets in the suburbs of Kumase and the maintenance of sanitation” and hygiene was organised and bureaucratised under a structure – that could be characterised as a public works department, headed by a chief who occupied the *Akwanbofo* stool⁵⁹. Workers for the department were dispatched every day to clean streets and instruct people to clean their surroundings when it was deemed necessary.⁶⁰

Frederick Boyle, a correspondent to the *Daily Telegraph* in Britain who was sent to cover the British expedition against Asante in 1874 remarked that their “...sanitary arrangements ... are equally strict and descent in all Ashantee [sic] dwellings...the smells of Coomassie [sic] are never those of sewage.”⁶¹ It has been reckoned that the Asante people also maintained wide streets adorned with beautiful shade trees. Capt. Henry Brackenbury and Capt. George Lightfoot Huyshe⁶² observed in 1874 that the streets of Asante “are generally very broad and clean, and ornamented with many beautiful banyan-trees affording grateful shade from the powerful rays of the sun.”⁶³

Thus, the evidence reveals that as much as the Gold Coast littoral appeared to share the unenviable label of a “graveyard and a dunghill”, the interior, as the case of

⁵⁷ Joseph Dupuis, *Journal of a Residence in Ashantee, Comprising Notes and Researches Relative to the Gold Coast and the Interior of Western Africa ...* (H. Colburn, 1824), 266.

⁵⁸ see Maier, ‘Nineteenth Century Asante’.

⁵⁹ This will translate literally as “stool in charge of road maintenance” and the occupant of the stool as the “Superintendent of Roads.”

⁶⁰ Maier, ‘Nineteenth Century Asante’.

⁶¹ Frederick Boyle, *Through Fanteeland to Coomassie, a Diary of the Ashantee Expedition* (London, Chapman and Hall, 1874), 352, <http://archive.org/details/throughfanteela00boylgoog>.

⁶² Brackenbury was an assistant secretary to the leader of the British expedition in 1874, Major-General Garnet Wolseley, and a former professor of military history at the Royal Military Academy of Woolwich, and Capt. George Lightfoot Huyshe was a deputy-assistant Quartermaster-General who was also part of the Wolseley expedition.

⁶³ Henry Brackenbury and George Lightfoot Huyshe, *Fanti and Ashanti, Three Papers Read on Board the S. S. Ambriz on the Voyage to the Gold Coast* (Edinburgh and London: W. Blackwood and Sons, 1873), 118, <http://archive.org/details/FantiAshanti00Brac>.

the Asante illustrate, were clean and salubrious, having kept intact their indigenous sanitary arrangements – a development that was possible because of the limited European influence on their traditional institutions. A late nineteenth-century observer, Moloney-Kimberley captured this in a profound statement when he noted that, "...but the sanitary systems in the coastal settlements were inferior to those in the African towns in the interior where contact with civilisation had not yet destroyed their primitive but practical sanitary arrangements."⁶⁴ On the strength of this evidence, it is suggestive that the European intercourse with the African population on the coast impinged on the health status of their towns/villages. Admittedly, the sanitation and health of the coastal settlements did not seem to be in good shape, yet the presence of European and their activities did not help to improve the situation either, at least, before the 20th century.

Conclusion

I have examined the health status of the Gold Coast up to the late 19th century when the first public health ordinance was enacted. I have highlighted the unanimity of European accounts of the insalubrity of the coastal environment, its unhealthy climate, and the poor state of sanitation in the coastal settlements — a condition which was held to be responsible for the high morbidity and mortality rate of European residents and sojourners. I have, however, demonstrated that it is not entirely accurate to label the entire settlements on the Gold Coast before this period as unhealthy and its people as generally predisposed to uncleanness and unhygienic habits. The interior regions adhered to strict regimes of sanitation and hygienic practices and their environment was salubrious and healthy.

I have therefore suggested that the European presence on the coast was itself implicated in the steady deterioration in the sanitary and health conditions in the settlements there. The steady inflow of traders to the coast and the consequent growth in population and the expansion in the size of the African settlements did not help in the sanitary situation in the coastal settlements. But, also the impact of European presence on chiefly rule crippled the local rulers in the coastal settlements who could no longer enforce their sanitary norms, and neither could the European administrators

⁶⁴ Moloney-Kimberley, 7 Aug. 1882, CO 96/142, cited in Gale, "Official Medical Policy in British West Africa", 48. I suppose by "civilisation", he meant European influence.

on the coast compel the African population to adhere to proper sanitation standards because of the transient nature of their authority before formal colonisation. Thus, by the late 19th century, when the Gold Coast was officially colonised the health status of the coastal settlements and their sanitation remained, from the accounts of European writers, merchants, etc., extremely depressing. How the colonial administration intended to address these sanitation and hygiene problems will form the focus of the subsequent chapters.



Chapter Three

The Organisation of Public Health Administration and Sanitary Reforms in the Gold Coast

Introduction

This chapter outlines the organisation of public health and sanitary administration. I begin by sketching the context and the state of public health administration and sanitary reforms during the late 19th century and the conditions which eventually led to the enactment of the first public health ordinance in 1878. The conditions under which the first-ever public health administrative structure, the GCMD was established are examined. The circumstances leading to the establishment of the Sanitary Branch of the GCMD in 1909 are then discussed. I also investigate the circumstances and discourses surrounding the evolution of a complex mix of administrative units, agencies, and agents viz – the Central Board of Health (CBH), Sanitary Committees, Native Authorities, Sanitary Inspectors and Village Overseers, and their respective roles in the public health administration and sanitary reforms. Thus, this chapter is as much about a description of the various rules, regulations and administrative units that were devised to administer sanitary reforms and public health, as it is about an analysis of the circumstances and discourses that produced these administrative structures and regulations.

Administering the Public Health and Sanitary Reforms: The Legalistic Approach

In chapter two, I discussed the health status of the Gold Coast before 1878. One of my conclusions was that despite the relatively better health status of the interior, the dire insanitary and health conditions in the coastal settlements was yet to be abated by the late 19th century. And of course, this was expected since no systematic efforts had yet been made to mitigate the poor sanitary conditions that rendered the coastal towns unhealthy. Indeed, Raymond Dumett has contended that by the close of the 19th century, of all the British West African colonies, the Gold Coast presented the

most formidable health problems.¹ To mitigate this challenge, initial attempts were made to provide basic health services, particularly, in the towns with a higher concentration of European population. In 1878, the army medical services that were based at Accra, Cape Coast, Keta, and Elmina were extended to civilians and a new medical hospital with admission facilities was constructed in Accra. By the early 1890s, health services were extended to other towns such as Ada, Dixcove, Salt Pond and Winneba.²

Before 1878, some rudimentary measures were taken to reverse the insanitary situation in the coastal settlements. For example, steps were taken to abolish home burials. To make this effective, plans for cemeteries were drawn up for Anomabu and Cape Coast in 1873 and 1874 respectively. Again, to provide potable water for the European officials residing in Cape Coast, a condenser was ordered in 1873.³ These measures were, however, too basic to address the many sanitary challenges and its associated health problems. And of course, the focus on the health of the European population meant that the health requirements of the African population remained unattended. Subsequently, the health status of the Gold Coast had shown little improvement by the late 1870s, particularly so, when public works crew mandated to embark on sanitary projects necessary to combat diseases had themselves, either been invalidated or killed by diseases.⁴

The lack of improvement in health conditions raised concerns in the Colonial Office and other official circles. For instance, in 1877, Dr Gage Brown, the medical advisor to the Colonial Office decried the deplorable health situation of colonial administrators who were posted to the Gold Coast. He lamented that many healthy men who were sent there returned home completely frail.⁵ It was because of the failing health of European officials in the colonial administration in the Gold Coast that in 1878, the Colonial Office conceded to a petition from officials to increase their leave period and reduce their tour period from eighteen to twelve months.⁶ Even though such

¹ Dumett, 'The Campaign against Malaria', 167.

² Addae, *The Evolution of Modern Medicine in a Developing Country*.

³ see Gale, 'Official Medical Policy'.

⁴ see Dumett, 'The Campaign against Malaria'

⁵ see Gale, 'Official Medical Policy'; Gale, 'The Struggle against Diseases in the Gold Coast'.

⁶ Gale, "Official Medical Policy in British West Africa"; Dumett, "The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898 - 1910" Before this period, a

a decision effectively meant that more money was to be expended on colonial officials than on improving the conditions in the Gold Coast, a Principal Clerk in the Colonial Office, A. W. L. Hemming noted that their "...first duty was to attend to the welfare of our officers, and only a secondary one to attempt to (we shall never get beyond this stage) to improve the colony."⁷ The tendency to slight the interest of the African population for those of the European officials as implied in Hemming's reasoning demonstrates the half-hearted attitude of the colonial administration towards solving the pressing health problems during this period.

Nevertheless, in 1878 the colonial administration took the first practical step towards solving health problems by enacting its first public health law, the *Towns, Police and Public Health Ordinance*. The ordinance was immediately applied in Accra, Cape Coast, and Elmina.⁸ The ordinance was repealed in 1892 and applied in twelve districts, namely, Accra, Ada, Axim, Cape Coast, Shama, Dixcove, Keta, Prampram, Saltpond, Volta River, Wassa and Winneba districts. Together, these districts had a total of thirty-nine towns under their jurisdiction.⁹ As it so often happened, the ordinance was modelled on public health Acts that were passed in Britain during the mid-1840s and the early 1870s, namely the Nuisances Removal and Disease Prevention Act of 1846, the Towns Improvement Clause Act of 1847, and the Public Health Act of 1875 which codified all the existing sanitary legislation.¹⁰

Essentially, the ordinance aimed at keeping the towns and villages in the Gold Coast clean and in proper sanitary conditions. To that extent, it entrusted the maintenance of streets, and the power to demolish 'dangerous' structures or buildings in the Director of Works. The colonial secretary could after paying the requisite compensation acquire any land or 'easement' "for the purposes of widening, opening,

colonial administrator had to serve in the colony for 18 months he could apply for leave. By this new arrangement, an officer after having served for 12 months could apply for leave.

⁷ Quoted in Gale, 'Official Medical Policy', 68.

⁸ see Gale, 'The Struggle against Diseases in the Gold Coast'; Gale, 'Official Medical Policy'; Dumett, 'The Campaign against Malaria'. The Act was also applied in Lagos which was then under the government of the Gold Coast colony.

⁹ Griffith, *Ordinances, Vol. II*, 737–38.

¹⁰Rosen, *A History of Public Health*, 2015, 123; Porter, *Health, Civilization, and the State*, 126; Gale, 'The Struggle against Diseases in the Gold Coast.' Deteriorating sanitary conditions in Britain following the emergence of the industrial revolution and the discontent that it engendered would compel the government to enact several legislative measures during the fourth decade of the 19th century. These acts formed the prelude to the first public health law in Britain which was passed in 1848.

enlarging, draining, or otherwise improving any street, or of making a new street.”¹¹ However, unoccupied lands could be acquired for the same purposes without paying compensation. Fines were imposed on persons who contravened the provisions of the ordinance. Fines could amount to forty shillings for each day during which the offence was continued, for erecting a structure that obstructed a street, or twenty shillings for committing an act of nuisance.¹²

Nuisance was defined broadly to include any act such as the existence of foul drain, ditch, gutter, or watercourse; accumulation of filth, the growth of weeds, impurity-filled water tanks, or any other act, whether in the public space or private abode which was injurious to health. To that extent, Inspectors of nuisances were mandated to conduct periodic inspections to homes and in public spaces to ascertain prevailing nuisances and to enforce the provisions of the ordinance. The ordinance also mandated the government to provide slaughterhouses and markets and to regulate their use.¹³ In this ordinance, we spot the emergence of an interventionist regime through which the colonial administration sought to intrude in the lives of the African population using legislation to regulate their conduct regarding sanitation and hygiene. It reflects the Foucauldian notion of governmentality – which broadly defined, refers to “tactics and techniques” designed by governments with the intent to “create governable subjects through actively shaping and normalising people’s conduct.”¹⁴

Yet the attitude of the government towards the enforcement of the Ordinance was largely lackadaisical. The ordinance remained a dead letter– a situation that provoked criticism both locally and in the metropole.¹⁵ For example, in 1881, the London *Daily News* lamented the “total neglect of all sanitary laws...inexcusable apathy on the part of authorities” and the “...wilful violation of the laws of health.”¹⁶ Indeed, by the late 1880s, there was little to show by way of sanitary improvement.

¹¹ Griffith, *Ordinances*, Vol. II, 737–55.

¹² Ibid.

¹³ Ibid.

¹⁴ John Morrissey, ‘Foucault and the Colonial Subject: Emergent Forms of Colonial Governmentality in Early Modern Ireland’, in *At the Anvil: Essays in Honour of William J. Smyth*, ed. Patrick K Duffy and William Nolan (Dublin: Geography Publications, 2012), 2.

¹⁵ Gale, ‘Official Medical Policy’, 71.

¹⁶ Quoted in *ibid.*

Almost all the towns continued to lack sanitary facilities, and this invariably meant a continuing deterioration in sanitary conditions.

Assistant colonial surgeons who were stationed in the various district headquarters complained in their reports, of the “very stinted and too often polluted water which the natives are compelled to drink”¹⁷ and the inefficient management of drainages in most towns and villages. Others complained about the negligence of District Commissioners in enforcing the provisions in the ordinance which had resulted in the “obstruction of many streets by huts, no supervision having been exercised when natives were building.”¹⁸ The first sanitary report compiled in 1885 described Accra as comprising of “hovels” that were placed “without any relation to one another.”¹⁹ The report criticised the building of houses without recourse to lay out and any sanitary precaution. It stated, “where there was room, houses were built, it might touch a neighbouring house, block a passage...stop ventilation and intrude upon the yard of neighbouring houses or prevent the entrance of light...”²⁰

In 1886, the Assistant Colonial Surgeon for the Accra District, Dr Farrell Easmon lamented that:

Political considerations have always influenced the government in their dealings with the people. To abolish by one stroke of the pen, in accordance with the Towns, Police, and Public Health Ordinance and the Pigs Ordinance, this source of nuisance would seem an easy matter, but in deference to the feelings of the inhabitants, the provisions of these ordinances have been suspended in this particular matter...²¹

The acting Governor admitted to his inability in solving the pig nuisance in Accra. Yet, he defended his inaction by arguing that:

...matters which may seem simple to those unacquainted with the difficulties of administration often involve far more difficulty to the Executive, upon whom

¹⁷ GGC, ‘Sanitary and Medical Reports for 1886 and 1887’, Annual, Her Majesty’s Colonial Possessions (London: Eyre and Spottswode, 1888), 115, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

¹⁸ Ibid., 120.

¹⁹ Quoted in Addae, *The Evolution of Modern Medicine in a Developing Country*, 114.

²⁰ Quoted in *ibid.*

²¹ GGC, ‘Sanitary and Medical Reports, June 1887’, 5.

the responsibility and means of devising measures for dealing practically with the subject in question ultimately devolve.²²

Nonetheless, other Assistant Surgeons complained either of the lack of, or of the limited availability of latrines in the towns. Official responses to such complaints often reflected apathy and indifference. For example, in 1887, the Acting Governor responding to complaints about the lack of toilet facilities in Accra stated that:

... in no other colony that I know of are latrines erected by the government. That such recommendation is desirable I admit, but in a colony, which is but 17 years old the government cannot provide for the various pressing sanitary and social requirements in one year, or, as I apprehend, looking to the unhealthy nature of the climate, will it be able to do so in 20 years...²³

Given such fatalistic attitude of the government and its officials towards addressing the sanitary needs of the colony, it was not surprising that little improvement could be achieved before the 20th century. Sidney Webb, a senior clerk in the Colonial Office, lamented after reading the health reports from 1885-1888 that “they show that government has as yet, hardly touched the insanitary evils.”²⁴ It would seem, therefore, that sanitary reforms in the Gold Coast suffered during this period because of the apathetic and the indifferent attitude of the government and its officials.

The narrative on the sanitary conditions of the Gold Coast mirrored most of the colonies of British West Africa. The sanitary conditions of Lagos, Freetown in Sierra Leone, and Bathurst in the Gambia, for example, were not any better, compared to towns in the Gold Coast.²⁵ For example, in 1872, a colonial surgeon, Major Waters, concluded in a report on Freetown that:

The inhalation of the moist and stagnant atmosphere, loaded with the products of faecal decomposition, produces a state of the system favourable to the development of all diseases.²⁶

²² Ibid., 6.

²³ Ibid., 26.

²⁴ Quoted in Gale, ‘Official Medical Policy’, 88.

²⁵ see Spencer H Brown, ‘Public Health in U.S. and West African Cities, 1870-1900’, *The Historian* 56, no. 4 (Summer 1994): 685.

²⁶ As quoted in Gale, ‘Official Medical Policy’, 58.

In a similar vein, in 1888 *The Mirror* lamented that in Lagos, “streets are choked with filth and dirt.”²⁷ Earlier in 1886, the *Observer* lamented that “the thoroughfares” of Lagos “are covered with rot, the streets, and even some of the principal areas are quite unfrequented and, in some cases, unknown to the scavengers.”²⁸ Thus, to know the sanitary and health conditions of the Gold Coast as presented in the colonial accounts was to know a cluster of British West African colonies whose towns and villages European colonists and writers described in very disparaging terms.

The seeming lack of improvement in the health and sanitary conditions in the Gold Coast, however, could be attributed firstly, to inherent weaknesses in the public health ordinance as well as official apathy towards its implementation. Whereas the ordinance established a legal framework for dealing with public health issues, it did not constitute any formidable administrative structure to be responsible for managing the health and sanitary challenges. The implementation of the provisions of the Act was vested in the governor and his officials including, District Commissioners, and health officials. These colonial officials were often indifferent to the health needs of the colony and they hardly applied the laws. An observation by Ernest Eiloart, a barrister who visited the Gold Coast in the 1880s is instructive:

...Laws are generally made to be enforced, but this is not the case with the Public Health Ordinance. That was made for the purpose of throwing dust in the eyes of the Colonial Office. This is clear from the fact that it discourses of cesspools, ash-pits, reservoirs, and aqueducts, while the officials who drew discussed, passed, and sent the Ordinance to England, knew that not one of these things exists from one end of the country to another...The Ordinance empowers the Governor to make rules for the prevention of the keeping of animals on any premises, and for compelling the clearing of bush around towns, and for providing places for the temporary deposit of refuse. Seeing that governors have never availed themselves of these powers, it is evident that the Ordinance was made to mislead the Colonial Office...²⁹

²⁷ As quoted in Liora Bigon, ‘Sanitation and Street Layout in Early Colonial Lagos: British and Indigenous Conceptions’, *Planning Perspectives* 20 (July 2005): 258.

²⁸ As quoted in Spencer H Brown, ‘Public Health in Lagos, 1850-1900: Perceptions, Patterns, and Perspectives’, *The International Journal of African Historical Studies* 25, no. 2 (1992): 341.

²⁹ Ernest Eiloart, ‘The Land of Death: A Pamphlet Addressed to the Members of Both Houses of Parliament with Some Observations on the Present Mode of Making Selections for Colonial Appointments’ (Hatchards, Piccadilly, 1887), 9–10, <http://www.jstor.org/stable/60230332>.

Secondly, the number of medical officers in the employment of the government during this period was woefully insufficient to meet the health needs of the colony.³⁰ And the few doctors appeared inefficient and often, indifferent to the health needs of the Gold Coast.³¹ Gale has, for example, accused Dr J. Jeans, the colonial surgeon before 1885, for being incompetent and uninterested in the sanitary affairs of the Gold Coast. In a similar vein, he accused Governor Samuel Rowe (1881-1884) of demonstrating disinterest in resolving the health challenges of the Gold Coast by condoning the incompetence of Dr Jeans.³²

This latter stricture must, however, be qualified. While the accusation of Rowe may have been correct, it is unjustifiable to single him out as solely responsible for the sanitary evils of the Gold Coast. He inherited the sanitary challenges which his predecessors had done little or nothing to improve. Nevertheless, in the absence of a properly constituted medical department, combined with the apathetic attitude of colonial officials, an improvement in the health and sanitary conditions appeared to be an almost impossible task.

The Establishment of the Medical Department

During the early part of the 1880s, the government took steps to properly constitute an administrative structure to oversee the health requirements of the Gold Coast. The first most important measure was the establishment of a medical department in 1884. The department was headed by a medical doctor who was designated as the Chief Medical Officer (CMO). J. D. McCarthy, then serving as Assistant Colonial Surgeon in Lagos was transferred to the Gold Coast to become the first CMO. He headed the department until 1892 when he resigned. The head of the department reported to the governor through the colonial secretary. His job included reporting on all the sanitary needs of the various districts, making recommendations for reforms and ensuring that such recommendations were implemented. The CMO was an official member of the Legislative Council until 1920 and a member of the Executive Council until 1950.

The Colonial Surgeon deputised for the CMO and the remaining staff comprised several Assistant Colonial Surgeons who attended to the health needs in the various

³⁰ see Dumett, 'The Campaign against Malaria'.

³¹ see Gale, 'The Struggle against Diseases in the Gold Coast'; Gale, 'Official Medical Policy'.

³² Gale, 'Official Medical Policy', 73-74.

districts and stations. Series of administrative reforms often resulted in changes in the title of the head of the GCMD. In 1900, the head was redesignated as the Principal Medical Officer (PMO) and in 1923, as the Director of Medical and Sanitary Services (DMSS). From 1934, the position was occupied by a Director of Medical Services (DMS).³³ In 1951, the department was brought under the Ministry of Health and Labour. But in 1952, following further restructuring which resulted in the splitting of the Labour and Health Ministry, the department came under the Ministry of Health. The DMS was subsequently re-designated as CMO and was equal in status to the Permanent Secretary.³⁴

A second significant development which was consequential for sanitary reforms and public health administration during this period was the appointment of a Medical Officer of Health for Accra (MOH) in 1884. This position, the first of its kind in the Gold Coast was held by Dr J. F. Easmon³⁵ until 1892 when he replaced Dr McCarthy as the CMO. Generally, a Medical Officer of Health was a professional doctor responsible solely for preventive health. The idea of appointing Medical Officers of Health to deal with public health issues originated in the early 1800s in Britain, but, it was firmly established in 1848 when local authorities were authorised to appoint such doctors to supervise and coordinate all local sanitary works.³⁶ Such an appointment in the Gold Coast, therefore, suggests a realisation by the colonial government of the urgency in tackling the deplorable sanitary situation in Accra. Another significant development was the repeal of the Native Jurisdiction Ordinance, 1878, as Native Jurisdiction Ordinance, 1883. This Ordinance made provision for Chiefs to formulate bye-laws to regulate sanitation. Even though it does appear that this provision was rarely invoked in the early periods, it became a significant tool for regulating sanitation, particularly in rural communities during the 1900s.³⁷

These new developments, interestingly, coincided with administrative changes in the colonial government. Governor Rowe was replaced in 1884 by William

³³ see Addae, *The Evolution of Modern Medicine in a Developing Country*; Patterson, *Health in Colonial Ghana*.

³⁴ see GGC, 'Report of the Medical Department for the Year 1952' (Accra: Government Printing Department, 1954), <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>. The Permanent Secretary was the senior technical staff of the Ministry.

³⁵ Dr Easmon was a Sierra-Leonean African and was the first African ever to head the Medical Department.

³⁶ see Porter, *Health, Civilization, and the State*, 117; Rosen, *A History of Public Health*, 124–25.

³⁷ see Griffith, *Ordinances, Vol. I*, 389–402 More on the role of Native Authorities in managing sanitation below.

Alexander G. Young who unfortunately died a year after his appointment. Bradford Griffiths (1885 – 1895) succeeded Young. Gale has commended Griffith for having committed to solving the sanitary challenges in the colony. Yet by the time he left office, his achievements were piece-meal. Griffith is credited for ending the pig nuisance in big towns, popularising the use of public cemeteries, providing dustbins, street lamps, and some limited number of public water tanks in some towns, and for ensuring relatively cleaner streets in some sections of the larger towns.³⁸ Yet, as important as these developments were, they were inconsequential for abating the many sanitary challenges. In 1897, it was reported that in Cape Coast, "...sanitary progress is very slow; indeed, it has to be confessed that no changes of a radical nature have recently been made in regard to the sanitation of the important town..."³⁹ And Accra was described in 1896 as a "sink of filth".⁴⁰

Exactly, how filthy Accra and the other coastal towns were, it is difficult to tell, except what we know from the narratives of colonial officials. These accounts seemed exaggerated and smacked of sensationalism if the sanitary conditions in the Gold Coast were compared to the metropole. As Porter has illustrated, "the defining feature of heavily overstressed towns" in 19th century Britain was their stench. "the stink of the urban environment" she writes, "must have seemed strong and foul enough to kill, or at least induce vomiting."⁴¹ Clearly, from Porter's account, some of the insanitary conditions that prevailed in the Gold Coast could also be found in England. It is, therefore, curious that colonial officials presented such gloomy impressions of the health conditions in the Gold Coast as if this was their first encounter with insanitary conditions.

Certainly, government officials, their medical advisors and other European authors might have 'sensationalised' the health and sanitary conditions of the Gold Coast as elsewhere in British West Africa with an intent, as Anna Crozier has argued, to force some notions of environmental difference and perhaps cultural superiority

³⁸ see Gale, 'The Struggle against Diseases in the Gold Coast'; Gale, 'Official Medical Policy'.

³⁹ "Enclosure 15 in Gold Coast No. 318 of 25th July 1898: Sanitary and Medical Report of the Gold Coast Colony for the Year Ended 31st December 1897," Annual, (1898), BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

⁴⁰ Gale, 'The Struggle against Diseases in the Gold Coast', 193.

⁴¹ Porter, *Health, Civilization, and the State*, 113.

between the metropole and the colony.⁴² Crozier notes that “sensationalism” was one means by which the British presented colonial rule as an acceptable enterprise in the metropole.⁴³ However, as Brown has argued, if Europeans foregrounded their expression of superiority to Africans on a superior regime of public hygiene in the metropole, then, that was misguided and self-serving. For the many colonial officials, and other European authors who complained so bitterly about the deplorable sanitary conditions in African cities and towns, “apparently had either never visited the poor sections of their own cities and towns, or they had forgotten what they had seen and smelled there.”⁴⁴

Nonetheless, by the late 19th century some sanitary improvements were made, yet these were insignificant compared to what remained to be done. In 1899, the CMO, W.R. Henderson admitted to this fact when he noted that “some improvement has been made in the sanitation of the principal towns in the colony...but much remains to be done.”⁴⁵ In the stereotypical manner of the period, Henderson blamed the lack of improvement on the African population. He remarked that:

...one of the difficulties in the way of carrying out efficient sanitary measures is the filthy habits and laziness of the people, who persist in throwing all descriptions of rubbish and dirt on the streets and will not take the trouble to walk to the public latrines....⁴⁶

However, some medical officials held contrary opinions. For instance, Dr Freeman, the Assistant Colonial Surgeon for Keta observed that:

The general tendency of the natives is, I consider, towards order and cleanliness, and I regard it as a distinct mistake to ascribe to “filthy habits of the people” insanitary conditions which are simply the result of the want of sanitary appliances; it is I think, sufficiently manifest that the absence of any adequate means for the removal of excreta and such litter as is unavoidable

⁴² see Anna Crozier, ‘Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa, 1890-1939’, *The Journal of Imperial and Commonwealth History* 35, no. 3 (2007): 393–415.

⁴³ *Ibid.*, 394.

⁴⁴ Brown, ‘Public Health in U.S. and West African Cities, 1870-1900’, 697.

⁴⁵ GGC, ‘Enclosure 16 in the Gold Coast No. 257 of July 1899: Medical Report on the Gold Coast for the Year Ended 31st December 1898’, 1899, 320, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

⁴⁶ *Ibid.*

must produce, as an inevitable consequence, cesspits, rubbish heaps, and nuisances of a like nature...⁴⁷

Nonetheless, without adequate sanitary facilities, and given the pervasiveness of conditions that were conducive for disease outbreaks, the mortality rate of the European population continued to rise. In 1895, it was reported that a “pseudo-epidemic form of malignant type, closely approaching in its clinical manifestations the yellow fever of the West Indies”, had caused very high mortality among the European population, increasing the death rate per thousand for the year to about 83.69.⁴⁸ Specific to the outbreak that year, thirty-eight (38) Europeans comprising officials and non-officials died. Still lacking understanding of the actual causes of the fevers of the West African coast, the official account claimed that, the insanitary conditions of the Gold Coast, “aggravated by the excessive humidity of the atmosphere, high shade of temperature” and limited amount of rainfall combined with “intensifying action of pathogenic organisms of every kind, and especially the endemic malarial poison, must be attributed the malignant type of the fever.”⁴⁹

This incident caused H.J. Read, an official in the Colonial Office to remark that, “At the best of times, the Gold Coast is more unhealthy than the other West African colonies, but...the mortality for some months past has been exceptional even for the Gold Coast...”.⁵⁰ The health conditions did not improve any significantly in subsequent years. In 1896 forty-one Europeans died from another virulent yellow fever outbreak during the first quarter of the year.⁵¹ In 1897 a slight improvement in the mortality rate was recorded over the previous years, but the death of forty more Europeans was significantly high. The health of officials employed in Asante and the Northern territories were, however, reportedly better compared to those in the colony proper.⁵²

⁴⁷ GGC, “Sanitary and Medical Reports,” Quarterly, Her Majesty’s Colonial Possessions (London: Eyre and Spottswode, 1887), 61, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

⁴⁸ see ‘Gold Coast Annual Report for 1895’, Annual, Colonial Reports (London: Eyre and Spottswode, 1897), 23.

⁴⁹ Ibid.

⁵⁰ Quoted in Dumett, ‘The Campaign against Malaria’, 167.

⁵¹ see GGC ‘Gold Coast Annual Report for 1896’, Annual, Colonial Reports (Darling & Son Ltd., 1897), 20.

⁵² GGC ‘Gold Coast Annual Report for 1897’, Annual, Colonial Reports (London: Darling & Son Ltd., 1898), 16–17.

Thus, by the late 1890s, neither the establishment of the medical department nor the changes in the administrative heads of the government had resulted in any significant reforms and improvement in the sanitary situation. So, what reason(s) explain the persistent lack of improvement in the health and sanitary conditions even after the establishment of the medical department? Gale is correct when he suggests that the reasons were no different from those of the late 1870s and early 1880s. He underscores the continuing indifference of the governors towards sanitary reforms. He states that:

Sanitary reform was still not seen as being a legitimate claim on the public expenditure as other items. Some governors pleaded lack of funds, while others explained that the situation was not as bad as portrayed in the sanitary reports.⁵³

Evidently, in 1889, the acting governor, Frederick Mitchell Hodgson, reported to Lord Knutsford, the Colonial Secretary, that “the provision of latrines and scavengers at government expense has had to be stopped for the present in the existing condition of the finances of the colony.”⁵⁴ Similarly, when in 1895, the British Chambers of Commerce, feeling alarmed by the high mortality of Europeans, complained about the dire sanitary conditions, the governor, William Maxwell dismissively admonished them to constitute Town Councils and tax themselves to finance sanitary improvements if they wished. Maxwell argued that the government had no obligation to provide sanitary amenities to the African population, the same way it was not duty-bound to provide Medical Officers for the European merchants. Interestingly, the Colonial Secretary, Joseph Chamberlain, supported Maxwell’s position.⁵⁵ Addae claims that Chamberlain was not altogether against sanitary reforms, rather, he was a gradualist, who wanted to proceed cautiously given the limited resources of the colony.⁵⁶ However, a close reading of the evidence suggests otherwise. The colonial logic as Berry has noted (quoting Earl Grey) was that “the surest test for the soundness of measures for the improvement of an uncivilised people is that they should be self-sufficient.”⁵⁷ Herein lies the contradiction of the colonial

⁵³ Gale, ‘The Struggle against Diseases in the Gold Coast’, 193–94.

⁵⁴ ‘Enclosure: Acting Governor Hodgson to Lord Knutsford’, 26 July 1889, 24, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

⁵⁵ see Gale, ‘The Struggle against Diseases in the Gold Coast’.

⁵⁶ see Addae, *The Evolution of Modern Medicine in a Developing Country*, 116–17.

⁵⁷ Berry, ‘Hegemony on a Shoestring’, 329.

project. As Berry argues, sometimes, the political and economic interests of the colonisers had contradictory implications for their strategies at hegemonic control.⁵⁸

Another reason for the lack of improvement in the sanitary situation was the transient nature of the appointments and tenure of colonial medical officers, especially, the assistant colonial surgeons who were stationed in the districts and outstations. A perusal of the sanitary and medical reports reveals that most of these officers were transferred from one station to another, sometimes after few months upon assuming duty in new stations. Such quick transfers prevented them from gaining the requisite understanding of the local health conditions, which was necessary if they were to execute their duties satisfactorily. Beyond that, the varying interests of such officers and the health conditions on which they decided to focus their attention during their work could have also impinged on their effectiveness. An observation by J.W. Simpson is revealing:

In the time unoccupied in the treatment of patients and in the study necessary to keep himself abreast of the times, one medical doctor may take an interest in the condition of the drains, another in the abolition of pools, another in the construction of houses, another in the water supply, another in the conservancy, while others may be more interested in research work or in surgery, and do not pay attention to practical sanitation, though interested in the causes which give rise to diseases in the locality. A station may thus progress in several respects under one medical man and fall back under another, and the net result is little improvement or if there is improvement in any special quarter of the town, there is deterioration in another.⁵⁹

Nonetheless, by the early 1900s, the mortality rate was beginning to decline, as some improvements seemed to have been made in the sanitary conditions. The efforts of governors Mathew Nathan (1900-1904) and John Roger (1904-1909) at controlling the conditions that bred mosquitoes had yielded some significant results.⁶⁰ Dormant aspects of the *Towns, Police and Public Health Ordinance* was repealed and a new ordinance, the *Towns Amendment Ordinance* was passed in 1901. This new ordinance allowed the Governor wide-ranging powers to execute sanitary reforms. Both governors, Nathan and Roger invoked their new powers to effect significant

⁵⁸ Ibid., 330.

⁵⁹ W. J. Simpson, 'Report by Professor W. J. Simpson on Sanitary Matters in Various West African Colonies and the Outbreak of Plague in the Gold Coast' (London: Her Majesty's Stationary Office, June 1909), 20, GH/PRAAD/ADM5/3/12, Accra.

⁶⁰ More on this in the next chapter.

reforms, including ordering the demolishing of dangerous and dilapidated structures, causing streets to be widened, and improving spacing between houses, especially, in urban centres.⁶¹

These notwithstanding, it appeared that there was still much work to do. In the absence of any organisation dedicated solely to abating the insanitary conditions, little could be hoped to be achieved. Nonetheless, the outbreak of a virulent bubonic plague in 1908 eventually led to a proper consideration of the sanitary question, which subsequently led to the much-needed reforms that set the public health and sanitary administration in the Gold Coast on a proper footing.

The Formation of the Sanitary Branch of the Medical Department

Following the outbreak of the plague epidemic in 1908, Professor J. W. Simpson was commissioned to investigate sanitary matters in British West African colonies and the outbreak of the Plague in the Gold Coast. After visiting about fifty towns and villages, Simpson reported that all these towns and villages possessed similar defects, “varying only in their sites which in some cases are healthy and others unhealthy.”⁶² He noted the lack of potable water and the continuing absence of any proper layout in any of the towns/villages he visited.

Simpson’s comments on Accra’s layout is very revealing. He observed that irrespective of its “exceptionally healthy site”:

...the crowding together and congestion of the houses and huts in the plague-infected parts were so great and produced such a bad state of sanitation that no remedy short of demolition was of any use.⁶³

He noted that this:

...huddling together of huts and houses excluded the possibility of efficient scavenging and drainage” and thus “brought about a condition wherein puddles containing urine and sileage water favoured the breeding of the larvae that contained malarial bearing anopheles.⁶⁴

⁶¹ see Dumett, ‘The Campaign against Malaria’, 170.

⁶² Simpson, ‘Report by Professor W.J. Simpson on Sanitary Matters’, 14.

⁶³ Ibid., 16.

⁶⁴ Ibid., 16.

Simpson observed more generally, that in almost all the towns and villages:

The most common defects are water holes and ponds for water supply – good protected wells are rare, pools which have been formed by excavations to obtain materials for the construction of mud huts; absence of good surface drainage, and consequent malarial conditions during the rains; unnecessary crowding together of huts in irregular clusters on too small a space...unhealthy plans of huts obstructing light and ventilation...and the existence of rank vegetation close to dwellings. These conditions affect the native injuriously and in turn the Europeans, for the latter only in a few large towns reside away from native dwellings.⁶⁵

Simpson noted, however, that these conditions were not so formidable as to evade prevention and remedy. He observed that these problems persisted because of the absence of any form of special health or sanitary department that was tasked to ensure that the prevailing conditions were removed and those anticipated, prevented.⁶⁶

It is interesting to note that advice on the need for a body solely dedicated to addressing the sanitary challenges was never lacking. What seemed lacking was the ears to listen and the will to implement such suggestions. For example, in 1886, the assistant colonial surgeon for Cape Coast, Dr Eyles lamented the inefficient system of sanitary administration and suggested the creation of a sanitary commission which would give some chiefs and kings some amount of power to implement sanitary measures. He suggested the levying of rates to cover sanitary expenses which were to be collected by the representatives of the people and expended entirely on their towns.⁶⁷ There is no evidence that his advice was ever considered before the end of the century.

However, during the first decade of the 20th century, Governor Nathan concluded that the lack of an administrative body responsible for dealing with sanitation was inhibiting sanitary reforms. He, therefore, proposed the establishment of a Health Department and tasked Dr C. Balfour Stewart, from the Liverpool School of Tropical Medicine, who was on a working visit to the Gold Coast to develop a scheme for the purpose. Unfortunately, the Acting PMO, Dr Murray opposed the

⁶⁵ Ibid., 14–15.

⁶⁶ Ibid., 15.

⁶⁷ see GGC, "Sanitary and Medical Reports for 1886 and 1887," Annual, Her Majesty's Colonial Possessions (London: Eyre and Spottswode, 1888), 114, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

scheme for reasons that are not known, and the idea was dropped.⁶⁸ Nevertheless, Simpson, in his report recommended to the governments of British West Africa the need to establish “a special health department...small in its constituent members, whose members should be specially trained and whose whole time should be devoted to public health duties.”⁶⁹ Such a department was to be headed by a Sanitary Commissioner, and its membership was to comprise the Medical Officers in the various stations and districts who would now defer in sanitary matters to the Sanitary Commissioner. He further recommended the creation a Central Health Board⁷⁰ to be headed by the PMO, yet in sanitary matters, recognise the Sanitary Commissioner as the expert and officer responsible.⁷¹

A Sanitary Branch of the Medical Department was established in 1909. The government expressed the optimism that:

...the establishment of the Sanitary Branch of the Medical Department, working in conjunction with the general scheme of Public Works, should, if the present degree of energy be maintained, result in improvements on a scale unthought-of before the epidemic plague in 1908.⁷²

The Branch which commenced operations in 1910 was initially headed by a Senior Sanitary Officer (SSO), who worked under the supervision of the PMO. The SSO was assisted by a Junior Sanitary Officer (JSO). Below them were lower-ranking officers of different categories, including Medical Officers of Health (MOH), Sanitary Inspectors and District Medical Officers who reported to the SSO on matters bearing on public health, disease prevention and control.

From 1921, following administrative reforms in the Medical Department, the SSO was designated as Deputy Director of Sanitary Services (DDSS), and the JSO as Senior Sanitary Officer. Below the JSO were Sanitary Superintendents who supervised the activities of several sanitary inspectors, categorised into different grades. From the 1920s, the Sanitary Branch was often referred to as the Health Branch.⁷³ Following further reorganisation of the Health Branch in 1946, the post of

⁶⁸ see Addae, *The Evolution of Modern Medicine in a Developing Country*, 117.

⁶⁹ Simpson, “Report by Professor W.J. Simpson on Sanitary Matters,” 21.

⁷⁰ More on Health Boards below.

⁷¹ Simpson, “Report by Professor W.J. Simpson on Sanitary Matters,” 21.

⁷² GGC, ‘Gold Coast Report for 1909’, Colonial Reports - Annual (London: Darling & Son Ltd., 1910), 32.

⁷³ Addae, *The Evolution of Modern Medicine in a Developing Country*, 117–18.

Assistant Directors of Health (ADH) was created and each regional headquarters was to have an ADH stationed. This arrangement was maintained into the 1950s. The ADHs were to be assisted by District Medical Officers.⁷⁴ The functions of the sanitary branch summarily included:

...General sanitation; refuse disposal; the construction and proper maintenance of drains, lagoon reclamation works and mosquito control; water supply; sewage and sewage disposal; market and slaughterhouses; the handling of epidemics; health education, and overseeing town and village planning along sanitary lines.⁷⁵

The branch also exercised a supervisory role over sanitation in mining health areas and directed activities of maternal and child welfare centres. Except for the oversight responsibility for town planning which was decoupled from the sanitary branch in the 1940s, all the other functions remained intact until a ministry of health was created in the mid-1950s and handed oversight responsibility for all health-related matters.

Despite its significant contribution to maintaining public health, the sanitary branch remained one of the most resented public institutions. It was resented by both the African and European population and sometimes, even political administrators clashed with the MOH.⁷⁶ For example, in 1932, when the MOH, Selwyn Clarke complained about the inefficiency of the health laws and the lackadaisical attitude of the political administrators towards the enforcement of health laws, the Chief Commissioner for Asante, described the MOH and his outfit as possessing “a narrow-minded belief that the world is largely peopled with persons who are wrong in everything and that the righteous minority consist exclusively of Health Officers”.⁷⁷

The resentment towards the branch was thus, because of its mundane activities which required its functionaries to intrude into people’s lives. The ‘ordinary person’ felt that:

The MOH and his African inspectors did not erect impressive hospitals or provide injections to heal the sick; instead, they poked around people’s compounds looking for mosquito larvae, unauthorised buildings, excess

⁷⁴ Ibid., 124–25.

⁷⁵ Ibid., 119.

⁷⁶ see Patterson, *Health in Colonial Ghana*, 20–21.

⁷⁷ Ibid., 21.

lodgers, or the sick; they issued steady stream of summons and fines for those who relieved themselves in a place other than the filthy public latrines, sold food on the streets without an expensive cover, or dumped garbage in a handy gutter than a distant and already overflowing dustbin. In short, the MOH and his men badgered people in many ways, without any obvious benefit to anyone except those who collected the fines or got jobs as Inspectors.⁷⁸

Despite its unpopularity, the branch's role in preventive health and sanitary administration and reform throughout its existence cannot be underestimated. Arguably, the branch laid the foundation for future sanitary reforms in the Gold Coast. However, the resentment it courted never really diminished for all the period it existed.

The Creation of Health Boards

Apart from establishing the Sanitary Branch, the colonial administration also implemented Simpson's recommendation for the establishment of Health Boards. A Central Board of Health (CBH) was formed for the colony proper, Asante, and the Northern Territories in 1920. The Board comprised the DMSS who was the *de facto* president, and the Director of Public Works, the DDSS, and the Senior Public Health Engineer, as members.⁷⁹ To complement the activities of the CBH, Local Health Boards (LHB) were formed for the three provinces in the colony proper viz – the Western, Central and Eastern Provinces, and Asante and the Northern Territories.

The Provincial Health Boards comprised the Commissioner as President, SSO or MOH (as the case may be), and the Provincial Engineer as members. For Asante, the Board comprised the Chief Commissioner, Asante (CCA), as President, the Assistant Director of Medical Services (ADMS), the SSO and the Provincial Engineer (for Asante and Northern Territories) as members. The Board for the Northern Territories was composed of the Chief Commissioner, Northern Territories (CCNT), as President, the ADMS and the Executive Engineer, based in Tamale, as members.⁸⁰ It must be remarked that the idea of a CBH and LHBs was another borrowing from Britain's 19th century public health experiments. The British had established a General

⁷⁸ Ibid., 20.

⁷⁹ 'Constitution of the Central Board of Health', n.d., 1, PRAAD/ADM23/1/2354, Central Regional Archives, Cape Coast.

⁸⁰ Ibid., 1–2.

Board of health in 1848 to coordinate the sanitary activities of local authorities and empower them to improve sanitary conditions.⁸¹

In the Gold Coast, the CBH served as an advisory body to the government on matters affecting public health. It was required to propose to government, policies and schemes that it considered to be in the interest of the public health.⁸² The CBH was responsible for considering and approving building permits, town and village layouts, and the erection of public infrastructure such as markets, slaughterhouses, latrines, among others. The LHBs, viz – Provincial, Asante and Northern Territories, on the hand, were required to submit to the CBH any policy or scheme bearing on public health which was initiated within their areas of jurisdiction. They could also exercise on behalf of the CBH, the power to approve or reject building permits. However, in 1932, following the abolishing of the post of Provincial Engineer, the power to approve and reject permits was curtailed in the colony, but not in Asante and the Northern Territories.⁸³

The LHBs were, however, required to advise on matters affecting public health within their areas of jurisdiction which was referred to them by the CBH.⁸⁴ In Asante, in addition to the Asante Health Board, a Public Health Board was created for Kumasi (KPHB) which commenced operation in July 1925. The KPHB, however, exercised the powers of a Town Council and was composed of government officials, representatives of the Kumasi Chamber of Commerce and African representatives.⁸⁵ The CBH, however, existed until 1945 when its functions were transferred to the newly created Town and Country Planning Board (TCPB) which assumed its roles, particularly, those bearing on the control of siting government works within planning areas. The LHBs,

⁸¹ see Rosen, *A History of Public Health*, 123–31. This Board was dissolved in 1854 and reconstituted in that same year and from then on, it functioned until 1858 when it was finally abolished, and its functions transferred to the Privy Council where it remained until 1871.

⁸² see 'Constitution of the Central Board of Health', 1.

⁸³ Central Board of Health, "Extract from Minutes of the 165th Meeting of the Central Board of Health Held on Monday, the 6th June 1932," June 6, 1932, ADM 23/1/368, Central Regional Archives, Cape Coast.

⁸⁴ 'Constitution of the Central Board of Health', 2.

⁸⁵ see John Maxwell, 'Ashanti: Kumasi—The Garden City of West Africa', *Journal of the Royal African Society* 27, no. 107 (1928): 226. The KPHB evolved from the Kumasi Sanitary Committee which was formed in 1910.

however, continued to operate, exercising control over siting of government works outside planning areas within their jurisdiction.⁸⁶

Formation of Sanitary Committees

The formation of sanitary committees was another important step in the sanitary and public health administration. The earliest mention of the formation of sanitary committees was in 1906 when it was reported that the governor, Mathew Nathan had approved of rules that were formulated by the Medical Department at Sekondi for sanitary committees and sub-committees of the Gold Coast Railway.⁸⁷ Two years later, in 1908, the governor approved of the formation of sanitary committees in all towns under the Towns Ordinance, No. 13 of 1892, where there did not exist a municipal council.⁸⁸ This effectively meant all towns under the Towns Ordinance, except Accra, Cape Coast and Sekondi, which had municipal councils.

By 1913, it was reported that seventeen sanitary committees were fully operational in their respective stations.⁸⁹ The composition of the committees comprised, the District Commissioner, as chairman, the medical officer, as secretary and the foreman of works of the public works department, as a member. Stations which did not have these three officers were to appoint officials from another department, if possible, to constitute the committee. Similarly, in villages and towns that were not under the Towns Ordinance and where there were no government officials, a set of simple regulations were provided to guide chiefs and headmen to enforce sanitary measures.⁹⁰

Essentially, sanitary committees were tasked to conduct periodic inspections, during which they were expected to inquire into the general sanitary conditions of

⁸⁶ Colonial Secretary, 'Central Board of Health', Circular No. 59/45, 18 December 1945, PRAAD/ADM 23/1/1746, Central Regional Archives, Cape Coast; Town and Country Planning Board, 'Circular, TCPB/1/48', 7 December 1948, PRAAD/ADM 23/1/1746, Central Regional Archives, Cape Coast.

⁸⁷ see GGC, 'Medical and Sanitary Report for the Year 1906' (London: Waterlow and Sons Ltd., 1907), BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910> Sekondi was the headquarters of the Gold Coast Railway. It would seem that the activities of the Railway Corporation had resulted in the influx of immigrants and this had worsened its sanitary problems. It was therefore, necessary that such a committee was formed for the purposes of managing sanitation in the town.

⁸⁸ see "W. C. F. Robertson, Ag. Colonial Secretary to Provincial Commissioners," August 15, 1908, PRAAD/ARG1/14/3/1, Ashanti Regional Archives, Kumasi.

⁸⁹ GGC, 'Medical and Sanitary Report for the Year 1913' (London: Waterlow and Sons Ltd., 1914), 21, BOA, <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.

⁹⁰ "W. C. F. Robertson, Ag. Colonial Secretary to Provincial Commissioners."

towns in their jurisdiction and make recommendations for improvements, as they considered necessary. They were expected to submit half-yearly reports containing recommendations that required special attention, for which approval was needed. Any other information on sanitation which they gathered was to be placed at the disposal of the PMO or his deputy during his periodic tours. The committees were also responsible for the enforcement of the Towns and Public Health Ordinance of 1892 and any other law bearing on the public health. They also considered and approved building plans.⁹¹

To ensure the effective and efficient delivery of their mandate an elaborate scheme was prepared to guide the committees on things to consider during inspections and in compiling reports. The scheme required the committees to conduct inspections of Native and European households, water tanks, and compounds. During inspections of African towns, they were to consider drainage, water supply, domestic sanitation (focusing on conditions such as overcrowding, mosquito breeding, etc.); erection of houses taking note of any sanitary defect such as swish pits, pools of water, and materials used for building. There were required to watch out for animals whose presence could constitute nuisance or danger to health; and inspect all latrines and rubbish dumps. The committees were further tasked to inspect all public buildings such as marketplaces, prisons, police stations, slaughterhouses, and public or private schools.⁹² From 1920 sanitary committees submitted their suggestions and reports to the CBH through the LHBs.⁹³

Town/Municipal Councils, Native Authorities, and Sanitary Administration

During the late 19th century, the government sought to administer sanitary reforms by devolving its functions to local government structures. In this regard, the government legislated the creation of Town Councils and Native Authorities and assigned them to, among other functions, the sanitary administration in their areas of jurisdiction. The colonial officials were convinced that the practical way of dealing with the sanitary and

⁹¹ 'Memo: Formation and Duties of Committees', n.d., PRAAD/ARG1/14/3/1, Ashanti Regional Archives, Kumasi.

⁹² 'Memorandum of Points to Be Made Subject of Inspection and Report by Sanitary Committees', n.d., PRAAD/ARG1/14/3/1, Ashanti Regional Archives, Kumasi.

⁹³ see 'Constitution of the Central Board of Health'.

health challenges was to have a local government system through which revenue could be raised to improve the sanitation of the towns. In this regard, the government hoped to raise the much-needed funds for urban sanitary reforms through the Town Councils and rely on the Local Authority Administrations (chiefs) to, *inter alia*, execute sanitary measures in rural communities.

As I have already mentioned, in 1897, Governor Maxwell, stressing the need for financing sanitary reforms through Town Councils directed the European merchants in the Gold Coast to form Town Councils and levy themselves to provide sanitary amenities if they desired them.⁹⁴ The Colonial Secretary, Joseph Chamberlain, agreed with Maxwell suggested further to the merchants that “it will be necessary that a Town Council should be created with the power to levy rates”⁹⁵ to provide for themselves potable water.

It is difficult to understand why the colonial officials were convinced that the Town Council approach provided the ideal mechanism for solving the sanitary problems in the Gold Coast when even in metropolitan Britain a similar approach had failed. In 1835, England passed the Municipal Corporations Act which placed the management of sanitation in local authorities; but by the late 19th century sanitary reforms were still tottering.⁹⁶ It would seem, then, as Gale has suggested that the idea of forming Town Councils to administer sanitary reforms appealed to both the Colonial Office and local officials in the Gold Coast either because of the limited availability of funds to finance pressing sanitary needs or a wilful neglect to expend money on sanitary reforms.⁹⁷ Indeed, by 1889, the official position of the Colonial Office was that if African colonies desired sanitary improvements “it must be a *sine qua non* that the money...should be raised by the municipality.”⁹⁸

The African population, however, stiffly opposed any form of municipal government in the Gold Coast. Before formal colonisation, an attempt to introduce

⁹⁴ see Gale, ‘The Struggle against Diseases in the Gold Coast’; Gale, ‘Official Medical Policy’.

⁹⁵ Gale, ‘Official Medical Policy’, 93. My emphasis.

⁹⁶ The University of Warwick, ‘Elected Mayors and City Leadership: Summary Report of the Warwick Commission’, 2012, 16–19,

<http://www2.warwick.ac.uk/research/warwickcommission/electedmayors/summaryreport/history/>; see also Gale, ‘Official Medical Policy’; Gale, ‘The Struggle against Diseases in the Gold Coast’.

⁹⁷ see Gale, ‘Official Medical Policy’; Gale, ‘The Struggle against Diseases in the Gold Coast’.

⁹⁸ Quote attributed to Colonial Secretary, Lord Knutsford Gale, ‘Official Medical Policy’, 98.

municipal/town councils at Cape Coast and Accra in 1858 by Governor Benjamin Pine was highly resented by the local chiefs and their people. Subsequently the experiment was abandoned in 1861. The African population repulsed further attempts to revive the councils in 1887, 1889 and 1892. The main contention was the association of municipal/town councils with direct taxation.⁹⁹ The African population contended that they were burdened with indirect taxes which created enough surpluses in most years which could be expended on improving the sanitation of their towns.¹⁰⁰

Indeed, the colonial office conceded that the colony derived little benefit from taxes that were collected. For example, in 1883 the colonial office admitted that, “we are doing absolutely nothing for the people out of the money we extract from them, except, what benefits this large staff may be supposed to give, and a mere trifle on education. Public works have been restricted to ordinary repairs for several years.”¹⁰¹ This was in response to complaints by commercial firms operating in the Gold Coast about a four per cent increase in taxation which they claimed had not resulted in improvements in sanitation and related municipal services. The people were thus, correct to suspect that the idea of a Town Council was a ‘dubious proposition’ that was intended as “a convenient means of raising more money,”¹⁰² that would benefit colonial officials rather than improve their towns and villages. Nonetheless, the educated African population argued for a ‘complete’ council in which they will be fully represented to administer their affairs and not “a board merely responsible for sanitation.”¹⁰³ Yet, the chiefs were suspicious that the Town Council, if allowed to operate could undermine their authority since they would not have exercised any influence in the council.¹⁰⁴

Despite persistent local opposition, however, in 1894, the Town Council Ordinance, No.17 was passed; but it had to wait four years before it could be applied in Accra in 1898. Even so, the unofficial members could not be elected as required, but rather appointed. The first Council in Accra comprised six members, three European officials nominated by the government, and three African unofficial, also

⁹⁹ see Pachai, ‘An Outline of the History of Municipal Government’; Kimble, *A Political History of Ghana*.

¹⁰⁰ see Gale, ‘Official Medical Policy’, 98.

¹⁰¹ Quote appear as footnote in Kimble, *A Political History of Ghana*, 308.

¹⁰² *Gold Coast Chronicle*, 19th November 1894 in, Gale, ‘Official Medical Policy’, 100–101.

¹⁰³ *Ibid.*, 98.

¹⁰⁴ *Ibid.*

nominated by the government.¹⁰⁵ In 1904, the Ordinance was applied in Sekondi and a year later, in Cape Coast.¹⁰⁶ By 1945, the Town Councils had been reconstituted. Under the Town Council Ordinance No. 18 of 1944, the constitution of the Cape Coast Town Council was revised in 1945 to give majority representation to elected unofficial members. The Sekondi Town Council was similarly dissolved and reconstituted as Sekondi-Takoradi Town Council in 1946 under Ordinance No.29 of 1945. Along similar lines, the Accra Town Council was also reconstituted in 1943 under Ordinance No.26 of 1943. The Kumasi Public Health Board was also reorganised as the Kumasi Municipal Council, under Ordinance No.13 of 1943, but unlike Accra, Cape Coast, and Sekondi-Takoradi, the Kumasi Municipal Council comprised an equal representation of official and unofficial members.¹⁰⁷ In the early 1950s, following constitutional changes, and the enactment of the 1953 Municipal Council Ordinance, membership to these Councils were substantially increased.¹⁰⁸

Essentially, the public health functions of the Councils included, among other things, making provisions for the removal of refuse and night soil; providing public latrines, and bathing places; ensuring sufficient supply of water; maintaining public wells and tanks and preventing them from contamination, as well as providing and maintaining drains. They were further required to engage, generally, in activities essential for the conservancy of the town and the preservation of the public health.¹⁰⁹ To be able to perform their functions effectively, the Town Councils through their Presidents appointed a MOH who supervised the public health and sanitary activities and the African Sanitary Inspectors and scavengers who were employed by the

¹⁰⁵ see Samuel S Quarcoopome, 'Municipal Administration at Accra', *Research Review* 14, no. 2 (1998): 96–106.

¹⁰⁶ Gale, 'The Struggle against Diseases in the Gold Coast'; Patterson, 'Health in Urban Ghana'; Kimble, *A Political History of Ghana*; Pachai, 'An Outline of the History of Municipal Government'. Before the end of the first decade of the 20th century, the membership to the Councils had been increased to eight (8), four officials nominated by government and four African unofficial elected by limited franchise. An attempt to introduce a new Municipal Corporations Act in 1924 that sought to give the Councils Unofficial African majority failed. In 1927, however, the 1894 Ordinance was re-enacted and passed as the Town Council Law. This amended Act provided for five official and five unofficial members, see, F. M. Bourret, *Ghana: The Road to Independence, 1919-1957* (London: Oxford University Press, 1960), 42.

¹⁰⁷ see GGC, 'Gold Coast Annual Report, 1950' (London: Her Majesty's Stationary Office, 1952), BOA, <https://microform.digital/boa/documents/7272/gold-coast-1950-1954>; 'Report on the Cape Coast Town Council for the Financial Year 1945-1946', 1946 1945, BOA, <https://microform.digital/boa/documents/7282/municipal-annual-reports-1934-1949>; William Burnett Harvey, *Law and Social Change in Ghana* (Princeton, New Jersey: Princeton University Press, 1966), 80.

¹⁰⁸ see Quarcoopome, 'Municipal Administration'.

¹⁰⁹ see Griffith, *Ordinances, Vol. II*; Pachai, 'An Outline of the History of Municipal Government'; Quarcoopome, 'Municipal Administration'; GGC, 'Gold Coast Annual Report, 1950'.

Councils. However, in 1911, when the Town Council Amendment Ordinance was passed, it removed health officers from the category of persons who could be appointed by the President of a Town Council and vested this responsibility in the central government.¹¹⁰ The Town Councils relied partly on house rates and various forms of license fees and, partly on grants-in-aid from the government to finance their activities and pay the wages of their sanitary inspectors and scavengers.¹¹¹

From the above narration, it would be realised that the Town and Municipal Councils were based mainly in the four most important towns in the colony until the 1950s. For the rest of the country which remained largely, small villages, the colonial government implemented its policies through Native Authorities (chiefs) who were supervised by District Commissioners. Native Authorities comprised essentially, traditional bodies whose powers were given legal force by government recognition. It was composed mainly of chiefs, assisted by Councils of elders and sub-chiefs who invariably represented the various sections of the community. The earliest attempt by the colonial government to administer the Africans through their native institutions was demonstrated through the enactment of the Native Jurisdiction Ordinance (NJO) of 1878, amended as NJO No.5 of 1883.¹¹² The ordinance provided a framework for setting up Native Authorities which effectively turned the chieftaincy institution into units of local government with the mandate to implement colonial policies.

The NJO made provisions that allowed Head Chiefs¹¹³, with the consent of their councillors and subject to the governor's approval, enact bye-laws to regulate the public health and ensure the sanitation of their villages. These bye-laws could be made, *inter alia*, for:

...Constructing, repairing, regulating, and protecting roads, wells, springs, watercourses, watering, and bathing places; ...regulating public fisheries...preventing and abating nuisances; clearing weeds, and

¹¹⁰ see GGC, 'Gold Coast Report for 1911', Annual (London: His Majesty's Stationary Office, 1912), 25.

¹¹¹ see GGC, 'Gold Coast Annual Report, 1950', 81; Addae, *The Evolution of Modern Medicine in a Developing Country*.

¹¹² The NJO was repealed in 1927 and in 1944. Its variants were applied in the Northern Territories in 1933 and in Asante in 1934. But essentially, its public health functions remained the same with few modifications. see Harvey, *Law and Social Change*, Chapter II; Harriet B. Schiffer, "Local Administration and National Development: Fragmentation and Centralization in Ghana", *Canadian Journal of African Studies*, Vol. 4, no. 1 (1970), 57-75.

¹¹³ The Ordinance defined a Head Chief as one who was not subordinate in the performance of his customary duties to any other chief.

bushwood(sic) from the outskirts of towns and villages; providing grounds for the burial of the dead, and regulating burials...¹¹⁴

In Asante and the Northern Territories, Native Authorities were empowered to control and administer their affairs and institute health measures. The Chief Commissioners in these areas were expected to make regulations bearing on the public health to guide chiefs and headmen of villages within their jurisdiction.¹¹⁵ In addition to the NJO, the Labour Ordinance also empowered Native authorities, to among other things, exact labour from their towns or villages within their jurisdiction to maintain markets, general sanitation, clearing roads and paths, digging wells, and maintaining local cemeteries.

Native authorities could hold sanitary trials in their tribunals and impose fines on those who contravened sanitary rules. In addition to a government Sanitary Inspector who could be appointed to act in an advisory capacity, Native Authorities employed their sanitary inspectors and other staff who were responsible for the sanitation of the villages. Such sanitary staff focused mostly on supervising the removal of night soil, managing rubbish dumps, collecting conservancy fees, conducting domiciliary inspections, summoning, and prosecuting sanitary offenders.¹¹⁶ Native Authorities, at their costs, sometimes sent young men from their communities to the District Headquarters to be trained as Native Sanitary Inspectors or Village Overseers by either the MOHs or the Sanitary Superintendents.

From the 1920s onward when training schools were available at Accra, Kumasi and later, Tamale and Kintampo, some of these staff were sent to these schools to receive training. Nevertheless, most of them remained untrained. For instance, in 1945, the acting Sanitary Superintendent in Saltpond complained that "Great difficulty is being experienced with the Native Administration Sanitary Inspectors in the discharge of their duties, due to lack of training in village sanitation, as a result, the management of latrines refuse sites and essential health duties are totally neglected."¹¹⁷ He subsequently, sought the approval of the District Commissioner to

¹¹⁴ Griffith, *Ordinances, Vol. I*, 400–401.

¹¹⁵ see C. H. Armitage (Ag. CCA), 'Sanitary Rules for the Guidance of Chiefs and Headmen of Villages in Ashanti', November 1909, PRAAD/ARG1/14/3/1, Ashanti Regional Archives, Kumasi.

¹¹⁶ see Addae, *The Evolution of Modern Medicine in a Developing Country*, 125–27.

¹¹⁷ 'From Acting Sanitary Superintendent to District Commissioner, Saltpond', 21 July 1945, PRAAD/ADM 23/1/987, Central Regional Archives, Cape Coast.

organise a three-month course to acquaint these inspectors with knowledge on how to construct the approved pit latrines, maintain refuse on rubbish dumps, construct and maintain field incinerators, maintain water supplies, and general measures of sanitation.¹¹⁸

Even though the sanitary work of Native Authorities appeared to have been somewhat central to improving sanitation in rural communities, their limitations seemed to be that, their staff remained inefficient. They worked rather mechanically, and their efficiency was measured in terms of “how much money they brought into Native Authority treasury.”¹¹⁹ Thus, sanitary work became more of an avenue for generating revenue than it was for improving the health of their communities. Even so, they remained critical to sanitary administration and reform until the late 1950s when their functions were transferred to newly established local government administrative units.

Sanitary Inspectors and Village Overseers

Popularly referred to as Sanitary Inspectors, they were at different periods called Nuisance Inspectors (during the late 19th century and the first two decades of the 20th century) or Health Inspectors (Used interchangeably with Sanitary Inspectors after the 1920s). Sanitary Inspectors played a key role in the Public Health and Sanitary administration in the Gold Coast. They were the public face of the Sanitary Branch, as they were the officials who often encountered the population. Their roles were wide-ranging. But essentially, they were responsible for ensuring adherence to sanitary rules and regulations and the education of the public on health-related issues. Among other things, a Sanitary Inspector could enter into houses to ascertain the presence of nuisances, mosquito larvae and cases of infectious diseases.

Home visits provided the Inspector with the opportunity to gain some idea of the general level of hygiene of the people, to give advice and to correct the presence of sanitary defects if it was within his power. But this role made them one of the most resented government officials. Writing in 1915, the SSO, D. Alexander observed that, “...It would be idle to think that the Sanitary Inspector is a welcome visitor, but at any

¹¹⁸ ‘From Acting Sanitary Superintendent to District Commissioner, Saltpond’, 27 July 1945, PRAAD/ADM 23/1/987, Central Regional Archives, Cape Coast.

¹¹⁹ Addae, *The Evolution of Modern Medicine in a Developing Country*, 126.

rate, he is now tolerated whereas before he was opposed."¹²⁰ If the Sanitary Inspector was opposed, it was because he was less known for his educational roles than he was for his law enforcement functions. As David Lennox, an acting DDHS during 1944 remarked, "...Much of the work of an Inspector in those days was controlling, usually, by the force of law, the habits of an ignorant population who tended usually unknowingly to perpetuate many and varied sanitary offences..."¹²¹

The designation of an official as a Sanitary Inspector in the Gold Coast dates to 1878 when the first public health ordinance was passed. The ordinance made provisions for and spelt out the roles of inspectors of nuisances. Such Inspectors were to be stationed in towns and district headquarters to assist Health Officers in the abatement of nuisances. However, their availability during the late 19th century was far and in-between. Few stations had one or two Inspectors, and many others had none. And the government during this period did not seem very keen to have Sanitary Inspectors posted to most stations which required them. For instance, as late as 1888, Ada, an important outstation had no Inspector, and when Dr Cole, the Assistant Colonial Surgeon for Ada requested for two Inspectors of Nuisances to be appointed, the CMO, showed little interest but rather proposed that one was enough.

Cape Coast had only one Inspector in 1888 and when the Surgeon stationed there, Dr Sullivan, requested for an Assistant Inspector, the CMO declined his request. Accra and Elmina had one Inspector each and the remaining stations had no Inspectors.¹²² By 1897 there were only eighteen inspectors of nuisances stationed in the entire colony.¹²³ It must be remarked that even though the records are not explicit on the kind of people who were appointed as Sanitary Inspectors during the late 1800s, it would seem that most of them were European and few others, Africans.¹²⁴ The majority of Africans were likely to have been appointed as Assistant Inspectors –

¹²⁰ GGC, 'Medical and Sanitary Report for the Year 1915' (London: Waterlow and Sons Ltd., 1916), 12, BOA, <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.

¹²¹ David Lennox, 'Inaugural Address at the Opening of School of Hygiene and Sanitation, Accra', 1944, 1, School of Hygiene and Sanitation Library, Accra.

¹²² GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888' (London: Her Majesty's Stationary Office, 1889), 11; 14, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

¹²³ GGC, 'Enclosure 16 in the Gold Coast No. 257 of July 1899', 205.

¹²⁴ For example, the Inspector of Nuisance for Elmina during 1887/88 was one Mr Hodibert and that of Accra was another Mr Allan. These are obvious European names.

a post that attracted few applicants because of the low wages that was offered to such grade of Inspectors.¹²⁵

The chronic shortage of Inspectors continued into the 1900s. While Towns like Accra, Sekondi and Kumasi appeared to have had regular services of Sanitary Inspectors during this period, most other stations continued to lack.¹²⁶ Indeed, in 1907, the number of Sanitary Inspectors in the colony was seventeen (17), one less than the number in 1897.¹²⁷ However, as the first decade of the 20th century inched to a close, the need was felt to recruit more African Inspectors for sanitary work. Consequently, a scheme was designed in 1909 to train African Sanitary Inspectors, albeit, of a lower grade compared to the European Inspector in terms of rank and salary. African Inspectors were classified on a scale of one to six. It is not clear what benchmark was used for the grading, yet the attainment of some level of elementary education might have been crucial. Nonetheless, in 1909, following the implementation of the scheme, it was reported that all such Inspectors who were trained were appointed to stations.¹²⁸ Their number was not mentioned.

As it was in the late 1800s, the post of a Sanitary Inspector continued to be unattractive to the African during the early 1900s. There were two reasons for this. Firstly, the poor wages that was offered to low-ranked Inspectors and secondly, the notoriety of the Sanitary Branch because of the nature of its work. In 1911, it was reported that:

Owing to the unpopularity of the service and the low rate of pay offered – less than that earned by a good cook – it was impossible to bring the 6th grade up to strength at any period of the year. Moreover, the standard of education, probity and intelligence exhibited by some members of this grade was not of a high order or calculated to accelerate progress of sanitation. Some years ago, I think it would have been possible to obtain suitable candidates of the wage

¹²⁵ see GGC, 'Medical and Sanitary Report for the Year 1902' (London: Waterlow and Sons Ltd., 1903), BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

¹²⁶ In 1902, Accra had one Chief Sanitary Inspector, Ferdinand Christian Lokko, who was assisted by five Assistant Inspectors while Sekondi and Kumasi had one each. The same staff strength of Inspectors was maintained in 1903, but this time, Accra had a European Inspector while Kumasi and Sekondi maintained the services of African Inspectors.

¹²⁷ GGC, 'Medical and Sanitary Report for the Year 1907' (London: Waterlow and Sons Ltd., 1908), <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

¹²⁸ GGC, "Medical and Sanitary Report for the Year 1909" (Gold Coast: Government Printer, 1910), BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

offered, but with the general prosperity of the colony, the standard of living has risen, and it is no longer possible to obtain on such terms any derelicts.¹²⁹

Indeed, in 1911 the Senior Town Council Sanitary Inspector was paid a paltry sum of £95 and a bicycle allowance of £9 per annum. Junior inspectors were paid between £36 and £40 per annum depending on their rank. And there was no provision for a regular increment of pay.¹³⁰ Without a doubt, the unattractive conditions of the service did not attract the best class of men for inspectorship which consequently affected the quality of inspection.

Following the inability to recruit people to the post of sixth-grade Inspectors, the grade was abolished at the beginning of 1912. Provision was then made for nineteen fifth grade Inspectors to be recruited in January 1912 on an improved salary scale of £40-60 per annum. At the same time, an African Sanitary Superintendent was to receive between £200-250 per annum, and second-grade Inspectors, between £100-150 per annum. Third and fourth-grade Inspectors received between £80-100 and £60-80 respectively per annum.¹³¹ Perhaps, because of the improved salaries, the staff strength of African Inspectors began to increase steadily. In 1911, there were thirty Inspectors including one European Sanitary Superintendent and two European Inspectors.

By 1912, the number had increased to forty-one African Inspectors and four Europeans in supervisory positions. In 1913, the staff strength of African Inspectors was forty-three, and it increased marginally to forty-seven in 1914. And for the first time, two female Inspectors were recruited.¹³² Even so, at the close of 1912, the fifth grade was ten below strength and there were seven more vacancies in 1913 of the fifth grade which could not be filled, and it was unlikely that the total of forty-seven Inspectors in 1914 was up to the staff strength. Unfortunately, the onset of World War I further affected the staffing position of Sanitary Inspectors. The War did not only

¹²⁹ GGC, 'Medical and Sanitary Report for the Year 1911' (London: Waterlow and Sons Ltd., 1912), 48, BOA, <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.

¹³⁰ *Ibid.*, 190.

¹³¹ GGC, 'Medical and Sanitary Report for the Year 1912', 63.

¹³² GGC, 'Medical and Sanitary Report for the Year 1913'; GGC, 'Medical and Sanitary Report for the Year 1914' (London: Waterlow and Sons Ltd., 1915), <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.

affect recruitment but also, it diverted the energies of the already limited staff towards war endeavours.¹³³

The situation, however, improved after the war. The African Inspectorate corps was reorganised into three categories – from ‘first to third class Inspectors’ –under the supervision of African Sanitary Superintendents. By 1920, there was a total of sixty-five Inspectors, five of whom were European Superintending Inspectors, and two African females.¹³⁴ From this period, the number of Inspectors continued to rise steadily. In 1921, the total number of Inspectors was sixty-six; in 1922/1923, the number was sixty-seven, yet vacancies existed for two more Senior Division and four Second Division Inspectors respectively.¹³⁵ In 1923/24, the number increased, but marginally to seventy-four. Out of this number sixty-nine were African Inspectors of varying ranks and the remaining five were Europeans who occupied supervisory positions.¹³⁶ The total number of permanent Inspectors for 1924/25 remained the same as 1923/24, but the composition had changed. There were seven European Superintendent Inspectors and sixty-seven African Inspectors. However, additional ten Inspectors were employed on a casual basis and stationed in plague-infested districts viz – Sekondi and Kumasi.¹³⁷

In 1925/26, the number of African Inspectors was sixty-five and by 1933/34, the number, including European supervisors had reached an appreciable level of one

¹³³ For example, V.T Massey and J. Fianu, both African Inspectors, acted as dressers during operations in Togoland and Lome, respectively. V.T Massey proceeded to Cameroon to provide similar services when hostilities ended in Togoland in August. N.H. Lamptey another African Inspector Joined the Togoland Field Force in August 1914 and provided similar services in Togoland and when operations ended proceeded to perform the same functions in Cameroon. Three European Sanitary Inspectors, G.S. Rix, H. Yeoman, and H. Williams were all enlisted for war duties.

¹³⁴ GGC, ‘Report on the Medical Department for the Year 1920’ (Gold Coast, Accra: Government Press, 1921), BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.

¹³⁵ GGC, ‘Report on the Medical Department for the Year 1921’ (Gold Coast, Accra: Government Press, 1922), BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>; GGC, ‘Report on the Medical Department for the Period January 1922 - March 1923’ (Gold Coast, Accra: Government Press, 1923), <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.

¹³⁶ GGC, ‘Report on the Medical Department for the Period April 1923 - March 1924’ (Gold Coast, Accra: Government Printer, 1924), BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.

¹³⁷ GGC, ‘Report on the Medical and Sanitary Department for the Period April 1924 - March 1925’ (Gold Coast, Accra, 1925), BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>. The actual number of permanent European Inspectors was two. The remaining five were seconded from the Royal African Medical Corps (RAMC) for plague work in the colony

hundred and six.¹³⁸ It would seem that because of the limited availability of jobs for the emerging literate class¹³⁹, and perhaps, the relatively improved wages of the African Inspector class, the post had become an attractive employment option to the educated African population. And indeed, potential job-seekers even volunteered as Inspectors when paid vacancies did not exist. For instance, it was reported in the 1930s that “In recent years there has been no lack of candidates who seek unpaid employment with the Town Councils in the hope of appointment to salaried posts when such fall vacant.”¹⁴⁰

As the recruitment of Inspectors improved, the pressing question that remained was the nature and quality of training given to these recruits before they were dispatched to commence work. Until 1920, when the training of African Sanitary Inspectors was given serious consideration, almost every Inspector who was recruited was trained on the job. Medical Officers of Health and Superintendent Sanitary Inspectors organised crash courses for recruits before they were deployed to their new stations. These courses lasted a few months and was certainly not sufficient. Inspectors were instructed by lectures and demonstrations as well as practical training. Occasionally, when the need arose for definite information and guidance, this was given by circulars, leaflets, etc.¹⁴¹ For most of this period, the level of education of most African Inspectors was elementary school.

However, starting from the early 1920s there was the felt need to regularise not only the training of Inspectors but also, to raise the standard of education that qualified an applicant to be recruited. It was stated in 1922/23 that:

The training of Sanitary Inspectors has been under consideration, and it is now proposed that all applicants for sanitary Inspector appointment must have passed the 7th standard before being accepted as a Sanitary Inspector-in-training. They will then be required to do a three years course. The first two years to be spent in Accra or in an outstation under a Medical Officer of Health

¹³⁸ GGC, ‘Report on the Medical and Sanitary Department for the Period April 1925 - March 1926’ (Gold Coast, Accra: Government Printer, 1926), BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>; GGC, ‘Report on the Medical Department for the Year 1933-1934’ (Gold Coast, Accra: Government Printer, 1934), BOA, <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.

¹³⁹ see Philip J. Foster, *Education and Social Change in Ghana*, (London: Routledge & Kegan Paul Ltd., 1965), 137–38.

¹⁴⁰ see GGC, ‘Report on the Medical Department for the Year 1933-1934’, 39.

¹⁴¹ see GGC, ‘Reports on the Medical and Sanitary Department for the Year 1919’ (Accra: Government Press, 1920), 18, BOA, <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.

or a Medical Officer. A final examination will then have to be passed before the candidate is appointed as a Second Division Sanitary Inspector on probation.¹⁴²

In November 1922, a training centre was opened in Accra under the supervision of a West-Indian Sanitary Inspector. It was reported that all important subjects connected with tropical hygiene and sanitation were taught as part of the training. The training program was divided into two parts. The first part comprised a three-month course in practical sanitation. It was mandatory for all probationers to go through this training before they were deployed to an out-station. Junior sanitary inspectors were subsequently brought from outstations to receive this training. The second component of the course was offered in three months and it focused on theoretical training for senior inspectors who had served between five to six years. Forty-nine candidates attended the first course in 1922, out of which eight were appointed sanitary inspectors during the first quarter of the following year, and four dismissed as unsuitable while the remaining were still undergoing training.¹⁴³

By 1925, the training of Inspectors had been formalised and well-structured. The nucleus of what became known as the School of Hygiene and Sanitation was subsequently started at Accra in 1925. Ten Sanitary Inspectors-in-Training were recruited and put under the instruction of an officer in the sanitation department and provision was made for ten more Inspectors-in-training to be recruited in 1926/27.¹⁴⁴ The selection of candidates was based on passing elementary general knowledge entrance exam. Upon completion, these Pupil-Inspectors were to be appointed as Second Division Inspectors.¹⁴⁵ In 1929, a special Training Officer was employed for the school to give the Pupil-Inspectors theoretical and practical training.¹⁴⁶ In addition to the training offered in the Accra school, Health Officers in the larger towns provided further training – through lectures and practical demonstration and fieldwork to newly recruited Inspectors.

¹⁴² GGC, 'Report on the Medical Department for the Period January 1922 - March 1923', 16.

¹⁴³ GGC, 'Report of the Medical Department for the Year Ending 1st April 1922 - 31st March 1923', Annual (Accra: Government Printing Department, 1923), 48–49, BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.

¹⁴⁴ GGC, 'Report on the Medical and Sanitary Department for the Period April 1925 - March 1926'.

¹⁴⁵ Ibid.

¹⁴⁶ GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929' (Gold Coast, Accra: Government Printing Department, 1929), BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.

Such concurrent training of Inspectors (at the school in Accra and in towns where a MOH was stationed) continued for most of the 20th century. For instance, in 1927/28, it was reported that training of sanitary staff was carried out in all stations where Health Officers were stationed.¹⁴⁷ Similarly, 1930/31, it was reported that in Cape Coast, Kumase, Accra and Sekondi, the Medical Officers of Health and Superintending Sanitary Inspectors gave weekly lectures to Pupil-Inspectors as well as practical demonstrations in infectious diseases as cases were obtainable. Lectures were also given at slaughterhouses to both butchers and their assistants. Theoretical lessons focused on anatomy, physiology, dietetics, infectious diseases, entomology, refuse and excreta disposal, mosquito control and disinfection as well as sanitary laws and meat inspection.¹⁴⁸

Unfortunately, few years after its establishment, the Accra school started to function spasmodically. For instance, in 1927/28, it was reported that:

Owing to demands made for the services of sanitary Inspectors from all parts of the colony and to the incidence of leave in the permanent staff, it is not always possible to allow Sanitary Inspectors-in-Training to remain for the whole of their three years course.¹⁴⁹

In 1931, the school could not operate fully for the entire year. This related partly to the shortage of staff and partly to an outbreak of yellow fever, which compelled the Health Branch to deploy most of the pupil Inspectors to assist in different parts in the colony to combat the disease.¹⁵⁰ The lack of funding, arising from the financial stringency of the 1930s also contributed to the jerky operations of the school. By 1933, the school was almost defunct. It was reported that "...most of the Sanitary Inspectors-in-Training have passed out as Second Division Sanitary Inspectors and no candidates for training have been taken on..."¹⁵¹ Subsequently, Medical Officers of Health in Accra, Cape

¹⁴⁷ GGC, 'Report on the Medical and Sanitary Department for the Period April 1927 to March 1928' (Gold Coast, Accra: Government Printer, 1928), BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.

¹⁴⁸ GGC, 'Report on the Medical Department for the Year 1930-31' (Gold Coast, Accra: Government Printer, 1931), BOA, <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.

¹⁴⁹ GGC, 'Report on the Medical and Sanitary Department for the Period April 1927 to March 1928', 32.

¹⁵⁰ see GGC, 'Report on the Medical Department for the Year 1931-32' (Gold Coast, Accra: Government Printer, 1932), 34, BOA, <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.

¹⁵¹ GGC, 'Report on the Medical Department for the Year 1932-33' (Gold Coast, Accra: Government Printer, 1933), 35, BOA, <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.

Coast, Sekondi and Kumasi were obliged to arrange training for their Inspectors in their respective headquarters.¹⁵²

Operations of the Accra school, however, resumed in 1935 when the government made available monetary support for the training of ten Pupil-Inspectors. The curriculum of the school was reorganised, and the entry requirement was raised. The 1934 medical and sanitary report emphasised that:

A higher standard of education is being demanded from candidates for posts in health Branch and it is intended to require from all new members the matriculation exemption certificate or a second-class Teachers' certificate after Four-years course in a training college.¹⁵³

Emphasis was placed on training Inspectors to be able to identify the causes of ill-health the prevention of diseases. The 1934 report noted that "the aim of the health branch is to teach the causes of ill-health and the means of disease prevention rather than to rely upon coercion."¹⁵⁴ The new standard was implemented immediately, and in 1936, older practising Inspectors were encouraged to re-enrol to upgrade their knowledge. The result was that two streams of students were in training during 1936: one stream comprising older Inspectors with the Seventh-standard Leaving Certificate (Middle School Leaving Certificate), and a second stream of newly recruited Pupil-Inspectors possessing the second-class teachers' certificate. This development, however, posed a practical challenge arising from how to correlate teaching to suit the two grades.¹⁵⁵

Nevertheless, following the restructuring of the curriculum of the school, it was expected that many of the Inspectors-in-Training would sit for the Royal Sanitary Institute (RSI) Examination¹⁵⁶, and thus qualify for promotion to a higher post. In 1938,

¹⁵² GGC, 'Report on the Medical Department for the Year 1932-33', 1933.

¹⁵³ GGC, 'Report on the Medical Department for the Year 1934' (Gold Coast, Accra: Government Printer, 1935), 25, BOA, <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.

¹⁵⁴ Ibid.

¹⁵⁵ see GGC, 'Report on the Medical Department for the Year 1936' (Gold Coast, Accra: Government Printer, 1937), 33, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹⁵⁶ The Royal Sanitary Institute (R.S.I) was founded in Great Britain in 1876 to train people in basic hygiene. It instituted its professional qualifying examination for Sanitary Inspectors in 1877. In the 1930s, the R.S.I. extended the qualifying examination to principal colonial centres. Its first organised local examination for Sanitary Inspectors in British West Africa was in 1932. It was repeated in 1933 in Lagos. See from Chief Secretary's Office, Nigeria to Colonial Secretary, Gold Coast, "Notice: Local Examination for Certificate of the Royal Sanitary Institute for British West Africa", 20 September 1933. PRAAD/CSO11/14/194, National Archives, Accra.

the RSI examination (West Africa) was held for the first time in Accra. Twelve candidates from the school were presented, out of whom eight passed.¹⁵⁷ Before this period, candidates had to travel to Lagos to write this examination. The Health Branch was, thus, elated about this development and remarked that:

The holding of this examination in Accra marks the beginning of a new era in the training of Sanitary Inspectors; and if it continues to be held at regular intervals, as it is intended, it should do much to help produce inspectors of higher standard of training.¹⁵⁸

Unfortunately, the hopes of the Health Branch were dashed as the school folded up for the second time in 1941 due partly to the non-replacement of the Training Officer who retired in 1939, and partly, to the shortage of staff, arising from wartime challenges. It was, however, reopened in 1944.¹⁵⁹ The curriculum was once again revised and made more comprehensive to cater to the changing health needs of the colony. Four Training Officers were put in charge of the school and courses were designed to meet the requirements of sanitation in bigger towns and for the “more responsible supervisory roles.”¹⁶⁰

Courses offered included Mathematics, English Language, Elementary Physiology and Anatomy, Public Health Hygiene, Gold Coast Sanitary Laws and Practice, Practical Meat Inspection and Examination of other Foods, Practical Disinfection, Outdoor Work, Field Work, and Elementary Entomology and Parasitology. The Sanitary Branch reckoned that:

The training given by the Accra school is considered absolutely essential to effecting any improvement in the present standards of the local environmental health services. It is essential for health Inspectors to know not only how a thing

¹⁵⁷ GGC, 'Report on the Medical Department for the Year 1938' (Gold Coast, Accra: Government Printer, 1939), BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹⁵⁸ Ibid., 38.

¹⁵⁹ GGC, 'Report on the Medical Department for the Year 1944' (Gold Coast, Accra: Government Printing Department, 1945), BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>. From this period, there was a steady enrolment of pupil Inspectors. There were 50 students in residence in 1947, out of whom 42 were ex-servicemen; 49 in 1948, out of which 6 passed the RSI examination and were appointed as second division inspectors; 40 fresh students in 1949 as 36 passed out. There was no new admission in 1950, but in 1951, there were 42 students in training, including two students from Liberia as 24 passed out.

¹⁶⁰ GGC, 'Report of the Ministry of Health, 1953' (Gold Coast, Accra: Government Printer, 1955), 3, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

is done but why it is done, and it requires a much higher basic educational standard as well as higher quality training than had hitherto been possible.¹⁶¹

Yet, apart from the Sanitary Inspectors, most of whom were stationed in the important towns and urban centres, sanitation work in rural communities was handled by a group of low-grade Inspectors called Village Overseers. It is not clear when the concept of Village Overseers was introduced in the Gold Coast, but it appears more probable that it was started in the late 1920s when the question of rural sanitation was under serious consideration. In 1927 five Village Overseers were in training alongside Pupil-Inspectors at the Accra School and by 1928/29 the number had increased to ten.¹⁶²

In 1930, the Senior Health Officer at Kumasi started a regular school for Village Overseers. Prospective Village Overseers were required to undergo preliminary training under the Kumasi Public Health Board as learners before they were accepted as Village Overseers-in-Training. Overseers-in-Training were drawn to fill vacancies in the Permanent staff of Village Overseers when such positions became available.¹⁶³ By 1933/34, the staff strength of Village Overseers was 19 and it remained the same in 1935.¹⁶⁴

In 1938, the government built a school for Sanitary Overseers in Tamale at a cost of £1200 to facilitate the training of staff for Native Administrations in the Northern Territories.¹⁶⁵ An earlier attempt to start such a school in Tamale was made in 1935, but this ran into a snag and the idea was subsequently abandoned. The school remained functional after its inception in 1938, graduating sixteen Overseers in 1940, twelve in 1941 and seven in 1942.¹⁶⁶ In 1943, the school was reorganised to

¹⁶¹ Ibid., 53.

¹⁶² GGC, 'Report on the Medical and Sanitary Department for the Period April 1927 to March 1928'; GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929'.

¹⁶³ GGC, 'Report on the Medical and Sanitary Department for the Year 1929-1930' (Gold Coast, Accra: Government Printer, 1930), BOA, <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.

¹⁶⁴ GGC, 'Report on the Medical Department for the Year 1933-1934'; GGC, 'Report on the Medical Department for the Year 1935' (Gold Coast, Accra: Government Printer, 1936), BOA, <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.

¹⁶⁵ GGC, 'Report on the Medical Department for the Year 1938', 38.

¹⁶⁶ GGC, 'Report on the Medical Department for the Year 1940' (Gold Coast, Accra: Government Printer, 1940), BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>; GGC, 'Report on the Medical Department for the Year 1941' (Gold Coast, Accra: Government Printer, 1942), BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>; GGC, 'Report on the

accommodate the training of Native Administration Vaccinators. However, because of war-time constraints and the concomitant shortage of staff the school after its reorganisation in 1943, remained in abeyance until 1951 when it was restructured and named the School of Hygiene, Tamale.¹⁶⁷ Following this development, the post of Village Overseers was abolished. Subsequently, all serving Native Administration Overseers serving in the Northern Territories were examined and those found suitable (nineteen) were enrolled in the school in January 1952 to complete a two-year course to qualify as Junior Sanitary Inspectors.¹⁶⁸

In March 1952, another School of Hygiene was started in Kintampo to serve Asante and the Colony Proper. The Kintampo school, running the same program as the Tamale school, started with a student capacity of thirty-two on the premises of a school that hitherto was used to train Dressers for Native Authority Administrations.¹⁶⁹ The training in these two schools was envisaged to be rural bias and emphasis was placed on the health education role which rural Sanitary Inspectors were expected to execute.¹⁷⁰ Both schools were intentioned to provide local authority administrations with a source of employees. And both schools were programmed to produce slightly lower-grade Sanitary Inspectors, for Asante, the Colony, and the Northern Territories. The courses offered were practical-oriented and students learned partly by “constructing various types of sanitary units and out-buildings, as well as by laying out new villages” within the vicinities where they were located.¹⁷¹ The entry requirement for the Kintampo school was the Middle School Leaving Certificate. For Tamale, it was said that “because of the backward state of the area” a considerably lower standard for admission was acceptable.¹⁷²

Medical Department for the Year 1942' (Gold Coast, Accra: Government Printing Department, 1943), BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹⁶⁷ GGC, 'Report on the Medical Department for the Year 1951' (Gold Coast, Accra: Government Printing Department, 1953), BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹⁶⁸ GGC, 'Report on the Medical Department for the Year 1952' (Gold Coast, Accra: Government Printing Department, 1954), BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹⁶⁹ GGC, 'Report of the Medical Department for the Year 1952'.

¹⁷⁰ GGC, 'Report of the Ministry of Health, 1953', 53.

¹⁷¹ Ibid.

¹⁷² Ibid.

Conclusion

I have examined public health and sanitary administration from the late 19th century to the mid-20th century. The contexts that prompted the various interventions that eventually culminated in the establishment of formal administrative structures, agencies and agents for administering public health and sanitary reforms have been discussed. Initial efforts at administering public health and sanitary reforms during the 1870s reflected in the enactment of ordinances and rules to regulate the habits of the African population – since these habits were held to be the cause of insanitary conditions. Yet, the apathetic and indifferent attitude of colonial officials towards the implementation of sanitary rules inhibited any significant improvement during the period. To that extent, there seemed to be tensions between what the colonial government ought to have done and in some instances committed to doing and what was done.

During the 1880s, however, a more pragmatic approach towards improving health conditions resulted in the creation of the first-ever administrative body, the GCMD, to address the health needs of the colony. Through this department, some few sanitary reforms and improvements in general health conditions were achieved. A rather contentious strategy that was adopted during the 19th century to administer sanitation and public health was the devolution of such responsibilities to Town/Municipal Councils and Native authorities. Even though this approach was initially opposed, it became a critical component of the overall machinery for administering sanitary reforms and public health throughout the colonial period.

Yet, at the beginning of the 20th century, the persistence of the sanitary challenges, a coincidental bubonic plague outbreak, and the reactions it engendered compelled colonial officials to implement a recommendation to create a Sanitary Department. This placed sanitary administration and reforms on a proper footing. In the meantime, sanitary committees were created in some towns starting from 1908 and vested with the responsibility to administer sanitation and public health in such towns. In 1920, a Central Board of Health was created to coordinate the public health activities, especially, sanitary reforms.

The mundane daily activities of the Sanitary Branch regarding the enforcement of sanitary regulations were carried out by an inspectorate corps, comprising Sanitary Inspectors and Village Overseers. The staffing of this inspector corps was, however, a challenge during the late 19th century and remained so for a significant part of the 20th century, worsening during the periods of the two World Wars. Nevertheless, measures were devised to train qualified Inspectors starting from the 1920s, and despite formidable challenges that constrained their training, particularly, during the 1930s and 1940s, by the 1950s their training had been institutionalised.



Chapter Four

Combating Dirt in the Gold Coast from the Late 19th Century – 1950

Introduction

...As we know it, dirt is essentially disorder. There is no such thing as absolute dirt: it exists in the eye of the beholder. If we shun dirt, it is not because of craven fear, still less dread of holy terror. Nor do our ideas about disease account for the range of our behaviour in cleaning or avoiding dirt. Dirt offends against order. Eliminating it is not a negative movement, but a positive effort to organise the environment.¹

The attitude of the colonial administration and its officials regarding dirt in the Gold Coast wittingly or unwittingly reflects Mary Douglas's conceptualising of dirt and ideas of cleanliness and pollution as emanating from concerns about ensuring social order. Mary Douglas employs the metaphor of dirt to represent anything that is polluting as a potential threat to the established socio-cultural order. For her, therefore, "dirt offends against order",² and Ruth Barcan adds, "against the categories that help to promote social stability."³ Therefore, to preserve the social order, it becomes imperative, as Barcan argues, for societies to eliminate, conceal or purify dirt. This observation encapsulates the colonial government's attitude towards the treatment of dirt in the Gold Coast. As Laporte has observed there is a sense in which Victorian Britain's imperialistic civilising tendencies was interlaced with its policing of waste.⁴

Late 19th century European accounts of the Gold Coast, particularly, its coastal settlements reflected a pathological landscape that was perceived to require the imposition of some form of order. European officials represented African habits and household practices as the cause of disorder and filth. For instance, when J.D. McCarthy arrived in Accra for the first time in 1882, he described the town as oozing with offensive smells resulting from stray pigs roaming the streets and indiscriminate

¹ Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo* (London: Routledge, 2001), 2.

² Ibid.

³ Ruth Barcan, 'Dirty Spaces: Separation, Concealment, and Shame in the Public Toilet', in *Toilets: Public Rest Rooms and the Politics of Sharing*, ed. Harvey Molotch and Laura Noren (New York and London: NYU Press, 2010), 25.

⁴ see Dominique Laporte, *History of Shit*, trans. Nadia Benabid and Rodolphe el-Khoury, Reprint edition (Cambridge, Mass. London: The MIT Press, 2002), 58–59.

littering with human and animal waste. He, therefore, requested the government to impose some order by dealing with the pig nuisance and related filthy habits.⁵ Thus, in the Gold Coast, sanitation measures targeted not only the elimination of dirt from homes and households but also the cleaning up of what was presented by colonial officials as disorderly streets, filthy surroundings and dirty villages. The intent being to impose cleanliness and orderliness on both the physical and social landscape. Yet, colonial policy was also undergirded by late 19th and early 20th century medical discourse that conflated social disorder with diseases.

This chapter examines the attempts at imposing order on the social and physical landscape through the management of excrement, street cleaning and refuse disposal, as well as the management of the sanitation of remote rural communities and mining towns/villages. I demonstrate that despite claims by the government of “improper” toileting habits by the African population, the attempt to supplant these toileting practices and introduce ‘new’ toilet technologies ended in abysmal failure. The various latrines that were provided were mostly primitive, *ad hoc*, and inadequate to meet the toileting needs of the people. At the same time, the method of disposal of night-soil remained largely inefficient.

In a similar vein, attempts to clean the streets, neighbourhoods and outskirts of villages and towns of filth were saddled with many difficulties arising from the use of badly constructed dust-bins, an inadequate number of labourers to perform scavenging duties, a limited number of incinerators, and sometimes, inefficient dumping methods. Furthermore, the sanitation of remote rural communities and mining towns and villages remained deplorable for most of the period under consideration. Underpinning these sanitary failures was the lethargy of the colonial government and their reluctance to commit sufficient financial resources to solve sanitation problems. Thus, while admitting that some attempts were made to improve sanitation through the provision of public toilets, the institution of the public dust-bin system, and the use of legislation to effect change in rural communities and mining

⁵ see Samantha Moyes, ‘The Making of the Everyday: A Study of Habits in Colonial Ghana (Gold Coast) during the Early Twentieth Century’ (Université d’Ottawa/University of Ottawa, 2014), 26–27, <https://www.ruor.uottawa.ca/handle/10393/31712>.

villages, on the balance sheet, these measures could hardly solve the problems they were intended to mitigate.

Managing Shit: Public Latrines and Night Soil Disposal

This section examines the provision of public latrines and the disposal of night soil. European colonists expressed disgust about what they described as ‘promiscuous defecation’ amongst colonised people who were yet to develop toilet and sewage systems along the lines of those that had developed in Europe by the 19th century.⁶ Ian Scott Todd links the history of the invention of the toilet and the development of toilet practices in Europe to the development of modernity and the modern city, to argue that toilet and public restrooms emerged to serve urban dwellers, especially, travellers who were often “caught short while away from their homes.”⁷ However, by the mid-19th century and well into the 20th century, many Europeans regarded toilet technologies as significant markers of progress.⁸

In most parts of Europe, during the 19th century, the toilet served more than just as places of convenience; its invention was presented as a symbol of modern life. It was inextricably linked to the growing concern regarding cleanliness, respectability and propriety that characterised the bourgeois society.⁹ Consequently, activities that hitherto, were seen to be natural to human bodily functions were now represented as “inappropriate” and “immoral” and therefore, uncivilised. This rendering of civilisation undergirded by the bourgeois values of cleanliness, respectability and propriety was applied to the natural functioning of the body such as defecation and urination - these acts being considered as dirty. And because of their potential to offend through smell and desecrate public spaces, defecation and urination increasingly became private affairs and every effort was made to conceal such acts from “both eyes and nose.”¹⁰ Alison Moore extrapolates from contemporary European attitudes towards toilet

⁶ see Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines*, New edition (Durham, NC: Duke University Press Books, 2006); Daniel J Walther, “Race, Space and Toilets: ‘Civilization’ and ‘Dirt’ in the German Colonial Order, 1890s–1914*,” *German History* 35, no. 4 (November 14, 2017): 551–67.

⁷ Ian Scott Todd, ‘Dirty Books: Modernism and the Toilet’, *Modern Fiction Studies* 58, no. 2 (2012): 192.

⁸ Alison Moore, “Colonial Visions of ‘Third World Toilets’: A Nineteenth Century Discourse That Haunts Contemporary Tourism,” in *Ladies and Gents: Public Toilets and Gender*, ed. Olga Gershenson and Barbara Penner (Philadelphia: Temple University Press, 2009), 108.

⁹ see Todd, ‘DIRTY BOOKS’; Walther, ‘Race, Space and Toilets’.

¹⁰ see Walther, ‘Race, Space and Toilets’, 555.

practices in post-colonial cultures to argue that they reflect 19th century European anxieties about excretory practices that were linked to ideas of ‘progress and or the “civilising process and excretory control.”¹¹

During the colonial encounter in the Gold Coast and elsewhere in other colonial enclaves, European colonists regarded anything short of the toileting practices that prevailed in Europe as contrary to the rules of hygiene regarding defecation and therefore an anathema to the prevailing notions of civilisation. Indeed, colonial administrators regarded what they perceived as ‘promiscuous defecation’ as a dangerous practice amongst colonised people that needed to be stopped. Moreover, 19th and 20th century Euro-Western medical discourses emphasised the dangers of excremental odours and the potential for excrement to operate as a vehicle for the transmission of germs.¹² Thus, out of concern for the public health, the health of Europeans in particular, and in keeping with Eurocentric notions of hygiene, respectability and propriety, the colonial state sought to supplant indigenous defecation habits with European modes and technologies of toileting and human waste elimination techniques.¹³

Colonial officials sought to inscribe their notions of what they believed to be “proper” toileting habits onto the inhabitants of the Gold Coast. This attempt to inscribe notions of proper toileting practices on the local population invokes David Scott’s concept of colonial governmentality. Inspired by Michel Foucault, Scott notes that in colonial governmentality “power (in this case medical discourses and technologies of human waste elimination)”¹⁴ is directed at the “destruction and reconstruction of colonial spaces” to produce “governing-effects on colonial conduct.”¹⁵ This implies an attempt to inculcate European values in the colonised population so that they would accept to do what is required of them out of self-interest rather than the use of force.¹⁶ However, in the Gold Coast, some of the normative practices and surveillance

¹¹ Alison Moore, “Colonial Visions of ‘Third World Toilets’: A Nineteenth Century Discourse that Haunts Contemporary Tourism,” in *Ladies and Gents: Public Toilets and Gender*, ed. Olga Gershenson and Barbara Penner (Philadelphia: Temple University Press, 2009), 106.

¹² Anderson, *Colonial Pathologies*, 104–5.

¹³ see Walther, ‘Race, Space and Toilets’.

¹⁴ *Ibid.*, 552.

¹⁵ David Scott, ‘Colonial Governmentality’, *Social Text*, no. 43 (1995): 204, <https://doi.org/10.2307/466631>.

¹⁶ Walther, ‘Race, Space and Toilets’, 552.

techniques that were adopted (such as prosecuting people for indiscriminate defecation and improper disposal of faecal matter) was coercive.

The colonial state also sought to change the toileting practices of the people through the provision of public latrines, particularly in the major towns and villages. Either way, the colonial government's attempts at providing public latrines, just like other public health measures, was slow in achieving results. The types of latrines provided were mostly *ad hoc*, inadequate, inefficient and 'primitive', particularly during the late 19th century. Also, for most of the 20th century, what were presented as improved latrine and sewerage facilities were either unsuitable or were not provided in sufficient quantities. Thus, the attempts to 'sanitise' toileting practices in the Gold Coast, was one of the colonial government's sanitary failures.

Pits, Trenches, Pans and Buckets

Accounts about indiscriminate defecation are found in early European writings on the Gold Coast, dating to the 18th and 19th centuries, particularly about towns along the southern coastal stretch where Europeans made the earliest contacts.¹⁷ And colonial records throughout the late 19th century and beyond complained about the indiscriminate defecation of the African population around their settlements. Gundona has, for example, noted that in the Northern Territories, colonial officials reported that "designated sites of excreta were alien to local inhabitants"¹⁸ before the inception of British rule. Thus, except in areas of very close proximity to residences, excreta could be disposed in any part of the village or town.¹⁹ As late as 1921 (and this was a period when public latrines had been introduced in the Gold Coast), J. M. Dalziel, the SSO observed that whereas in some villages along the coast the African population used some form of pit latrines, in many other towns and villages along the eastern and western coast such as Keta and Apollonia, "promiscuous use of the sandy surface seems to be the universal custom."²⁰

¹⁷ see for example Willem Bosman, *A New and Accurate Description of the Coast of Guinea, divided into the Gold, the Slave, and the Ivory Coasts* (Sir Alfred Jones, 1705), 105–6. See also Chapter 2 above

¹⁸ Sylvester Gundona, "Coping with This Scourge: The State, Leprosy, and the Politics of Public Health in Colonial Ghana, 1900- Mid 1950s" (University of Texas, 2015), 150.

¹⁹ see *ibid.*

²⁰ GGC, 'Report on the Medical Department for the Year 1921', 18.

Such narratives, however, betray a familiar colonial discourse. Stephanie Newell drawing on McClintock and Burke has highlighted how the writings of European visitors to Africa during the colonial period drew circular and self-serving connections between cleanliness and civilisation. She argues that viewed and described with an imperial gaze, Europeans constructed the image of the “dirty Native” to legitimise their “cultural expansion into the most intimate corners of Africans’ daily lives.”²¹ It can thus, be inferred that such denigrating remarks about the toileting practices of the Gold Coasters, even if there were any merits in them, were meant to justify the need to intervene to impose so-called ‘civilised’ defecation practices on the indigenous population.

Writing on civilising strategies in late 19th century Philippines, Warwick Anderson shows how above anything else, it was the toilet that undergirded the “extension of the boundaries of modern hygienic space”²² or as Jackson and Robins put it, “the purified space of the public sphere from the metropole to the colony.”²³ Thus, the European accounts of the toileting habits of the African population in the Gold Coast as elsewhere on the Guinea Coast cannot be accepted unreservedly. It was ideologically laden and was meant to justify a need to intervene and reorder African’s daily lives along so-called civilised lines. It reflected what Dipesh Chakrabarty writing on colonial India referred to as “modernist desires” that were implicit in British imperialist projects of social reform.²⁴

Indeed, there is evidence that in the Gold Coast, before the inception of British rule, the African people had their forms of latrine and toileting practices. Sjaak van der Geest has noted that among the pre-colonial Akan – the dominant cultural group in the Gold Coast, inhabitants of villages used as toilets, large pits covered with scaffolds. These were constructed outside the town or village, normally in the bush. As evidence of this claim, he points to euphemisms of defecation that have been retained in the

²¹ Stephanie Newell, ‘Dirty Familiars: Colonial Encounters in African Cities’, in *Global Garbage: Urban Imaginaries of Waste, Excess, and Abandonment*, ed. Christoph Lindner and Miriam Meissner, Routledge Research in Sustainable Urbanism (London New York: Routledge, 2016), 2.

²² Warwick Anderson, ‘Excremental Colonialism: Public Health and the Poetics of Pollution’, *Critical Inquiry* 21, no. 3 (Spring 1995): 658.

²³ Shannon Jackson and Steven Robins, ‘Making Sense of the Politics of Sanitation in Cape Town’, *Social Dynamics* 44, no. 1 (2018): 74.

²⁴ see Dipesh Chakrabarty, ‘Open Space/Public Place: Garbage, Modernity and India’, *South Asia: Journal of South Asian Studies* 14, no. 1 (1 June 1991): 15–31.

Akan language that evokes the “the memory of poles on which people had to squat to relieve themselves.”²⁵ For example, “*kɔ̃ dua so* (lit. to go on a tree),” in Twi (a dialect of Akan) is a euphemism which directs a person to use the toilet. Again, an Akan proverb reproduced by the Basel Missionary, Linguist and Philologist, Johann Gottlieb Christaller in his book on Akan proverbs alludes to the wooden poles of the traditional toilet: “*obi se ɔ̃bɛma woane’ a, ɛnte se woankasa wosɛn yanɛɛ so* (if someone says, he will help you to shit, it isn’t the same as sitting yourself on the poles).”²⁶ In his Twi dictionary, Christaller explains *yanɛɛ* to mean “the scaffolding of poles outside the town used as a privy...”²⁷ It is thus, certain that, at least, among Akan societies, people used public latrines that were located in the bush away from the village. These existed before the colonial period and continued to exist during the colonial era.

It is, therefore, safe to argue that if there was such persistence of random defecation during the late 19th century and beyond as reported by colonial officials, it was partly a consequence of the processes of colonial urbanisation. Indeed, the long period of commercial activities between African and European merchants presaging colonial rule coupled with the growth in economic activities which was concomitant with colonial exploitation initiated massive migration into centres of economic activities and complicated their sanitary conditions. It can, therefore, be conjectured that a reason for the persistence of indiscriminate defecation could be the absence or the insufficiency of functional alternatives for the average person, which was the consequence of the pressures that were brought on existing places of convenience because of the emerging urban dynamics.

Yet, as with other sanitary problems, even as the colonial administration complained about the unsatisfactory nature of the toileting situation, they were reluctant to commit themselves to remedy the situation. As Liora Bigon has argued, colonial administrators in British West Africa were, generally, quick to condemn the sanitation of their colonies, yet they showed little commitment to sanitary reforms as

²⁵ Sjaak Van der Geest, “The Night-Soil Collector: Bucket Latrines in Ghana,” *Postcolonial Studies: Culture, Politics, Economy* 5, no. 2 (2002): 197, <http://www.tandfonline.com/doi/pdf/10.1080/1368879022000021092>; see also, Sjaak Van der Geest, “Akan Shit: Getting Rid of Dirt in Ghana,” *Anthropology Today* 14, no. 3 (June 1998): 8–12.

²⁶ Quote in Van der Geest, “The Night-Soil Collector,” 197.

²⁷ Quoted in *ibid.*

sanitation was not considered as a legitimate target for public expenditure.²⁸ Thus, in the Gold Coast, the insufficiency or the lack of public latrines became the subject of complaint by many colonial health officials during the late 19th century and well into the 20th century. Yet, no effective mechanism was put in place to find a lasting solution.

For example, in 1884, the CMO complained that because of the lack of public latrines, the people of Accra were “compelled to take advantage of the shelter of every bush and old ruin they find in hand.”²⁹ He conceded that it would be “...useless to try and stop them” from defecating “around and about the town while they are unprovided with a sufficient number of public latrines.”³⁰ To mitigate the situation, he tasked a special gang of sanitary labourers to pass along the beach where indiscriminate defecation occurred to cover any such deposit of ordure found there.³¹ In a similar vein, Dr J. W. Rowland, the Assistant Colonial Surgeon of Axim lamented that:

Latrines are much required as the natives at present resort to the beach and bush for want of other accommodation, with result which is so common in all African towns – dysentery by this means is maintained as an endemic disease.³²

Dr Eyles, the Assistant Colonial Surgeon of Elmina also decried the lack of latrines in the town in his 1884 report. He, therefore, recommended the erection of two latrines in the north end of the town, each to accommodate eighteen or twenty seats.³³ Even in Kumase, the capital of the Asante which was noted for its inclination to good sanitary management and practices, James Brown observed that by the late 19th century, the general decline of the Asante empire following the Anglo-Asante wars had affected the maintenance of public latrines.³⁴ He wrote, “...Only chiefs had pit latrines

²⁸ Bigon, ‘Sanitation and Street Layout in Early Colonial Lagos’, 247.

²⁹ J D McCarthy, ‘Enclosure 1 in No. 5: Sanitary Report on the Station of Accra for the Year Ending 31st December 1885’, 1886, 108, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

³⁰ *Ibid.*, 109.

³¹ *Ibid.*, 110.

³² J W Rowland, ‘Enclosure 6 in No. 5: Sanitary Report on the Station of Axim for the Year Ending 31st December 1885’, 1886, 120, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

³³ Dr Eyles, ‘Enclosure 4 in No. 5: Sanitary Report of Cape Coast and Elmina for the Year Ending 31st December 1885’, 1886, 116, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

³⁴ James Wilson Brown, ‘Kumasi, 1896-1923: Urban Africa during the Early Colonial Period’ (University of Wisconsin, 1972), 34.

within their houses; for others, the encroaching bush provided a convenient substitute.”³⁵

It was not until 1886, during the governorship of Brandford Griffith that a public latrine was completed for use in Accra. In that year, the Surveyor General was said to be taking additional measures to have about a dozen more latrines built behind the town for the use of the African population.³⁶ This was the first practical attempt to provide public latrines in any part of the Gold Coast. A statement by McCarthy is revealing:

...long as the settlement has been under our jurisdiction, and frequently as the great need for the erection of public latrines on the beach and inland has been urged on the government, this is the first practical attempt that has been made to supply the want. It is a step in the right direction, and I am convinced, an earnest of what we may expect from his Excellency, Governor Griffith in the way of sanitary measures throughout the colony.³⁷

In 1887 a latrine for females was under construction in Accra and a vote for the construction of four more latrines (it was not whether they were to be erected for men only or both sexes) was approved. The erection of separate latrines exclusively for use by women reflects 19th century European gendered ideology of separate spheres which made the erection sex-segregated latrines a prominent feature of the development of public toilets.³⁸ In Europe, public toilets were critical spaces that constructed and shaped gender relations and re-enforced the binary division between men and women.³⁹ There is sufficient evidence that in the Gold Coast, separate public latrines were built for men and women in most instances. However, how this contributed to the conditioning of gender relations is beyond the scope of this dissertation.

Accra was not the only town where public latrines were constructed. Elmina had two public latrines by 1887, but this was not enough and so, Dr Rat, the Assistant

³⁵ Ibid.

³⁶ GGC, ‘Sanitary and Medical Reports for 1886 and 1887’, 105.

³⁷ Ibid., 110.

³⁸ see Olga Gershenson and Barbara Penner, “Introduction: The Private Life of Public Conveniences,” in *Ladies and Gents: Public Toilets and Gender*, ed. Olga Gershenson and Barbara Penner (Philadelphia: Temple University Press, 2009), 1–32.

³⁹ see *ibid.*, 9.

Colonial surgeon requested for four more to be constructed.⁴⁰ By the close of the 19th century, other principal stations and districts such as Keta, Ada, Akuse, Saltpond and Kumase were all provided with public latrines. Even so, these latrines were never sufficient for most of the towns. For instance, Axim still lacked enough public latrines by 1887 – for which reason the Assistant Colonial Surgeon stationed there lamented that:

... no town on the Gold Coast, which I have seen that is so badly in need of latrines as Axim...Under the cover of the forest, the environ of the town are made use of for latrine purposes, with the result that one is entirely deprived of what might otherwise be pleasant afternoon ...⁴¹

Similarly, in 1887, Cape Coast was said to be in need of additional twelve latrines for men and another twelve for women.⁴² In Winneba, approval was given for the erection of eight latrines in 1887, yet, by the end of the year, not one had been provided – for which reason, J. Spielsburg Smith, the Assistant Colonial Surgeon, in his fourth quarterly report demanded the construction of ten latrines in the town.⁴³

With all the limitations during this period, the public health agents of the colonial administration claimed that the provision of public pit latrines had significantly impacted on sanitation. For instance, in 1887, J. D. McCarthy even while acknowledging that more public latrines were needed in Accra insisted that "...the public latrines which were established last year have somewhat modified the abiding foul odour which helps to render Accra unsafe for Europeans to reside in."⁴⁴ Similarly, in 1887, R. Austin Freeman, the Assistant Colonial Surgeon of Keta while conceding to the limited accommodation of latrines still noted that the few " public latrines are undoubtedly a great convenience to the Natives and indirectly to the Europeans."⁴⁵ F.W. Sullivan, the Assistant Colonial Surgeon of Cape Coast also noted that the latrines in the town "...are well appreciated by the Natives, and their good effect is

⁴⁰ GGC, 'Sanitary and Medical Reports, June 1887'.

⁴¹ GGC, 'Sanitary and Medical Reports, March 1887', 17.

⁴² GGC, 'Sanitary and Medical Report, November 1887', Quarterly, 1887, 47, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

⁴³ see GGC, 'Sanitary and Medical Reports, June 1887'; GGC, 'Sanitary and Medical Report, November 1887'. Public latrines in Accra were still insufficient even by 1897.

⁴⁴ GGC, 'Sanitary and Medical Reports, March 1887', 29.

⁴⁵ GGC, 'Sanitary and Medical Report, September 1887', Quarterly, 1887, 61, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1990>.

visible to a great extent from improved sanitary condition which parts of the town now present.”⁴⁶

However, there were complaints that the African population were not always willing to use these public latrines. Colonial officials linked the evasion of the use of the public latrines to the African’s inherent primitiveness and their unwillingness to adapt to European civilisation. For instance, in 1887 the CMO lamented that:

Though they for whose special wants the latrines are provided know that it is for their benefit they are erected, they avoid using them whenever they can, preferring the primitive and time-honoured method of relieving nature to the most decent, sanitary and civilised arrangement furnished by government for their use.⁴⁷

The people’s unwillingness to use these latrines was, however, neither wilful nor a lack of willingness to adapt to so-called ‘civilised’ arrangement. Rather, these latrines were avoided because of the unsuitability of their designs. Most of the latrines provided before the 20th century was of the trench type. The seats made of beams like the bannister of a staircase was certainly not comfortable.⁴⁸ They were mostly unkempt as sanitary labourers often failed to cover the faeces with dry earth daily as was required. An Assistant Colonial Surgeon C.H. Eyles, commenting on the evasion of latrine use in Accra conceded that:

...the trench system lends itself to carelessness on the part of the scavengers, who, if not constantly watched, are apt to lay on dry earth at intervals of three, four, or more days without being detected.⁴⁹

Following this observation, Eyles objected to the continuing use of trench latrines. He suggested that it should be replaced with the bucket system of latrine. This way, the faecal matter could be removed from the drums and transferred to trenches that were to be dug at some considerable distance at the outskirts of town. Eyles was not alone in his objection to the use of trench latrines. The CMO, McCarthy admitted that it was the simplicity of the trench latrine that had induced him to advocate it “but viewing the matter from all parts” he conceded “that the bucket system has many

⁴⁶ Ibid., 55.

⁴⁷ GGC, ‘Sanitary and Medical Reports, March 1887’, 29–30.

⁴⁸ see GGC, ‘Sanitary and Medical Report, September 1887’, 51.

⁴⁹ Ibid.

advantages over that of the trench."⁵⁰ He, however, blamed the inefficient nature of the trench latrine on the negligence of the inspector of nuisances. Even so, the trench latrine was not abandoned. It remained the most common for most of the late 19th century and beyond, existing alongside few bucket/pan latrines.

For example, rather than replace the trench latrines, in 1888, the Surveyor General proposed an improvement to experiment in Accra. The Assistant Colonial Surgeon of Accra, Dr Waldron, described the proposal as "promising" because it could "render the trench latrine the success which we feared at one time it would not be."⁵¹ The new scheme entailed the acquisition of a tract of land that measured eighty yards wide and extended nearly the entire length of the back of the town. The health officials, were, however, concerned that the scheme could be foiled by the refusal of the African population to give up their lands for the construction of these latrines.

Indeed, the acquisition of land for latrine purposes seemed to have been a challenge for the colonial administration. For instance, in 1887, McCarthy lamented that among other challenges:

The presumed owners of unoccupied land ...on which these latrines are sought to be placed frequently object to their presence, and have been known from sheer pig-headed perversity to refuse to yield their consent even to an offer of compensation for the little plots occupied by them...⁵²

Fearing potential obstructions, Waldron admonished the government that:

...if the important question of efficient latrine accommodation for Accra is ever to be successfully solved, the government must not allow itself to be obstructed in carrying out a measure which has for its object the physical and moral well-being of the whole community...it is of the uttermost importance that the strip of land marked out by the Surveyor General for the purpose of erecting latrines should be permanently secured against all intrusion on the part of builders as well as against presumed ownership.⁵³

Eventually, the land was acquired, and the scheme was implemented. By 1889 eight men were employed exclusively to dig trench latrines.⁵⁴ Fourteen trench latrines,

⁵⁰ Ibid., 50.

⁵¹ GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 6.

⁵² GGC, 'Sanitary and Medical Reports, March 1887', 30.

⁵³ GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 6.

⁵⁴ GGC, 'Gold Coast Medical and Sanitary Report for 1889' (London: Her Majesty's Stationary Office, 1890), 68, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

each measuring thirty feet long and ten feet deep were expected to be constructed. Each latrine was to have a movable iron screen and roof – the roofing being necessary to prevent the content of the latrine being liquified during the rainy season. Inspectors of nuisances accompanied by sanitary labourers were to be assigned to visit the latrine at 4 pm each day to ensure that all contents were covered with layers of dry soil. As each latrine became full it was to be covered with dry earth and the screens and roof removed to a new pit previously dug.⁵⁵ To keep the latrines clean, it was recommended that a watchman each be placed in charge of every two adjacent pits and one for each pit if they were placed far apart. Their duties included dropping soil over the contents of the pits every hour and the prevention of people from committing nuisances outside and around the latrines.⁵⁶

In the meantime, in 1889, the colonial secretary, Percival Hughes wrote to all District Commissioners to collaborate with health officers in their districts to induce the chiefs and their people to provide for themselves suitable means of disposing of excrement, especially in places where the government had not been able to provide public latrines. He also instructed the District Commissioners to arrange for the provision of cesspits in specified localities for the reception of private sewerage.⁵⁷

By the early 1900s, pan/bucket latrine was becoming popular, particularly, in the major towns and villages that had considerable European population.⁵⁸ That is not to say that pit latrines were abandoned. They continued to exist alongside the bucket latrines– and a third type, the sea/beach latrine was adopted in coastal towns. In 1901, Accra had thirty-five public latrines out of which five were beach latrines, fifteen pit latrines and the remaining, pan latrines. Sekondi had seven public latrines, all of them being pan latrines. In 1904, Kumase had latrine houses that were of the pan-type, and by 1906, most of the “old bush latrines” were reported to have been replaced by pan latrines. These pan latrines were housed in permanent buildings of corrugated iron with stone floors – and they numbered thirty-five by 1907. In 1906, Tarkwa had seven

⁵⁵ see GGC, ‘Gold Coast Sanitary and Medical Report for 1887 and 1888’, 6.

⁵⁶ *Ibid.*, 33–34.

⁵⁷ see GGC, ‘Gold Coast Medical and Sanitary Report for 1889’, 71.

⁵⁸ The pan/bucket latrine system was improved in subsequent years. Throughout the second decade of the 20th century efforts were made to improve the pan latrine system to adapt them to local needs and make them more hygienic.

pan latrine houses of the kind in Kumasi. In the Northern Territories, pan latrines were introduced in 1904, they were used mainly by Europeans.⁵⁹

In 1910 seventy-two public pan latrines were erected in the parts of the Gold Coast where sanitary work was being done. Of this number, forty-six were for men and twenty-six, for women. And there were three hundred and forty-one pit latrines still in use in the larger towns. Some private individuals, mainly Europeans and some few affluent Africans also kept bucket/pan latrines in their residences. By 1910, there were six hundred and eighty-two pan latrines in the major towns owned exclusively by private individuals. By 1911, there were three hundred and thirty-two public pan latrines in use in the colony. In some few instances, European residents, both official and unofficial and some educated and wealthy Africans used earth closets – a type of toilet which dry earth was used to cover the excrement pending its removal at a later period.⁶⁰

By 1915, in all important places like Accra, Sekondi, Cape Coast, public pan latrines served most of the population. Also, there were in several of the coast towns, one or more sea latrines. Sea latrines were said to be more suitable compared to pan latrines if they were properly situated because they required no servicing (that is the removal of excreta) and could serve a much larger number of people than pan latrines.⁶¹ Even so, pan latrines remained the preferred choice, especially where the sanitary branch had sufficient staff to undertake conservancy work.⁶²

Yet, the demand for public latrines outstripped their supply. D. Alexander, the SSO, commenting on the provisioning of public latrines and sewerage facilities in 1914, remarked that “this question is always a difficult one in West Africa from the government’s point of view, and in the case of large towns it is one that is getting more important year by year.”⁶³ For instance, in 1927, the Provincial Engineer of the Central Province informed the Provincial Health Board that latrines were required in every part of the province – for which reason the required number of latrines for the Winneba and

⁵⁹ Gundona, ‘Coping with This Scourge’, 151.

⁶⁰ GGC, ‘Medical and Sanitary Report for the Year 1915’, 17; GGC, ‘Medical and Sanitary Report for the Year 1914’, 42.

⁶¹ see GGC, ‘Medical and Sanitary Report for the Year 1914’, 41.

⁶² see GGC, ‘Medical and Sanitary Report for the Year 1915’, 17.

⁶³ GGC, ‘Medical and Sanitary Report for the Year 1914’, 41.

Saltpond districts were reduced in order to be able to provide for the latrine needs of other communities within the province.⁶⁴ The DDHS reported in 1938, that “the central congested areas of certain of the larger centres cannot be considered as being adequately served with public latrine accommodation.” This was particularly the case of Accra where the DDHS complained that “sanitary sites” were “few and often badly situated; and where fresh sites” were “very difficult to obtain.” Thus “the pans in public latrines, in spite of frequent emptying” were “usually overfull and the nuisance” was considerable.⁶⁵

Just like the late 19th century, the colonial administration continued to plead the lack of funds for the inability to provide enough public pan latrines to meet the growing needs of the African population. As Njoh has observed, the “paltry budget of the colonial state thwarted any attempt to address the myriad of health or other problems that characterised colonised territories” in Africa.⁶⁶ Njoh’s claim is corroborated by Liora Bigon who argues forcefully that in British West Africa, “conquest and administration were only backed by meagre resources, run on shoestring budgets and chronically underfunded and undermanned.”⁶⁷ Indeed, pondering on the question of funding for British colonial administrations in Africa, Lord Lugard, admonished that, “if the British nation” was “not prepared to bear the cost of an enterprise which promises good returns ...it were better that it had never undertaken it.”⁶⁸

But the question of funding for sanitary reforms was not peculiar to British West Africa. In French West Africa, it was observed that in the early 1900s, the federal government based in Dakar, was not only short of funds to carry out urban sanitation and sanitary policing, but also, that the sanitary services were insufficiently equipped, understaffed and poorly trained.⁶⁹ Even so, as Njoh has argued, when funds were available, the interests of European officials were prioritised. Njoh reckons that colonial governments in Africa were required, first and foremost, to protect the social and

⁶⁴ ‘Minutes of the Provincial Health Board Held at Cape Coast on the 31st August 1927’, 1927, 1–2, ADM23/1/368, Central Regional Archives, Cape Coast.

⁶⁵ GGC, ‘Report on the Medical Department for the Year 1938’, 30.

⁶⁶ Njoh, *Urban Planning and Public Health in Africa*, 25.

⁶⁷ Bigon, ‘Sanitation and Street Layout in Early Colonial Lagos’, 249.

⁶⁸ F. D. Lugard, *The Dual Mandate in British Tropical Africa*, 1922, 144, <http://archive.org/details/in.ernet.dli.2015.20995>; Bigon, “Sanitation and Street Layout in Early Colonial Lagos,” 250.

⁶⁹ Bigon, ‘Sanitation and Street Layout in Early Colonial Lagos’, 250.

economic interests of Europeans residing in the colonies, and health ranked high among these interests, especially, because the continent was perceived to be disease-ridden.⁷⁰

Thus, owing partly to chronic underfunding for sanitation projects in the Gold Coast as in other British West African colonies, neither the adoption and use of bucket/pan latrines nor sea latrines was an unmitigated success. As recounted in the annual medical and sanitary report of 1911, the pan latrine system "...whilst a vast improvement on the old one of none-at-all," was "not an ideal solution of the conservancy problem."⁷¹ In 1913 the SSO observed that the latrine system constituted one of the most difficult sanitary challenges, not only in the Gold Coast but in other parts of British West Africa.⁷² He noted that whereas pan latrines were provided where possible, most rural communities continued to rely on pit latrines whose conditions he described ambiguously as "more or less satisfactory." The problem, as he recounted, related to "...the expense involved in the provision of staff for supervision, and the great difficulty in obtaining labour, even when money" was "available." He concluded that "improvement, except in the larger towns"⁷³ seemed far-fetched.

Thus, the colonial intervention to provide public toilets notwithstanding, the bush that surrounded houses in smaller villages remained, in most cases, the common latrine in most rural communities even during the 20th century. To mitigate such conditions, especially in rural areas, the colonial administration reverted to the provision of pit latrines, albeit, of improved type during the second decade of the 20th century. The first kind was the Salga pit latrine, which was provided in places where the sub-soil water was low.⁷⁴ The Salga pit latrine was a dug-out pit up measuring about four feet square. A small house with a light trap entrance was erected over the pit, leaving the whole interior as dark as possible, the only source of lightning being a fly trap that was made from an old kerosene or petrol tin.⁷⁵

⁷⁰ Njoh, *Urban Planning and Public Health in Africa*, 26.

⁷¹ GGC, 'Medical and Sanitary Report for the Year 1911', 59.

⁷² GGC, 'Medical and Sanitary Report for the Year 1913', 27.

⁷³ Ibid.

⁷⁴ see *ibid.*

⁷⁵ see Jane Drew, Maxwell Fry, and Harry L. Ford, *Village Housing in the Tropics: With Special Reference to West Africa* (Routledge, 2013), 80.

In areas where the Salga cesspits could not be provided the colonial administration induced the chiefs and their people to dig what the colonial records refer to as Native pits. These were rectangular pits normally between fifteen to twenty feet deep by two to three feet wide with a roofed structure erected over it to prevent rainwater from filling it up.⁷⁶ By the 1920s, another kind of pit latrine called the 'smoke pit latrines' was being constructed and used particularly in large rural communities in Asante. However, despite its relative usefulness, the health officials complained that the smoke-pit latrine was difficult to maintain because it required some amount of semi-skilled attention.

Thus, despite their obvious insanitary features, pit latrines remained the most common type of public toilet for most of the 20th century, especially in rural communities where the government was slow in extending its public health measures. Even in major towns, pit latrines were said to be returning into use during the 1930s because the government could not provide enough pan latrines due to financial difficulties. For instance, in 1933, Accra had between fifty to sixty pit latrines that were in use. Colonial officials remained uncertain about the sanitary merits of these pit latrines.

As it was before the 20th century, some colonial health officials were concerned that when badly constructed, sited or neglected, pit latrines caused "nuisances of the first order."⁷⁷ A senior health officer, W.M. Howells wrote in 1932/33 that the pit latrine "...at its best is a fly nursery."⁷⁸ Yet, he claimed that "when well-constructed, that is floored and roofed, and provided with lidded drop-holes, screened as far as possible, and provided with a good fly-trap in its lighter open extension" it could be "a moderately sanitary convenience."⁷⁹ It was reckoned that its greatest advantage was that it prevented indiscriminate defecation and ensured that faeces were confined to one spot.⁸⁰

Even so, such a claim could only have been the ideal. For, in most cases, the construction of a satisfactory public pit latrine in rural communities was difficult to

⁷⁶ see GGC, 'Medical and Sanitary Report for the Year 1914', 42.

⁷⁷ GGC, 'Report on the Medical Department for the Year 1932-33', 1933, 27.

⁷⁸ Ibid.

⁷⁹ Ibid.

⁸⁰ Ibid.

achieve.⁸¹ Their temporary nature and the consequent need to constantly make new ones to replace exhausted pits made their provision almost a *Sisyphian* task. The government's expectation that chiefs would mobilise free labour for latrine construction was never met. For instance, in 1935, a sanitary inspector, Jos. Kobbina, after inspecting nine villages and towns within the Kumase district reported in almost all cases, the neglect and reluctance of the chiefs and people of these villages to either construct new pit latrines or complete those that were under construction. Yet, these villages either had no latrines or the existing ones were full. And as he noted in one instance, "the chief and elders have been warned and even served with notices but have given no heed to all that."⁸² It is difficult to understand how the government expected the chiefs to be able to mobilise free labour for the construction of pit latrines when colonial rule had itself impaired and dwarfed the powers and influence of the local rulers to exact voluntary communal service from their subjects. In any case, colonial officials themselves often complained of the non-availability of paid labour to do conservancy work.

The Problem of Night-Soil Disposal and the Introduction of Septic Tank Latrines

If providing appropriate and adequate latrine facilities proved difficult, the task of removing and disposing the faecal matter from bucket/pan latrines was as much a herculean challenge for the colonial administration. When the pan/bucket latrine system was first introduced, the colonial administration relied on scavengers who were labelled as latrine men to remove and deposit the night soil at designated locations. In the coastal areas, latrine men carried the latrine receptacles on their heads and deposited the contents mostly into the sea. In the interior towns, the contents were emptied into trenches and pits dug at a sufficient distance from the town.⁸³ In the 1930s, as a rule, night soil in smaller towns was deposited into protected areas – that is fly-proofed and fly-trapped disposal pits.⁸⁴ These methods remained the major means of disposing of night soil for most of the 20th century, except in Adansi Obuasi

⁸¹ see GGC, 'Report on the Medical Department for the Year 1935', 23.

⁸² Jos. Kobbina, 'Report on Sanitary Conditions in Beposo, Bank, Mampong Akronfuso, Oyoko, Juaben, Kasam, Safo, Ntonso, & Odumasi', 8 February 1935, 1, ARG6/14/3, Ashanti Regional Archives, Kumasi.

⁸³ see GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 57; GGC, 'Annual Medical and Sanitary Report on the Gold Coast Colony for the Year Ended 31st December 1901', 1902, 17, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

⁸⁴ see GGC, 'Report on the Medical Department for the Year 1932-33', 1933, 27.

– a gold mining town – where, by 1929, the night soil was mixed with sawdust and burnt in a specially constructed incinerator.⁸⁵ By 1931/32, incineration of night-soil had been extended to other mining areas.⁸⁶

The emptying of night soil into the sea was however held to be objectionable by some health officials who argued that it caused the pollution of the foreshore of the sea.⁸⁷ Others contended that the “question of disposal was made doubly difficult by the filthy habits of the people” who continued to defecate on the beach, the inefficient emptying of the latrines pans into the sea and nuisances caused by sea latrines as a result of faecal matter being washed onshore from them.⁸⁸ Even so, the practice of emptying excreta into the sea continued throughout most of the 20th century. In practically every sea town the contents of the pan/bucket latrine were emptied into the sea. D. Alexander observed in 1914 that where enough supervision was available – and this was often not the case – this method of disposal was satisfactory, except when local circumstances compelled the tipping of a proportion of the night-soil upwind and upstream of some towns.⁸⁹

In 1936 it was reported that the sea disposal of night-soil in Accra was a “nuisance of the first order.”⁹⁰ J. D. Mackay, the DDHS lamented that “the method of final sea disposal at Accra is extremely insanitary.”⁹¹ However, rather than find a solution to this problem, the consensus among government officials and the health branch was that it was inexpedient and uneconomical to spend funds to improve the situation in the short term. The colonial administration deferred any such improvement to the availability of a comprehensive water-carriage sewer-borne which was expected to be introduced in Accra in the future.⁹² Once again, the fiscal economy prevented a long-term solution to a major sanitation challenge.

⁸⁵ GGC, ‘Report on the Medical and Sanitary Department for the Year 1929-1930’, 37.

⁸⁶ GGC, ‘Report on the Medical Department for the Year 1932-33’, 1933, 27.

⁸⁷ see GGC, ‘Sanitary and Medical Report, September 1887’, 61.

⁸⁸ see GGC, ‘Medical and Sanitary Report for the Year 1911’, 197.

⁸⁹ see GGC, ‘Medical and Sanitary Report for the Year 1914’

⁹⁰ GGC, ‘Report on the Medical Department for the Year 1936’, 26.

⁹¹ GGC, ‘Report on the Medical Department for the Year 1937’ (Gold Coast, Accra: Government Printer, 1938), 25, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

⁹² see GGC, ‘Report on the Medical Department for the Year 1936’, 26; GGC, ‘Report on the Medical Department for the Year 1937’, 25.

The government's attempts at providing water-borne carriage was, as it were with other sanitary measures, a failure. Indeed, no water-borne sewerage system existed in any part of the Gold Coast until the 1920s. An attempt to develop a sewerage scheme for Accra in 1914 was aborted because of the outbreak of World War I.⁹³ The first water-carriage sewerage system for disposing of night soil was introduced at the new African hospital at Korle-Bu which was completed in 1923. Here, Imhoff tanks⁹⁴ were installed and the effluent which was described as "exceedingly pure" was discharged into the Korle lagoon.⁹⁵ This remained the only one in any public hospital until about 1930/31 when another one was installed in the European Hospital at Sekondi. Other water-carriage sewerage systems were installed during the late 1920s and 1930s at the Prince of Wales College (Now Achimota School) and two other public latrines in Accra that were connected to a water-borne carriage by 1931.⁹⁶

In the 1930s, the government, as before, pleaded inadequate funds as the key obstacle to the implementation of a comprehensive water-carriage sewerage scheme. Curiously, private individuals (predominantly Europeans and few prominent Africans) were keen to install water-carriage sewerage (flush toilet) facilities in their residences during the 1930s and beyond. In this regard, the health branch developed type-plans and drew up specifications to guide the installation of water-borne sewerage in private residences to avert potentially dangerous ground pollution from faecal matter.⁹⁷

By the 1940s, however, some few government buildings, residences of commercial firms and government institutions such as the African hospital, the European hospital, both in Accra, and a public hospital in Cape Coast, had water closets and water-borne sewerage systems installed. There is no evidence, however, to suggest that the situation improved any significantly during the 1950s. Indeed, a plan to provide a water-carriage sewer to cover the entire city of Accra for which an

⁹³ Anna Bohman, "Framing the Water and Sanitation Challenge: A History of Urban Water Supply and Sanitation in Ghana 1909-2005" (Umea University, 2010), 69.

⁹⁴ A type of tank with a chamber suitable for the reception and processing of sewerage named for a German engineer Karl Imhoff (1876-1965).

⁹⁵ GGC, 'Report on the Medical Department for the Period April 1923 - March 1924', 15.

⁹⁶ GGC, 'Report on the Medical Department for the Year 1930-31', 34.

⁹⁷ GGC, 'Report on the Medical Department for the Year 1934', 18; GGC, 'Report on the Medical Department for the Year 1935', 19. In 1935, discussions were underway to reduce the cost involved in installing water-borne sewerage facilities in private residences. In this regard, discussions focused on producing a modified simpler and cheaper system for bungalows situated in places other than 'residential' areas.

annually estimated expenditure of £30,000 was set off against the capital charge was never implemented.⁹⁸

The limited availability of labour and sometimes, the inefficiency of the available labour also did impinge on the proper disposal of night soil. For instance, in 1887, the assistant colonial surgeon of Keta, Dr Austin Freeman lamented that there were no scavengers employed in the town to empty latrine pans. By 1888, the town still had no scavengers. The health office, therefore, had to rely on convict labour to perform this task, which for Austin could be economical, if convicts were always available to perform this task. As it turned out, there was, for instance, only one prisoner in 1887 in Keta to execute this task – the result was that the latrines were abandoned.⁹⁹

Reports about unkempt latrines because of the lack of labourers were common during the 20th century. For example, latrines were reported to be badly kept in Saltpond in 1902 because of the lack of labour.¹⁰⁰ In Sekondi, it was reported that scavengers were unreliable and detested their job as latrine men. As the Senior Medical Officer of Sekondi noted: "...this occupation the men cordially dislike, and as they constantly desert in consequence, much inconvenience results."¹⁰¹ In 1911, the medical officer of Cape Coast complained that attempts to use Kroo boys¹⁰² for latrine work had failed abysmally because of inefficient inspection by sanitary inspectors and the reluctance of the Kroo boys to work in gangs as they thought that doing so made them look much like prisoners.¹⁰³ What we are not told, however, is whether the men disliked their job because of the arduous nature of it or because they were not adequately remunerated. Whereas the former could be a probable reason, to attempt an answer to the latter will be speculative since the records do not speak to the remuneration of latrine men.

To solve the labour problem and save cost for conservancy work the colonial administration resorted to the increasing use of convict labour at the beginning of the 20th century. For instance, in 1902, health officials in Sekondi proposed the use of

⁹⁸ see Addae, *The Evolution of Modern Medicine in a Developing Country*, 140.

⁹⁹ GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 18.

¹⁰⁰ GGC, 'Medical and Sanitary Report for the Year 1902', 18.

¹⁰¹ *Ibid.*, 29.

¹⁰² Kroo was a general term used to refer to migrant labourers from Liberia.

¹⁰³ GGC, 'Medical and Sanitary Report for the Year 1911', 18.

prisoners exclusively for the removal of excreta. In Elmina, prison labour was already in use in 1902 for sanitary work because their number was significant enough to execute such a task.¹⁰⁴ In Kumase convict labour was in use for the removal and disposal of excreta by 1906.¹⁰⁵ By 1911, it was reported that most stations where sanitary work was being done relied on convict labour for the removal and disposal of excreta, and the total number of prisoners available for latrine work in all stations during 1911 was thirty-two.¹⁰⁶ Conservancy work was extended to private residences where the sanitary branch supervised the removal of excreta at a fee. Indeed, the system of collecting and emptying pan latrines for European residents who were willing to pay was started on pilot basis in 1902 in Sekondi.¹⁰⁷

However, until 1935 there was no law regulating the removal and disposal of night soil from private homes and so, private individuals could either pay the town councils (where it did exist), or local sanitary committees for conservancy services. Private individuals could also make their arrangements for their night soil to be removed. However, this arrangement did not seem to conform to the expected sanitary standards. Consequently, in 1935, the Towns Removal of Night Soil Regulation was passed to regulate the removal of night soil from private premises. This ordinance proscribed the use of any other labour apart from that which was approved by the Medical Officer of Health or his assignee. Owners or occupiers of premises in which private latrines were kept were charged five shillings per month or part of a month and two shillings and sixpence per month or part of a month for each additional pan. This regulation was applied in August 1935 to all districts where sanitary work was being done.¹⁰⁸

A system of night-soil disposal using motor transport was started in the Gold Coast in the mid-1920s. However, these conservancy lorries were confined to the larger towns and stations where European administrators were stationed. By 1930/31, conservancy lorries were available in Accra, Kumasi, Sekondi, Tamale and Cape

¹⁰⁴ GGC, 'Medical and Sanitary Report for the Year 1902', 29.

¹⁰⁵ GGC, 'Medical and Sanitary Report for the Year 1906', 26.

¹⁰⁶ GGC, 'Medical and Sanitary Report for the Year 1911', 59.

¹⁰⁷ see GGC, 'Medical and Sanitary Report for the Year 1902', 29.

¹⁰⁸ Gold Coast Colony, 'Regulations Made by the Governor in Council under Section 38 of the Towns Ordinance', 1935, PRAAD/ADM/1/2237, Central Regional Archives, Cape Coast.

Coast.¹⁰⁹ In smaller townships and villages, head-loading and, in some few cases, the use of hand-trucks remained the major means of disposing of night soil. Notwithstanding, its comparative effectiveness, because of cost, the use of conservancy lorries was not always encouraged. The setting up of conservancy schemes that involved the use of lorries even in important towns was a measure of the last resort and colonial officials did everything within their power to discourage it when there seemed to be a cheaper alternative. For instance, a conservancy scheme that was developed by the Winneba sanitary committee in 1927 requiring the acquisition and use of two lorries was rejected by the Central Province Health Board “as it was not considered justified with prison labour available.”¹¹⁰

In any case, the use of motor conservancy could not abate the challenges of dealing with inefficient night-soil disposal. In 1928, the Accra Town Council reported that the whole enterprise of night soil disposal was very expensive to maintain, labour alone costing £3000 annually. Besides, the existing system of removal and disposal was described as “inefficient from...sanitary point of view” as it exposed for many hours daily “accumulations of faeces in non-fly-proof receptacles” as well as “inevitable spilling on removal.” The Council also lamented the unpleasant smell on the streets when latrines were being emptied.¹¹¹

It was thus, the need to reduce costs incurred on labour and conservancy lorries, and the need for efficient removal and disposal of night soil that compelled the government to start experimenting during the late 1920s with what was described as “simple cheap septic-latrines.” The need for a different type of latrine system was also underpinned by the feeling that the continuous use of pan latrines in urban areas was obsolete. Septic latrines were designed to exclude the use of latrine-drums which was associated with pan/bucket latrines. Colonial officials reported that the septic tank latrine eliminated “to a great extent disinfectants and cartage of night-soil to the

¹⁰⁹ GGC, ‘Report on the Medical Department for the Year 1930-31’, 34.

¹¹⁰ ‘Minutes of Meeting of the Provincial Health Board Held at Cape Coast on the 6th October 1927’, 1927, PRAAD/ADM23/1/368, Cape Coast Regional Archive.

¹¹¹ GGC, ‘Municipal Reports for the Year 1927-1928’, Annual Departmental Report (Accra: Government Printing Department, 1928), 7, PRAAD/ADM5/1/86, Accra.

disposal area” and in doing so, did away with the “necessity of the very expensive motor conservancy arrangements now in vogue at all the larger centres.”¹¹²

In 1930, the experiment was reported to have been completed and proto-types were erected for use; three at Labadi and, one at Teshie in Accra. During the following year, a modified type was designed by the MOH of Cape Coast and was erected for use at Mfantsipim school. This latter experiment was reported on as “eminently successful.”¹¹³ Similarly, in 1934, another experimental septic-tank latrine was erected at the cost of £50 at Keta. By 1936, septic tank latrines had become popular and its use was said to be steadily increasing in both larger and smaller towns.¹¹⁴

In subsequent years, many government-sponsored septic tank latrines were installed in various towns, both large and small, and existing pan latrines were converted into the septic type.¹¹⁵ Owners of private residences and trading firms also took interest and constructed septic disposal systems in their residences.¹¹⁶ In the Northern Territories, a simple type of septic tank latrine was developed for use in rural areas. This type served two purposes. Apart from serving as a receptacle for faecal matter, it was designed in such a way that the resultant digested faecal waste could be collected and used as manure.¹¹⁷

By the mid-1940s, septic tank latrines could be found in almost every part of the Gold Coast. In 1944, it was stated in the annual medical and sanitary report that, “steady progress has been made towards the substitution of the septic latrine for the unsatisfactory bucket and pit latrine wherever possible.”¹¹⁸ Consequently, a scheme for the installation of these types of latrines in all the important towns and villages throughout the Gold Coast was considered.¹¹⁹ Yet, just like the other types of latrines,

¹¹² GGC, ‘Report on the Medical and Sanitary Department for the Year 1929-1930’, 37.

¹¹³ GGC, ‘Report on the Medical Department for the Year 1930-31’, 34. These septic-latrines were merely ventilated yet water-tight cesspits that allowed some amount of liquification of the faecal matter. Another experimental latrine that seemed to be in use during the 1930s though to a very limited extent was a type that consisted of a battery of barrels in which could break excreta into more unobjectionable liquids.

¹¹⁴ see GGC, ‘Report on the Medical Department for the Year 1936’, 26.

¹¹⁵ see GGC, ‘Report on the Medical Department for the Year 1937’, 25; GGC, ‘Report on the Medical Department for the Year 1938’, 30.

¹¹⁶ GGC, ‘Report on the Medical Department for the Year 1936’, 26.

¹¹⁷ GGC, ‘Report on the Medical Department for the Year 1937’, 25.

¹¹⁸ GGC, ‘Report on the Medical Department for the Year 1944’, 6.

¹¹⁹ *Ibid.*

the septic tank latrine was not an unmitigated intervention. Often, in the larger towns, the number provided was insufficient to serve an ever-growing urban population.

And where insufficient numbers were provided, overloading of the facility often created nuisances, which its introduction was partly meant to avoid. This was especially the case when the facility was sited in congested areas. Indeed, in 1937, Mackay lamented that:

If funds did not exist initially to provide an adequate number of this type of latrine for any place, it is only by the careful siting of these latrines in the suburbs where overloading cannot take place that nuisances can be avoided. The practice of siting such latrines singly, or in pairs, in the centre of busy towns, near markets and lorry parks, is simply demanding trouble and tends to bring this useful and economic method into undeserved disrepute...¹²⁰

For the sanitary branch, this problem could be resolved if “adequate number of such latrines” were “installed simultaneously in any one area.”¹²¹ This was never the case. The result was that by the mid-1940s, after several decades of experimentation, tinkering and implementation of different conservancy schemes, very little had been achieved regarding the provisioning of public latrines and night-soil disposal. Indeed, the 1945 annual medical report on sewerage disposal lamented that:

Little progress can be reported. Pan latrines in the central congested areas of the larger and older centres are often an abominable nuisance. They are often repeatedly filled and require frequent emptying, often during busy times of the day. Water-borne sewerage systems are overdue. Much excrementitious matter, also finds its way into the street gutters, where mixing with sullage water and street draining constitute, at times, a first-class nuisance...¹²²

Earlier, in 1942, Governor Allan Burns wrote to alert the Colonial Office of the dire sanitary conditions in Accra and requested for a comprehensive sewerage scheme for the town. He wrote that:

The principal difficulty is that the town has been allowed to develop without a sufficiency of household sanitary offices and the majority of work-places and private dwelling houses are without latrines. It is estimated that the population

¹²⁰ GGC, 'Report on the Medical Department for the Year 1937', 25.

¹²¹ GGC, 'Report on the Medical Department for the Year 1945' (Gold Coast, Accra: Government Printing Department, 1946), 12, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹²² Ibid.

of the municipality has increased from 60,000 – 78,000 in the last ten years and the public latrines are thronged with ever-increasing crowds of people.¹²³

On account of the increasing population without a matching number of public latrines, Burns noted that many in Accra "...who were unable to find accommodation in the public latrines resort to open spaces or use domestic utensils which they empty in the open concrete drains."¹²⁴ Thus, in the wake of increasing population of many towns and the consequent rapid urbanisation throughout the 1940s and beyond, without corresponding provisioning of public latrines, the toileting situation could hardly have improved any significantly during the 1950s.

The Dustbins of History: Street Cleaning and Refuse Disposal

Before the 20th century, the colonial administration's attitude towards maintaining clean streets and neighbourhoods could be described, at best, as lackadaisical. There were never enough scavengers to clear dustbins, sweep public streets and to rake and clear refuse heaps in the major towns where sanitary work was being undertaken. A perusal of the annual medical and sanitary reports for the late 19th century reveals the frustration of the various assistant surgeons who had the responsibility to maintain sanitation in their various stations. For instance, Dr F. W. Sullivan complained in 1887 that refuse in the outskirts of Cape Coast was difficult to deal with because of the limited number of scavengers available to do sanitary work.¹²⁵ In a similar vein, Dr J. Sylvester Cole lamented that sanitation in the Ada district could improve if the government had employed more sanitary labourers. Dr Cole lamented that despite the availability of carts to collect rubbish in the district, "there is not a single convict labour in the whole district to work them; the result is the filth, rubbish and co. that are allowed to accumulate in various parts of the town from want of men to perform the work."¹²⁶

The proper disposal of refuse was equally a difficult challenge. The need to deal decisively with the improper disposal of refuse arose in response to the nascent processes of urbanisation which had resulted in the growth in the population of the principal towns during the late 19th century. Indeed, in 1888, the Assistant Colonial

¹²³ quote in Bohman, 'Framing the Water and Sanitation Challenge', 77.

¹²⁴ Quote in *ibid.*

¹²⁵ GGC, 'Sanitary and Medical Reports, March 1887', 47.

¹²⁶ *Ibid.*, 58.

Surgeon of Accra raised this concern when he observed that “the disposal of waste products other than human excreta” was “a subject the importance of which increases with the growth of the population.”¹²⁷ He subsequently suggested to the government to make provisions for dust pits in which refuse could be deposited.¹²⁸

A public dustbin system was already in place during the late 1880s, except that it did not seem to be efficient. Dustbins were put at strategic locations in neighbourhoods for inhabitants to deposit sweepings from their homes and surroundings. Scavengers emptied these dustbins and carried the refuse away to the outskirts of towns and villages and buried or burnt them.



Figure 2: An Old Iron Dustbin. Source: GCC, 'Medical and Sanitary Report, 1911.'

Public dustbins continued to be an important facility for the disposal of refuse beyond the 19th century. The challenge, however, was that even by the early 1900s, there were still very few of them in use anywhere in the colony where sanitary work was being done. For instance, in 1902 the Health Officer of Accra, G. J. Rutherford

¹²⁷ GCC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 34.

¹²⁸ Ibid.

complained that there were insufficient dustbins. The few ones that were in use were badly constructed – smaller in size with small openings that made them very difficult to empty. The situation, however, improved after 1905 when the colonial administration started to replace the old iron dustbins with permanent concrete and relatively spacious dustbins.¹²⁹ In 1908, permanent concrete dustbins could be found in Kumasi and others were being constructed in Obuasi and Kintampo.¹³⁰

By 1910, the number of permanent dustbins in use in principal towns and villages where sanitary work was being carried out was one-hundred and ninety-five and by 1914, this had increased to two-hundred and six. By 1914, all the important towns had concrete dustbins erected as “...the old iron boxes” were being “discarded for fixed masonry bins.”¹³¹ These dustbins were, however, reckoned to be unsatisfactory to the needs of the African population. D. Alexander, the SSO in 1914 remarked that “...I think it is doubtful whether we have yet arrived at the type of bin most suited to the idiosyncrasies of the natives.”¹³² By the 1920s, however, public dustbins were somewhat improved and some of the permanent concrete dustbins were fly-proofed.¹³³



¹²⁹ GGC, 'Medical and Sanitary Report for the Year 1905', Annual (London, 1906), see, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

¹³⁰ see GGC, 'Medical and Sanitary Report for the Year 1908', Annual (Accra: Government Printer, 1909), BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

¹³¹ GGC, 'Medical and Sanitary Report for the Year 1914', 42.

¹³² Ibid.

¹³³ see GGC, 'Report on the Medical and Sanitary Department for the Period April 1924 - March 1925', 22.

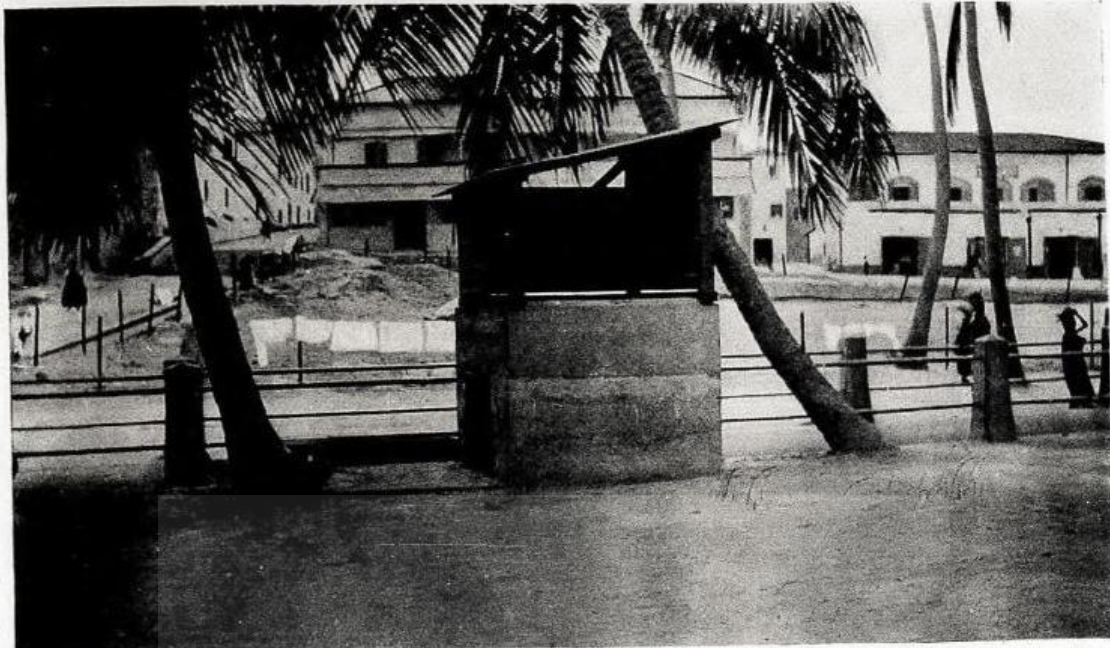


Fig. 8. Concrete Dustbin, with concrete raking platform. Too high for goats and fowls to get in. (For plan see Appendix Q.)

Figure 3: Improved Concrete Dustbin. Source: Medical and Sanitary Report, 1911.

Public dustbins were not an unmitigated intervention. Rather than limit the incidence of filth in the streets, it seemed to have aggravated the situation. As was characteristic of the period, the European officials blamed the African population, accusing them of inappropriate use of public dustbins. An Assistant Surgeon of Axim, Woodburn Heron remarked in 1888 that:

The public dustbin system has not been found an unmitigated benefit. Like every inch conceded to the natives, it has resulted in their taking several miles from the giver. Before the establishment of the dustbins, every householder was compelled to keep his own premises clean. There were then no carts to go round and carry out of the town the refuse of most of the neighbouring houses and each and every occupier burnt or carried away the daily sweeping of his hut and yard. As it is now householders simply collect their rubbish and throw it in the nearest dustbin, with the result that each of those four receptacles is quickly full and on the site of each of dust box there is soon a large heap by the roadside, which is offensive to sight and smell.¹³⁴

Such castigation of the local population's careless use of public dustbins became a colonial mantra. For example, W. M. Howells, a Senior Health Officer

¹³⁴ GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 53.

lamented in 1932/33 that dustbins were an “insufferable nuisance.” “The people are careless, and as often throw their refuse on the ground near the bin and not into it.”¹³⁵ A similar sentiment was expressed in the 1938 annual medical and sanitary report when it was noted that “the roadside collecting bins, owing to carelessness on the part of the public are, as a rule, a nuisance of the first order.”¹³⁶ Because of the nuisance, it caused, sometimes, their placement in some neighbourhoods was met with disapproval from residents. For example, in 1930, the head of the Ahmadiyya Mission petitioned the sanitary committee of Salt Pond to cause to be removed a dustbin that was placed in the precincts of a proposed mosque for fear that it would be a potential source of nuisance. The committee refused. They reasoned that its relocation to a new site was likely to be met with the disapproval of the residents. Such a response confirms the unpopularity of the public dustbin system.¹³⁷

The claim that the careless use of dustbins by the African population caused them to be nuisance requires some qualification. It mirrors not only the condescending posturing of the colonial administrators but also, as Bohman argues, their racist and prejudiced attitudes towards the local population.¹³⁸ Indeed, the real challenge was the design of these bins and not the attitude of the African population. Most of these dustbins, despite supposed improvements, were poorly constructed and were rarely adapted to the needs of the African population. Indeed, in 1943, L. G. Eddy, the MOH of Sekondi conceded that “...the design of these structures [dustbins] is largely responsible for the general disrepute in which they are held.”¹³⁹

In another instance, a private citizen, J. Quist-Therson wrote to the Governor, Allan Burns, in 1943 complaining of nuisances caused by a dustbin that was placed at Amantra street in Christiansborg. He noted that:

There are two main defects from which this dust-bin suffers: It is so small that it is obviously inadequate for the community which it serves and is of so ancient

¹³⁵ GGC, ‘Report on the Medical Department for the Year 1932-33’, 1933, 27.

¹³⁶ GGC, ‘Report on the Medical Department for the Year 1938’, 30.

¹³⁷ see ‘Minutes of a Meeting of the Saltpond Sanitary Committee Held on Friday August 8th, 1930’, 1930, 1, ADM23/1/2436, Central Regional Archives, Cape Coast.

¹³⁸ Anna Bohman, ‘The Presence of the Past: A Retrospective View of the Politics of Urban Water Management in Accra, Ghana’, *Water History* 4, no. 2 (July 2012): 142.

¹³⁹ ‘From Medical Officer of Health, L. G. Eddy to the President, Sekondi Town Council’, 8 December 1943, CSO 11/14/376, PRAAD, Accra. Emphasis added.

a type that it strikes even a layman as constructed with scarcely any regard for sanitary considerations.¹⁴⁰

Again, it must be stated that dustbins were never provided in sufficient quantities neither was there ever enough scavengers to convey the refuse from the bins to the designated dust heaps. This combined with their inappropriate design, improper siting and poor management caused the unsightly scene that colonial officials blamed on the African population. Thus, while the colonial administration complained about filthy streets in towns and villages, their attempts to mitigate these conditions using public dustbins was anything but satisfactory.

But, the public dustbins were only collecting points for refuse and not the destination for their disposal. Several methods were thus, adopted to destroy or dispose of rubbish. During the late 1800s and the early 1900s, most rubbish was either head-loaded or hand-carted to designated points in the outskirts of towns where they were either buried in trenched grounds, old quarry holes or burnt.¹⁴¹ Refuse that were incombustible were used to fill swamps and low-lying areas.¹⁴² The use of refuse to fill swamps was reckoned to be an effective way of disposal and an efficient method by which many swampy and low-lying areas were reclaimed and put to economic use.¹⁴³ For instance, in 1914 a large proportion of incombustible rubbish such as tins, and bottles were, where European supervision was available, used either in the form of crude refuse or clinker to fill up excavations and reclaim low-lying and marshy ground.¹⁴⁴ In 1920 twenty-three thousand square yards of wasteland was reclaimed in Sekondi by the use of such refuse.¹⁴⁵ Similarly, in 1928/29, many low-lying and swampy areas in large towns were successfully reclaimed using incombustible rubbish.¹⁴⁶ However, this method was found to be objectionable in some instances.¹⁴⁷

¹⁴⁰ 'From J. Quist-Therson to Governor Allan Burns, 17th June 1943', 1943, 1, CSO11/14/326, PRAAD, Accra.

¹⁴¹ see GGC, 'Medical and Sanitary Report for the Year 1910' (London: Waterlow & Sons Limited, Printers, London Wall, 1911), 53, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

¹⁴² see GGC, 'Medical and Sanitary Report for the Year 1915', 17; GGC, 'Report on the Medical Department for the Year 1930-31', 35.

¹⁴³ see GGC, 'Medical and Sanitary Report for the Year 1915', 17; GGC, 'Report on the Medical Department for the Year 1930-31', 53.

¹⁴⁴ see GGC, 'Medical and Sanitary Report for the Year 1914', 42.

¹⁴⁵ GGC, 'Report on the Medical Department for the Year 1920', 20.

¹⁴⁶ GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929', 30.

¹⁴⁷ See chapter 6.

The colonial administration also adopted the use of incinerators to destroy rubbish. It is not certain when incinerators were first installed for use in the Gold Coast, but the first mention of its use was in 1906 when a refuse destructor was being experimented with in Kumasi. In the subsequent years, other principal towns and villages were provided with incinerators. By 1910, forty-three incinerators had been erected and were in daily use throughout the colony and others were still under construction in principal towns and villages. In 1914, it was reported that "...in the vast majority of towns under the Towns Ordinance, incinerators have been built and in the Northern Territories a home-made type of destructor" was found in several stations."¹⁴⁸

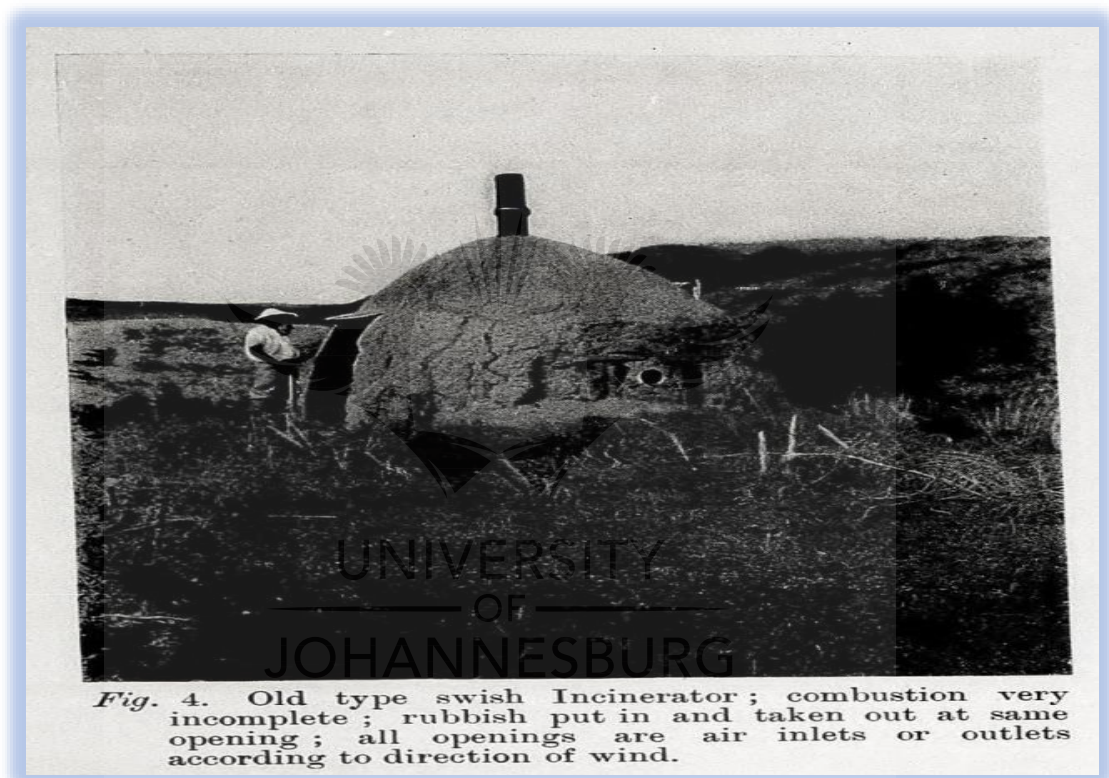


Figure 4: Old Swish Type of Incinerator. Source: GGC, Medical and Sanitary Report, 1911.

By the 1920s, the colonial administration was engaged in building incinerators in almost every part of the Gold Coast where sanitary work was being done. For instance, Selwyn-Clarke the Ag. DDSS noted in 1926/27 that, "in large towns where the chiefs and their people had shown keenness in improving the health conditions the government constructed a number of brick destructors" for their use. Some Medical Officers of Health improvised by producing simple incinerators with local materials. For instance, in about 1924, Major A. L. Ottaway, the MOH of Sekondi after some

¹⁴⁸ GGC, 'Medical and Sanitary Report for the Year 1914', 42.

experimentation introduced incinerators on field service principle.¹⁴⁹ These incinerators were small, simple and constructed of mud. This type of incinerator was described as well adapted “for village use as Africans are accustomed to swish (mud construction) and any headman, once shown could make one.”¹⁵⁰ In subsequent years, therefore, the colonial administration encouraged and supported chiefs and headmen in rural communities “where interest in sanitary matters was evinced” to construct incinerators of the kind developed by Ottaway.¹⁵¹ In 1928/29, it was noted that “...numbers of field incinerators have been built throughout the colony as a temporary expedient until all the more populous centres can be equipped with high-temperature destructors.”¹⁵²

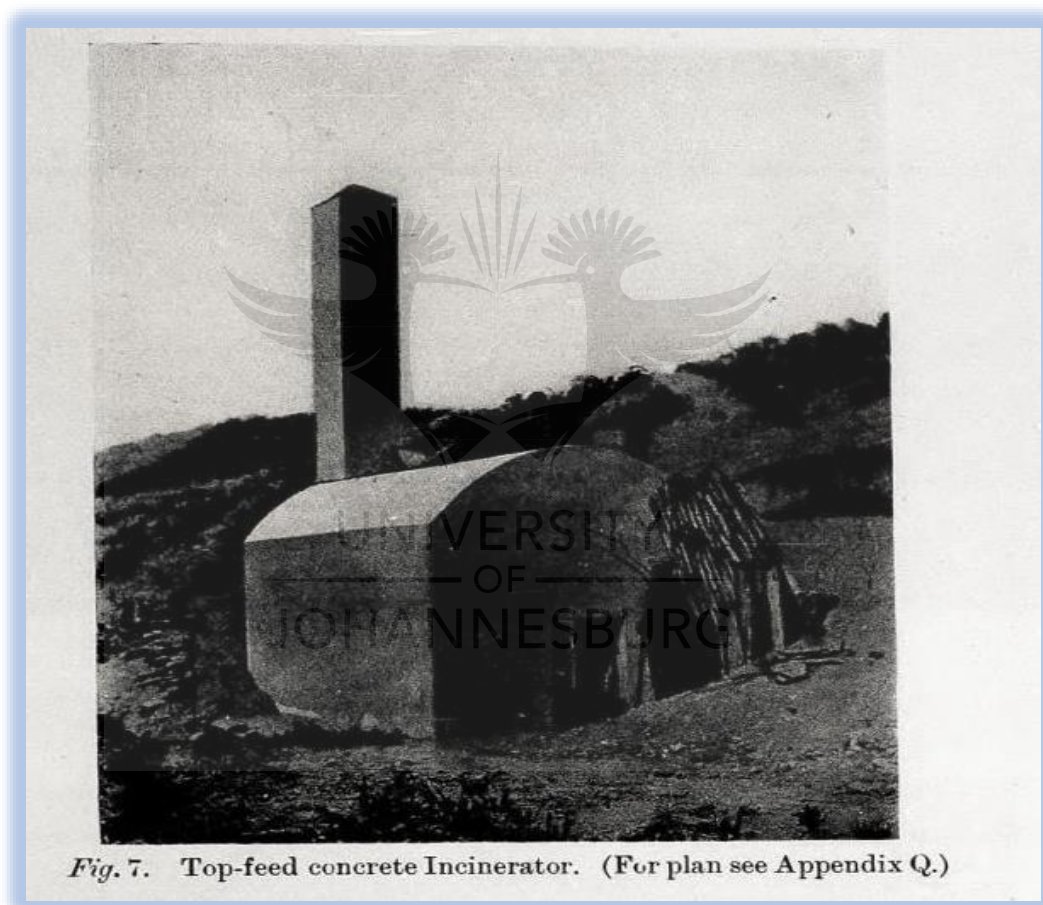


Figure 5: An Improved Concrete Incinerator. Source: GGC, Medical and Sanitary Report, 1911.

¹⁴⁹ It is not defined what field service principle meant. But these incinerators designed by Ottaway, about 15 of them were located on the spot close to a swamp which was being reclaimed and for which the residue of the incineration was needed.

¹⁵⁰ GGC, 'Report on the Medical and Sanitary Department for the Period April 1924 - March 1925', 22.

¹⁵¹ see GGC, 'Report on the Medical and Sanitary Department for the Period April 1926 - March 1927', 28.

¹⁵² GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929', 30.

Thus, by the 1930s various methods were being used to destroy combustible refuse, and various kinds of incinerators served this purpose. For instance, for most of the 1930s, Accra relied on the forced-draught incinerator for the destruction of rubbish. In most towns and villages brick-built incinerators of the bee-hive type and the field-service type made of mud were in use.¹⁵³ In many of the small villages where there were no incinerators, controlled dumping at designated sites was practised. In such places, refuse dumped at designated locations was burnt when weather conditions permitted. However, this practice was very inefficient and as a result “too often the overgrown perimeters of these villages” became “filled with potentially water containing debris”¹⁵⁴ which gradually became the nursery sites for the dreaded *anopheles* mosquito. As the health department observed in 1941, while in rural areas dumping was the key means of disposing of refuse, “...too often such dumping” was “entirely uncontrolled.”¹⁵⁵

It must be noted, however, that whereas incinerators were advantageous, especially, during the rainy season (as they permitted the combustion of rubbish which otherwise could not be burned on dumping grounds); they were useful only to the extent that they were sufficiently numerous, and if they were directly accessible to householders without the intervention of dustbins. However, in areas where there were few incombustible refuse, the use of incinerators was eminently satisfactory.¹⁵⁶ Yet, colonial officials were not always enthused about the use of incinerators and, therefore, its provision was sometimes tempered with the colonial cost-saving logic. For example, in 1914 it was reported that:

...in places where there were swamps and water holding holes urgently needing filling it has been found politic to take all the refuse straight to these places. By this means time and labour is saved, and the holes and c., get more quickly filled in with the crude refuse than they would with the clinker from the incinerators.¹⁵⁷

For most of the first three decades of the 20th century, the collecting and carting of refuse from bins into either designated incinerators or to specified dumping grounds,

¹⁵³ see GGC, ‘Report on the Medical Department for the Year 1932-33’, 1933.

¹⁵⁴ GGC, ‘Report on the Medical Department for the Year 1938’, 31.

¹⁵⁵ GGC, ‘Report on the Medical Department for the Year 1941’, 6.

¹⁵⁶ see GGC, ‘Medical and Sanitary Report for the Year 1914’, 42.

¹⁵⁷ Ibid.

old quarries or dust pits was done predominantly by scavengers and in some few instances by using mule-drawn carts. Whereas for most of the late 19th century the number of scavengers employed remained insufficient, during the 20th century, some efforts were made to increase their number. That is not to say, however, that scavengers were ever sufficient to execute this onerous task.

Indeed, by 1910 it was estimated that four-thousand three hundred and twenty-nine headloads of rubbish were being removed by scavengers daily. And an estimated twenty-one headloads of tins, cans and other combustible materials were being removed and buried by scavengers on daily basis.¹⁵⁸ The record for 1910 does not state how many scavengers were employed to perform this task. But, we can extrapolate from the 1911 figure of two-hundred and forty-four that about the same number or even less were engaged in 1910. When in 1912, a total of two hundred and fifty scavengers were employed they were removing and burning an average of one thousand two hundred and thirty-one headloads of refuse daily.¹⁵⁹ For the sixteen towns where sanitary work was being done in 1914, three-hundred and seven scavengers were engaged to remove rubbish.¹⁶⁰ The colonial administration seemed to have employed more scavengers for sanitary work in subsequent years, except in the 1930s and the 1940s when the economic recession and the outbreak of the Second World War seemed to have constrained the financial position of the government. Thus, throughout the 1930s and 1940s scavengers were maintained only in Accra, Sekondi, Kumasi and Cape Coast.

By the 1920s, it had become obvious to the colonial administration that scavenging labour alone could not be relied upon if refuse was to be properly and efficiently disposed of given the increasing growth in population, particularly in the larger towns and villages. The administration, therefore, instituted a system of motor transportation in the major towns during the 1920s to convey refuse from bins and street sides to the incinerators and other designated dumping sites. Kumasi had its first refuse disposal lorry in October 1924 and by 1925 the number had increased to three. Similarly, Accra had six lorries in place for conveying refuse from bins to incinerators and other dumping sites by 1924. And in Tamale, three conservancy

¹⁵⁸ GGC, 'Medical and Sanitary Report for the Year 1910', 53.

¹⁵⁹ GGC, 'Medical and Sanitary Report for the Year 1912', 96.

¹⁶⁰ GGC, 'Medical and Sanitary Report for the Year 1914', 63.

lorries were in use in 1929.¹⁶¹ However, the earliest use of motor transport to convey refuse in any part of the Gold Coast appeared to have been started in Sekondi, where, in 1923, three lorries were already serving this purpose.¹⁶² Thus, from the 1930s and beyond, three systems of collecting and disposing of refuse viz motor lorry, hand-carts and head-loading were in place in the larger towns. In most of the villages, however, the use of hand-trucks and head-loading remained the most popular means for removing and disposing of refuse.

In most of the smaller towns and villages lacking sanitary labour the colonial administration sought to deflect the cost of dealing with the refuse problem to local chiefs. In the 1930s the colonial administration was actively engaged in inducing chiefs and headmen of some towns under the Towns Ordinance to recruit their labour to collect and dispose of refuse. And where this arrangement was impracticable refuse dumps were sited on lands adjoining latrines so that the disposal of refuse could be confined to definite areas easily accessible to the inhabitants. However, this arrangement was fraught with challenges. For instance, in 1930/31 it was observed that:

In several townships in Ashanti, the system of chiefs and headmen maintaining a gang of scavengers has worked satisfactorily on the whole, although payment of wages has been delayed or stopped without notice at times and the labourers trained by the Health Branch have left the place. It has only been possible to inaugurate schemes of this nature to a very limited extent in the Colony proper...¹⁶³

It is difficult to see how chiefs, especially, those of small townships, were expected to maintain scavenging labour to properly and efficiently deal with refuse collection and disposal given the labour-intensive nature of the task and the meagre stool revenues available to the chiefs. The colonial administration, however, hoped “that provision will be made under the new Native Revenue Ordinance for the allocation of a definite percentage of stool revenue for health work, thereby ensuring the necessary attention being paid to health requirements.”¹⁶⁴ Yet, by 1934, incinerators erected by the government and manned by labourers employed by chiefs

¹⁶¹ GGC, ‘Report on the Medical and Sanitary Department for the Period 1928-1929’, 30.

¹⁶² see GGC, ‘Report on the Medical and Sanitary Department for the Period April 1924 - March 1925’, 22; GGC, ‘Report on the Medical and Sanitary Department for the Period April 1925 - March 1926’, 30.

¹⁶³ GGC, ‘Report on the Medical Department for the Year 1930-31’, 26.

¹⁶⁴ GGC, ‘Report on the Medical Department for the Year 1931-32’, 26.

in many small towns were no longer in use because chiefs could no longer pay the labourers.¹⁶⁵

Sanitation of Remote Villages and Mining Areas

This section considers the sanitation of rural communities, and mining towns and adjoining villages where for most of the colonial period sanitation work did not come under the direct control of the colonial health agencies and agents. A striking feature of colonial sanitation and public health measures in the Gold Coast was its lopsided application. Whereas, the government did not altogether abandon the sanitation of small villages and rural communities in the remotest parts of the colony, the greater part of sanitation work was confined to large towns and villages which served directly or indirectly the economic interests of the government or areas of some administrative importance. From 1892 sanitation and all related public health works were done predominantly in areas that were brought under the Towns and Public Health Ordinance. In mining areas, the sanitation and health of mining villages, towns and camps were left to mining companies with little or no assistance from the colonial administration until the mid-1920s.

Villages and towns were only brought under the Towns Ordinance through the governor's proclamation as and when it was considered necessary. For most other villages in the hinterlands that were yet to be brought under the Towns Ordinance, sanitation work was delegated to chiefs and headmen. In such areas, the chiefs or headmen led their people in clean-up exercises, directed the burning of rubbish in designated locations, ensured the digging of latrines, selected sites for cemeteries, and enforced any other regulation related to the public health, more generally.¹⁶⁶ In the early 1900s, extensive rules for regulating towns and villages that were not under the Towns Ordinance was made for the Northern Territories and Asante. These rules empowered chiefs and headmen to punish any individual who defied their sanitary orders.¹⁶⁷ Indeed, by 1927 when the Native Authority Ordinance was passed, some "head chiefs" could adjudicate sanitary offences in their tribunals.

¹⁶⁵ see GGC, 'Report on the Medical Department for the Year 1934', 19.

¹⁶⁶ see Gundona, "Coping with This Scourge," 135–36.

¹⁶⁷ see "Sanitary Rules for the Guidance of Chiefs and Headmen of Villages in Ashanti," November 1909, ARG1/14/3/1, Ashanti Regional Archives, Kumasi; Gundona, "Coping with this Scourge," 136–37.

Yet sanitation in rural areas lagged for the most part during the period under consideration. The reason, according to Gundona, drawing on the experiences of the Northern Territories related to the non-enforcement of sanitary regulations. He argues that very few chiefs wielded the needed political clout, the confidence and the political will to be able to enforce sanitary regulations in their localities. This problem partly related to the nature of the implementation of the indirect rule system in the Northern Territories where few groups had centralised political structures. For many of the other groups who remained acephalous, chiefs were often imposed, yet such chiefs were incapacitated to make anybody obey them.¹⁶⁸ Even in Asante, where it appeared that sanitary work was taken more seriously by the chiefs and headmen, the enforcement of sanitary by-laws, just like in the Northern Territories remained a critical challenge.

However, in Asante the inefficient implementation of sanitary by-laws related to inherent weaknesses that prevented small chiefs from dealing with sanitary offences summarily and decisively. Indeed, responding to a memo from the Commissioner of the Eastern Province of Asante on the need to revise existing sanitary laws in rural areas, the District Commissioner of Bekwai ascribed the inefficiency of the existing laws to the inability of chiefs to forcefully implement them because of their inherent limitations. He noted in paragraph three of his letter that:

In my own opinion, the failure of the inefficient working of these or any other similar bye-laws is a foregone conclusion unless the chief or headman in the charge of each village or hamlet has the power to deal summarily with an offender. If a village headman can only obtain obedience to his orders by prosecuting an offender before his chief's tribunal often at great trouble and expense to himself, he is being placed in an equivocal position and he would be the loser by endeavouring to see these bye-laws enforced.¹⁶⁹

Other officials shared similar views. Indeed, in a meeting of the Asante Health Board in March 1927, when the question of rural sanitation was raised, the SSO suggested that because of the limitations of the existing regulations for maintaining sanitation in rural areas, "it might be worth considering the possibility of introducing sanitary by-laws under the Native Jurisdiction Ordinance as has been done in the

¹⁶⁸ see Gundona, 'Coping with This Scourge', 137–38.

¹⁶⁹ 'From District Commissioner, L.W. Judd to the Commissioner, Eastern Province, Ashanti, 4th June 1927', 1927, 1, ARG1/14/3/6, Ashanti Regional Archives, Kumasi.

colony.¹⁷⁰ The president of the Board obliged him and instructed that he should draft model laws for consideration.¹⁷¹ Even though there is a thread of discussion of such model by-laws that was drafted for the consideration of the Board, it is not clear if these laws were ever implemented.

What is evident is that in the absence of effective implementation of existing sanitary by-laws, in many villages and small towns, filth of varying kinds and degree could accumulate in the streets and surroundings. For example, when in 1910, Dr J. A. Berringer, the Medical Officer of Salaga toured the central and west Gonja districts in the Northern Territories, he observed that the sanitation of most villages was distressing. He noted that:

Excluding Salaga and Tamale, it may be at once said that all the villages passed through were dirty, whilst those of the beaten track of Europeans and out of the more frequented trade routes were disgustingly dirty with the accumulation of filth of ages. Huts mostly of the usually round type of this district, of swish with grass roof, containing human beings and animals, often indiscriminately mixed, were dirty and frequently little swept, compounds, were littered with rubbish and vegetable filth; whilst sweepings, broken utensils and all sort of rubbish were thrown over the walls or deposited a few yards beyond them...¹⁷²

Similarly, in Asante, the District Commissioner of Western Akim observed in 1922 that, in Nsuaem and Akim Swedru, two villages within his district, "Conditions are bad and I do not think that any appreciable improvement will be effected until these towns are brought under the Towns Ordinance."¹⁷³ In a similar vein, J.W. Simpson reported in 1924 that in some interior parts of Asante and the Northern Territories, their "outstanding features appear to be the very insanitary conditions into which the villages have lapsed." The results of which, according to him, was that many villagers suffered from "wasting disease, ulcers, yaws and sores, poorness of physique, indolence and mental dullness."¹⁷⁴

¹⁷⁰ "Extract from Minutes of Meeting of Ashanti Health Board Held in the Chief Commissioner Ashanti's Office on Tuesday March 22nd, 1927," 1927, 1, ARG1/14/3/6, Ashanti Regional Archives, Kumasi.

¹⁷¹ Ibid.

¹⁷² Quoted in Gundona, 'Coping with This Scourge', 139–40.

¹⁷³ see 'Memo: From the Deputy Director of Sanitary Services to the Director of Medical Services', 1927, 2, ARG1/14/3/6, Ashanti Regional Archives, Kumasi.

¹⁷⁴ William J Simpson, 'Report on the Sanitary Condition of the Mines and Mining Villages in the Gold Coast Colony and Ashanti' (London; Dunstable; Watford: Waterlow and Sons Ltd., 24 November 1924), 6.

In 1933/34, the DDHS admitted that:

During the last few years, rural sanitation has suffered adversely to no small degree. This is particularly evident in Ashanti where the standard was, and is, considerably higher than in the colony generally...Now money is scarce in the rural areas and the work devolves on the people themselves. It is a very great difficulty that anything can be accomplished and is too often impossible. As a result, overgrown, tin, bottle and rubbish littered perimeters have appeared and many villages and small townships, and latrines have fallen into ruin and disuse...¹⁷⁵

What is being implied in the above quote is that, apart from everything else, financial resources which were key to the maintenance of sanitation in the rural areas were not readily available, especially if it had to be raised by the chiefs and their people.

However, because of the distressing sanitary conditions, by 1932/33 the question of rural sanitation was being seriously considered by the government. This resulted in some changes in policy that permitted the extension of sanitary supervision beyond what was considered as principal towns and villages. The colonial administration had come to the realisation that it was undesirable “with safety to adopt a principle of “pin-point” sanitation in the Colony, i.e., the sanitation of the larger centres alone and allowing the rural areas to fall back in sanitary standard to be improved sometime in the future through a long process of education and persuasion.”¹⁷⁶

As officials of the health department correctly observed, if sanitary conditions of the rural areas were neglected the so-called larger centres could “run the risk of repeated infection from surrounding rural areas with all the attendant curtailment of movement and stagnation of trade.”¹⁷⁷ J.M. Mackay the DDHS in 1936 put it more succinctly:

Whatever means of control is decided for the future, it is stressed as previously that sanitation of the larger centres, only, cannot hope to be successful. Such centres will be invaded, time and time again, from the outside insanitary squalor resulting in the imposition of quarantine of funds and curtailment of trade.¹⁷⁸

¹⁷⁵ GGC, ‘Report on the Medical Department for the Year 1933-34’ (Gold Coast, Accra: Government Printer, 1934), 37, BOA, <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.

¹⁷⁶ GGC, ‘Report on the Medical Department for the Year 1935’, 27.

¹⁷⁷ Ibid.

¹⁷⁸ GGC, ‘Report on the Medical Department for the Year 1936’, 31.

Thus, even while seeking to improve the sanitation of the rural communities, the overarching concern of the colonial administration remained, how to sustain their economic interest.

However, the shift in policy was not so radical after all. The government continued to rely on the native authorities. From about 1935, the colonial administration sought to improve the sanitation of rural communities by devolving the responsibility to the newly constituted Native Authority Administrations.¹⁷⁹ By stimulating the interests of the Native Administration and soliciting their support by making them responsible for the supervision and control of sanitation in their localities, the colonial administration hoped that the sanitation of the rural areas could be improved. At the same time, the government also encouraged the formation of Township Boards in rural communities to assist with improving sanitation.

The colonial administration hoped to co-opt “educated and public-spirited Africans” to serve on such Township Boards with the intent that their influence could have “far-reaching effects in the furthering of health measures; their experience and knowledge being brought to the assistance of their less well-equipped fellow countrymen...”¹⁸⁰ A close reading of the evidence, however, reveals that the colonial administration’s attitude towards rural sanitation was that of lethargy and indifference. In 1937, the health branch admitted that:

Generally, in the rural areas of the colony, the Health Branch can do little or nothing...All that the staff can do at present is steadily to preach the gospel of sanitation and confine actual work to the mosquito-control of such places to which the provision of the mosquito ordinance may have been applied.¹⁸¹

It is, therefore, not surprising that apart from the Northern Territories where the Native Authorities seemed to have been very effective in improving sanitation in the remote areas during the 1930s, in Asante and the colony proper, sanitation in rural areas continued to lag. In 1937, the DDHS reported that:

¹⁷⁹ In 1935, the Native Administration Ordinance of 1927 was revised. The revised Ordinance joined together the central colonial government and the local authorities into a single governing system. New native authorities, appointed by the governor, were given wide powers of local government under the supervision of the central government's provincial commissioners. In 1939, the Native Treasuries Ordinance was promulgated, and this allowed for Native Authorities to prepare their own budgets for local development.

¹⁸⁰ GGC, ‘Report on the Medical Department for the Year 1936’, 34.

¹⁸¹ GGC, ‘Report on the Medical Department for the Year 1937’, 31.

It is very encouraging to be able to report a steady advance in the standard of rural sanitation under the aegis of the Native Administration in the Northern Territories. In Ashanti little progress, only, can be claimed. As explained, formerly, a good deal of the lost ground in Ashanti can be referred to economic causes. In the Colony, no advance is patent save in such places as Asamankese and Akwatia where the Stool Treasuries are on a sound basis.¹⁸²

Again in 1938, it was noted that:

Great progress can be reported in the Northern Territories, under the aegis of the Native Administration, in all branches of rural sanitation. This steady advance is most encouraging, and the progress already made should act as a stimulus to the rest of the Gold Coast. In Ashanti matters remain much as in recent years, and little advance can be recorded. In the Colony apathy is the general rule, and no progress can be reported save in the few instances where Stool treasuries are on a sure footing.¹⁸³

It does appear that what might have induced the steady progress in the sanitation of rural communities in the Northern Territories during the 1930s was the relatively sound Native Administration system that was in place. And the ability of the health officers there to elicit the cooperation of the chiefs to support the sanitation scheme which was devised for the improvement of the area. A statement contained in a letter that was addressed to the Provincial Commissioner by the Assistant District Commissioner of Navrongo in 1934 describing the sanitation scheme in his district is instructive:

I may say that this scheme was not set on foot without the prior consent of the chiefs of the two Native Administrations. Apart from pointing out to them the desirability from a health point of view of sanitation in their villages, I did not press the scheme upon them. They were told that no chief need send a man for training if he did not so desire. Out of 26 chiefs, each representing a village 22 sent men for training. As a result of this precaution no chief who has an overseer is antagonistic to the scheme, some, of course, are keener than others.¹⁸⁴

However, in Asante and the colony proper limited financial resources available to the Native Authorities due partly to the economic difficulties of the 1930s, but also, the preponderance of local political intrigues affected their capacity to improve the sanitation in rural communities. Many native authorities were involved in long histories

¹⁸² Ibid., 30.

¹⁸³ GGC, 'Report on the Medical Department for the Year 1938', 36.

¹⁸⁴ "From L. J. Mothersill (Assistant District Commissioner, Navrongo) to Chief Commissioner, Northern Territories, 2 August 1934," 1934, 2, CSO11/14/208, PRAAD, Accra.

of political instability before the 1930s and beyond – and this affected their ability to raise and control public funds effectively. Because of the political disputes taxes could not be easily levied, and the Native authorities were also prone to expend the little revenues they could raise on administration and repayment of debts incurred in political disputes – leaving little or nothing for expenditure on social and development services.¹⁸⁵

However, the reluctance of the colonial administration to commit financial resources to improve sanitation in rural communities was no less important. As Brown has argued, regarding sanitary reforms in British West Africa, economy and self-sufficiency remained unrepentantly, the basic government policy.¹⁸⁶ The net effect was that the sanitation of rural areas continued to suffer greatly throughout the 1930s and during the 1940s. With the onset of World War II and its concomitant effects on finance and labour, no tangible improvements could occur in sanitation in rural areas for most of the 1940s.

However, the shift in focus of the colonial government from sanitation to the medicalisation of public health, focusing more on vaccination, medical research, the creation of dispensaries and the increased administration of doses of medications, such as quinine, may have undermined environmental health, sanitation and hygiene initiatives. Battams notes that in the aftermath of World War II:

...the discovery of new drugs and other irrefutable medical progress laid the foundations for a strong belief in the ability of doctors and the health services to solve all the major health problems. Health policy became increasingly synonymous with medical care policy, with the debates centring on how we should finance and recruit personnel to an ever-swelling hospital sector.¹⁸⁷

Thus, by the 1950s, rural sanitation in most parts of the Gold Coast was anything but improved. Even so, the colonial administration was still committed to its policy of leaving rural sanitation as the exclusive responsibility of local government. Indeed, the 1951 development plan even while acknowledging the need for a

¹⁸⁵ see GGC, 'Annual Report on the Gold Coast for the Year 1946' (London: His Majesty's Stationary Office, 1948), 98.

¹⁸⁶ Brown, 'Public Health in Lagos, 1850-1900', 339–40.

¹⁸⁷ Quoted in Mario J. Azevedo, 'Public Health in Africa: Theoretical Framework', in *Historical Perspectives on the State of Health and Health Systems in Africa, Volume I*, African Histories and Modernities (Cham: Palgrave MacMillan, 2017), 9,

concerted effort to improve rural health and sanitation was still insistent that local authorities must be charged to do so. It noted that:

There is a pressing need for the improvement of health in rural areas and it is hoped that local authorities will play an increasingly important part in rural health work and thus enable rapid progress to be made in the next few years....¹⁸⁸

This time, however, the government promised to provide financial assistance to support rural health work and provide training for staff who would be deployed to do health work in rural communities. Yet, most of the preventive health work that took place from the mid-1940s and beyond focused more on 'medical' prophylactic such as vaccination at the expense of environmental sanitation work and hygiene.¹⁸⁹

The maintenance of sanitation in mining townships/villages/camps, and adjoining villages seemed to have been the "bug-bear" of rural sanitation. Curiously, whereas the exploitation of the mineral resources of Ghana dates back to the 1880s – the period marked as the first "gold rush" – no records were kept on the sanitation and health of the mining areas. Anecdotal accounts of health in mining communities began to appear in the annual medical and sanitary reports during the first decade of the 20th century.¹⁹⁰ This situation in itself can be interpreted to mean a lack of concern on the part of both the mining companies and colonial officials for the health of African employees in the mines on the one hand and the inhabitants of villages and towns where mining exploration took place on the other. It is, therefore, not surprising that for most of the colonial period, the sanitary and health conditions of mining areas remained deplorable. Considering that gold and later, diamond mining alongside cocoa provided the greatest share of revenue, it is difficult to understand why more was not done to improve the health of mine labourers and the sanitation of mining towns and villages.

¹⁸⁸ Quoted in Gundona, 'Coping with This Scourge', 149.

¹⁸⁹ Most of the annual reports of the 1940s emphasized the building of dispensaries, the training of dispensers, building of hospitals, the administration of preventive medications, medical research and the work of the Medical field units that were responsible for fighting the prevalence of Trypanosomiasis.

¹⁹⁰ see Raymond Dumett, "Disease and Mortality among Gold Miners of Ghana: Colonial Government and Mining Company Attitudes and Policies, 1900-1938," *Soc. Sci. Med.* 37, no. 2 (1993): 213–32. Before the First World War, capitalist mining complexes were concentrated in the Western region in the twin township of Tarkwa and Aboso with an adjoining mining centre at Heman-Prestea. In Asante, there was the Ashanti Goldfields Corporation which started the famous Obuasi mines in 1897.

Raymond Dumett is correct in pointing out that from the onset of the gold rush in the Gold Coast in the 1880s, mining towns/camps and adjoining villages were “beset by an awesome congeries of housing, street sanitation, sewage disposal, water supply and hygienic problems”¹⁹¹ of varying degrees. Recounting the experiences of mining villages in and around the Tarkwa and Aboso mines in the Western Province, Dumett observed that:

By 1881, the quick fabrication of hoards of make-shift shanties and lean-tos to make room for the influx of non-Wassa wage labourers, plus coastal traders and substantial floating population had given the town and outlying villages a run-down, squalid appearance. Bathing facilities refuse pick-up and sanitary amenities were deplorable for the rapidly growing population.¹⁹²

The deplorable sanitary conditions during the late 19th century and beyond related to the astronomical increases in the population of mining towns. This was a direct consequence of migrant labour who trooped to find job opportunities in these mining towns. For example, from a small African hamlet of some few hundred during the mid-19th century, Tarkwa’s population escalated to over two thousand (2000) during the first gold rush of the 1880s. Similarly, Adansi Obuasi was a tiny forest settlement until 1897 when the Ashanti Goldfields Corporation won the concession to mine gold in the area which transformed this otherwise small settlement into a bustling mining town.¹⁹³

Beyond the influx of migrant mine labour, however, the construction of the Gold Coast’s first railway lines between 1899 and 1903 which sought to connect the coastal town of Sekondi through Tarkwa to Kumase, connecting other mining villages along the path, also added to increasing the population and its concomitant social and health problems in mining areas. As Dumett observed:

With a total complement of 12,417 workers stationed at various sections in overcrowded and poorly sanitised tent towns along the line of rail, railway construction itself aggravated the spread of disease even before the mining towns reached their peak of settlement.¹⁹⁴

¹⁹¹ Ibid., 215.

¹⁹² Raymond E Dumett, *El Dorado in West Africa: The Gold-Mining Frontier, African Labour, and Colonial Capitalism in the Gold Coast, 1875-1900* (Athens: Ohio University Press; Oxford: J. Currey, 1998), 189–90.

¹⁹³ Dumett, ‘Disease and Mortality among Gold Miners in Ghana’, 213–15.

¹⁹⁴ Ibid., 213–14.

Be that as it may, by 1910, the combined mine labour force of Aboso and Tarkwa was five thousand one hundred and twenty-eight (5128). This increased to six thousand six hundred and eighty-one (6681) in 1921. Dumett estimates that the combined population of Tarkwa, Aboso and their adjoining villages including mine labour, their wives and children and other itinerant traders included added up to twenty-six thousand five hundred (26500) by 1921. Obuasi and its adjoining villages and camps had a population totalling about fifteen thousand (15000) in 1911 which was of similar composition as those of Tarkwa and Aboso.¹⁹⁵

The increasing population in mining townships and villages without corresponding sanitary infrastructure, combined with inadequate and poorly built houses and non-existent town planning schemes led to severe public health problems.¹⁹⁶ Yet, it would seem that neither the government nor the mining companies took any serious interest in improving the sanitation of the mining areas beyond the piecemeal work that was done to improve the sanitary and health conditions of European miners and officials living in such communities.¹⁹⁷

The result of this lethargic attitude of the mining companies and the government towards the sanitation of the mining towns and villages became evident when in 1903, the PMO reported that mortality among European employees of mining companies which stood at 4 per 1000 could have been much lower:

...But for one mine at which several men were crowded into a house (17) which was much too small; the condition of the camp was most insanitary and in close proximity to native villages, tins and rubbish thrown anywhere (many of the tins swarming with mosquito larvae) ...the result was what might be expected; within a very short time six of the men died, and some of them were sent away.¹⁹⁸

Because of the increasing potential health risk to European mine officials and employees of the mining companies of an unsanitary mining village or camp, some

¹⁹⁵ Ibid., 213–15.

¹⁹⁶ see Dumett, *El Dorado in West Africa*, 190.

¹⁹⁷ European Employees of mining companies were accommodated in better built camps located on hills or highlands while camps for African employees were situated lower down in the valleys. By 1909, Europeans were accommodated in better type bungalows in which there was cross ventilation of the rooms, with relatively good wide verandahs and high rooms.

¹⁹⁸ GGC, 'Medical and Sanitary Report for the Year 1903' (London: Waterlow & Sons Limited, Printers, London Wall, 1904), 16, BOA, <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

attempts were made to improve African mining quarters during the first decade of the 20th century. The attempt, however, achieved mixed results. During his investigation of the plague outbreak in the Gold Coast in 1908, Simpson observed that “the native mining camps vary much in their sanitary condition, and even the best have the tendency to deteriorate.”¹⁹⁹

Thus, even while acknowledging that the native mining camp at Obuasi was well-laid out and houses built to conform to sanitary standards, with an added advantage of improved drinking water, Simpson also observed that sanitary conditions were fast deteriorating. He attributed this situation to the inefficiency of the sanitary committee that had been recently formed to maintain the sanitation of the town.²⁰⁰ He remarked that:

Recently a Sanitary Committee has been formed, but this Committee so far does not appear to have grasped the fact that it must demolish all the irregular huts that have been allowed to be built and which created, and are fast creating, insanitary areas, and only allow developments on lines similar to those on which Obuasi was first planned out...²⁰¹

In other African mining camps in the Wassa area of the Western Province, similar developments as those in Obuasi regarding the layout of the camps, improved buildings, and the availability of potable drinking water were noticeable by 1908. Indeed, by 1908, Dr Davidson had been appointed to supervise the sanitation of the native mining camps at Tarkwa and Aboso. Here, workers paid one penny a night for their huts towards the maintenance of the sanitation of the camp. At the Abbontiakoon mining camp, which adjoined that of Tarkwa, Dr Moir, the Medical Officer of the mine, had the additional responsibility of maintaining sanitation. Even so, the adjoining African villages as distinguished from the native mining camps, such as the native village of Tarkwa was reported to be badly laid-out, houses irregularly built with little or no ventilation, streets were strewn with rubbish, and surroundings encumbered by the bush.²⁰²

The lethargic attitude of the colonial administration and the mining companies towards the health and sanitation of mining villages and towns led to a considerable

¹⁹⁹ Simpson, ‘Report by Professor W.J. Simpson on Sanitary Matters’, 61.

²⁰⁰ see *ibid.*, 61–62.

²⁰¹ *Ibid.*

²⁰² *Ibid.*, 62–63.

lapse in the improvements that was started in the early 1900s. The crux of the problem related to the indifference of the colonial government towards the exercise of political power and administrative control at mining centres. The result was that a tenuous arrangement regarding sanitary administration was put in place in mining areas. Dumett captures the essence of this problem more succinctly:

From the start, Obuasi, controlled by a single concessionaire – the Ashanti Goldfields Corporation – was more like ‘a company town’ than any of the others; but even the AGC reneged on its responsibilities. At Obuasi and Tarkwa at least three entities – the mining companies, the colonial state and to a lesser extent the traditional kings and chiefs of the surrounding areas vied for municipal authority, but when the crunch came, each tried to withdraw from responsibilities of expenditure on town upkeep, public works and sanitary improvements. It was not deemed appropriate to apply the Town Council’s Ordinances of the Gold Coast in the mining towns since these Council’s (despite representation by educated African leaders) had experienced potent popular opposition and a very limited effectiveness in the three coastal cities where they had been implemented. There was some variation in the sanitary administration of the Wassa mining towns and those of Ashanti. At Tarkwa housing, street sanitation, sewage disposal and anti-malarial preventive measures were entrusted almost entirely to the companies, with some assistance from the local district commissioner. At Obuasi, because the Ashanti Goldfields Corporation did not want to shoulder the entire burden, responsibility was delegated to a Towns Sanitary Committee, towards which the company, the government and the local people (through municipal taxes), as represented by the headmen of ethnic subdivisions made contributions.²⁰³

The result of this tenuous sanitary and health administration was that by the 1920s, the sanitary conditions of mining towns was distressing – a situation that resulted in increased mortality of mine labourers. It was partly in response to this problem that the Secretary of State, RT. Hon. L.S Amery commissioned William Simpson to examine and report on the sanitary condition of the mines and mining villages in the Gold Coast. He was tasked to inquire into and report on the causes of high mortality among Native labourers employed in the mines, particularly, those recruited from the Northern Territories, and suggest remedial measures to be taken to mitigate these conditions.²⁰⁴

²⁰³ Dumett, ‘Disease and Mortality among Gold Miners in Ghana’, 216–17.

²⁰⁴ Simpson, ‘Report of the Sanitary Condition of the Mines and Mining Villages’, 3. Simpson was also commissioned to further investigate the cause of the second major outbreak of bubonic plague in Ghana during the first half of 1924.

Simpson arrived in the Gold Coast on 22 July 1924 and after an extensive tour of the mining areas reported that the high death-rate among miners related to a multiplicity of causes. One key cause being the prevalence of anchylostomiasis (hookworm infestation). He noted that the prevalence of anchylostomiasis related to the presence of infected and insanitary latrines in the mining villages that facilitated its spread due to constant re-infestation. Anchylostomiasis, while not fatal, lowered the vital powers of resistance in the body and increased the liability of an infected person to other diseases. Simpson noted that most of the causes of death in the mining villages resulted from the recruitment of youth from the Northern Territories, many of whom were already tuberculous and were, therefore, liable to break down soon after exposure to underground mining which they were unaccustomed to, and which was unsuitable for them in their condition. He observed further that unsatisfactory housing conditions, over-crowding, polluted and insufficient water supply, especially, in Aboso and Tarkwa, in addition to inadequate medical arrangements in most of the mines exposed labourers to diseases that resulted in their death.²⁰⁵

He subsequently recommended, *inter alia*, that in addition to recruiting healthy labourers and improving hospital accommodation, mine managers should provide improved sanitary amenities in the mines and mine villages and ensure their efficient supervision. He further recommended half-yearly inspection of sanitary conditions of mines and mine villages by a senior medical inspector of the sanitary department. Also, he instructed that all latrines both underground and above ground should be remodelled according to a type-plan which he provided. Latrines were to be inspected twice daily by a European supervisor to secure their cleanliness and disinfection. Furthermore, Simpson recommended that houses that accommodated African labourers should be remodelled to allow for adequate ventilation and lighting, and its walls secured from dampness. Each labourer, except those who were married, were to be assigned their rooms. The floors of all rooms were to be cemented and provided with at least a bed. Not least, he instructed the drawing up of layouts for villages adjoining mining camps. These villages were to have adequately spaced buildings

²⁰⁵ see Simpson, "Report of the Sanitary Condition of the Mines and Mining Villages" 4-10; GGC, "Report on the Medical and Sanitary Department for the Period April 1924 - March 1925," 20-21; see also, Dumett, "Disease and Mortality among Gold Miners in Ghana," 221.

with a “minimum width of streets” at thirty feet and “minimum distance” of eight feet in-between houses.²⁰⁶

Dumett has observed that Simpson’s report in spite of its castigating tenor, blaming the colonial government of failing to take its supervisory role of the mining companies seriously, “constituted one of the rare turning points in the history of public health administration where a commissioned report actually propelled policy change.”²⁰⁷ Indeed, by the first half of 1925, the medical inspection of labourers recruited from the Northern Territories as recommended by Simpson was already being implemented. At the same time, improvements in the sanitary arrangements at mines were also being carried out. For example, to contain anchylostomiasis among mine labourers, “precautionary measures” were adopted in 1925/26 “by improving the type of latrine both on the surface, and also, underground...”²⁰⁸

Similarly, a MOH was stationed at Tarkwa and charged with the responsibility to keep the mining health areas under proper sanitary control. Perhaps, the most important development following the release of Simpson’s report was the enactment of a legislation to provide for better sanitary control in mining areas. Ordinance No. 19 of 1925 known as the Mining Health Areas Ordinance was passed in January 1926 with a manifest aim to provide for the power to improve the health and housing of mine labourers.²⁰⁹ This ordinance was amended in 1935 as the Mining Health Areas Amendment and Extension Ordinance, No. 19. The regulations of the amended ordinance focused on the sanitation and condition of buildings in mining health areas, proper medical attention and in certain areas, depending on the number of labourers employed, for the building and maintenance of a hospital.²¹⁰

The ordinance also provided for the division of mining health areas into purely mining area (inner mining zone) comprising shafts, power stations, workshops, quarters for Europeans personnel and African labourers, and an outer area surrounding the mine area so demarcated, where conditions were likely to affect the

²⁰⁶ Simpson, ‘Report of the Sanitary Condition of the Mines and Mining Villages’, 9–10.

²⁰⁷ Dumett, ‘Disease and Mortality among Gold Miners in Ghana’, 221.

²⁰⁸ GGC, ‘Report on the Medical and Sanitary Department for the Period April 1925 - March 1926’, 16.

²⁰⁹ GGC, ‘Report on the Medical and Sanitary Department for the Period April 1924 - March 1925’, 21; GGC, ‘Report on the Medical and Sanitary Department for the Period April 1925 - March 1926’, 13.

²¹⁰ see GGC, ‘Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1935 - 36’, Annual, Colonial Reports (London: Her Majesty’s Stationary Office, 1936), 76.

health of mine employees. Mine managers were made responsible for the health conditions in the mining zone, while the government took responsibility for the outer zone.²¹¹ It was hoped that this new arrangement could help “prevent the occurrence of the grossly insanitary and overcrowded rookeries which surround many existing mines, and which are not only a menace but a reproach.”²¹²

Yet, reports on the general sanitation of mines and mining villages for most of the 1930s and beyond reflected mixed results – indicating both significant improvements as well as formidable challenges. Whereas official reports indicated improved sanitation there were also admissions that the existing conditions were still below the desideratum aimed. It was often reported that the influx of migrants of varying origins to mining areas and surrounding villages, and delayed application of the mining health ordinance to emergent villages within the vicinity of mining areas complicated sanitary control. Itinerant migrants, who had no obligations to local chiefs disregarded the sanitary directives of native authorities who oversaw sanitary administration in such villages.²¹³

From the late 1930s, a recurrent sanitary challenge in mining areas was the presence of stagnant pools that resulted from the excavation activities of surface miners. Without an effective legislation regulating surface mining, some companies left their excavated pits uncovered – and these became potential nursery sites for mosquito breeding.²¹⁴ Indeed, when the Provincial Commissioner of the Central Province visited Oda in 1937, ostensibly to inspect and confirm reports of neglected open excavations on the mining concession of the West African Diamond Syndicate, he was confounded by what he saw.²¹⁵ In a letter to the DDHS, he stated, among other things, that:

²¹¹ GGC, ‘Report on the Medical Department for the Year 1934’, 22–23.

²¹² *Ibid.*, 23.

²¹³ see GGC, ‘Report on the Medical Department for the Year 1936’, 30.

²¹⁴ see GGC, ‘Report on the Medical Department for the Year 1937’, 30–31 & 101–2.

²¹⁵ His visit was occasioned by a Memo that was written by the MOH of Oda in July 1937 to the DDHS complaining of uncovered ditches very close to the Oda town that had resulted from the mining activities of the West African Diamond Syndicate. His memo sparked series of exchanges between the DDHS, the Provincial Commissioner of the Central Province and the District Commissioner on the one hand and the DDHS and the concessionaire on the other. The tenor of discussions seemed undecided. Whilst the political and health officials felt that it was prudent that these excavations should be covered, they were also concerned that the mining company had neither the operational capacity nor the financial means to execute such an exercise. In

...The first point which struck me was the enormous extent of land which has been left with no attempt having been made to fill in the excavations caused by mining. Not only is this huge tract of land, which has reverted to bush, been rendered utterly valueless to posterity but it is to my mind a menace to the surrounding country-side by reason of its innumerable pools of water...²¹⁶

What appeared to be the most formidable sanitary challenge in mining areas, however, was the continuous erection of low standard houses and the presence of hovels and shanties within the vicinity of mining areas. It does appear that the slow pace at which mining companies improved existing houses and implemented new housing schemes created a situation where unsuitable and hastily constructed houses emerged within the vicinity of mining areas to accommodate mine labourers who could not be housed in mining quarters. Itinerant traders and other immigrants who thronged to mining areas in search of opportunities also complicated the housing problem as they either put up hovels to accommodate themselves or depended on inhabitants in mining villages who rented out to them hastily constructed structures. Indeed, in 1935, it was reported that “the standard of sanitation in the vicinity of mining areas is lamentably low.”²¹⁷ This observation referred “particularly to housing” and was “applicable more forceably(sic) to the privately-owned house.”²¹⁸ A similar observation was made a year later, when Dr Duke Whamond, the Ag. Senior Health Officer of Takoradi informed the DMS that “the sanitary conditions of the environs of the mining areas were far from satisfactory owing to the fact that a vast amount of uncontrolled building was taking place.”²¹⁹

And this problem persisted for a long time. For instance, in 1937 it was stated in the annual medical and sanitary report that:

It is sufficient to say...that the actual “mining areas” i.e. the areas controlled by mining companies themselves, good progress has been and is being made, the same unfortunately cannot be said of the corresponding “mining health areas” i.e. the areas immediately surrounding the “mining areas” where masses of hovels have sprung up and inhabited by a very cosmopolitan crowd...In such

the end, the company was advised to revise its method of operation and a suggestion was made for the introduction of a legislation to compel them to leave ground worked by them in a satisfactory condition.

²¹⁶ ‘From Ag. Provincial Commissioner, Cape Coast to Deputy Director of Health Services’, 18 September 1937, 2, ADM23/1/948, Central Regional Archives, Cape Coast.

²¹⁷ GGC, ‘Report on the Medical Department for the Year 1935’, 26.

²¹⁸ Ibid.

²¹⁹ “From D. Duff (Director of Medical Services) to the Deputy Director of Health Services: Sanitary Conditions of the Environs of the Mining Areas,” June 8, 1936, 1, CSO11/14/264, PRAAD, Accra.

mixed populations – badly housed and subject to little control, comprising gold-thieves, prostitutes, money-lenders and other hangers-on of a hardworking mining community – are apt to originate infectious diseases as well as other possibly far-reaching troubles.²²⁰

Two years later, the Governor, in his sessional address to the legislative council re-echoed the same position when he noted that whilst efforts were being made to extend control to villages within the vicinity of mining areas, the “mass of unauthorized buildings – hastily erected before full control was possible” would take time before they could be cleared away.²²¹

A key issue concerned the standard of building permitted to be erected in mining health areas and surrounding villages. Whereas the 1935 mining health ordinance set the same standard of housing for mining areas, and mining health areas, local concerns were that the standard was too high. However, the health department and political officials feared that if these local concerns were considered, the mining companies were likely to also insist on building similar low standard houses for their labourers. Consequently, the demands of the local people were often ignored.²²² The official explanation was that:

...Mining towns may be placed either under the provisions of the Towns Ordinance or under those of the Mining Health Areas Ordinance and a good deal of anxiety is felt with regard to them. The building standards required under the two ordinances are exactly similar and, although they are by no means high, many a prospective builder finds himself unable, or shows himself unwilling, to satisfy them. It is obvious, however, that were they to be lowered, the effect would be disastrous, as is proved by the unhappy fate of villages where legal action has not been possible in time to prevent a sudden inrush of squatters and the resulting mushroom growth of insanitary hovels.²²³

Unfortunately, what the colonial officials feared could happen, and therefore, sought to avert, played out in a different form and became the bane of sanitary control in mining areas. Most local people who were willing to build in mining villages but could not meet the set standards often drifted further into the rural communities away from the immediate vicinity of the ‘mining areas’ under sanitary control. And here,

²²⁰ GGC, ‘Report on the Medical Department for the Year 1937’, 30.

²²¹ Gold Coast Colony, ‘Legislative Council Debates: Session 1939, No.1’ (Accra: Government Printer, 1939), 11.

²²² see GGC, ‘Report on the Medical Department for the Year 1936’, 30–31.

²²³ GGC, ‘Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1938-39’, Annual (London: Her Majesty’s Stationary Office, 1939), 25.

uninhabited by control over building activities, erected sub-standard structures, creating new villages or adding to the populations in existing ones whose sanitary conditions, created anxieties in official circles.

Thus, even if the mining companies formulated and implemented 'admirable' housing schemes as was often reported in official circles, these were, as was stated in the 1938/39 general annual report:

...hampered by the existence of haphazard and badly constructed villages which in the past have sprung up with great rapidity outside but closely adjacent to the concession areas. The huts in these villages were built to no particular plan and no regard was had to lay-out or to method of construction. They were erected by petty financiers and let out to labourers working on the mines and to small storekeepers and others who depend for a livelihood on the labour employed by the mining companies. The inhabitants of these villages are mostly strangers to the districts and, as they owe no allegiance to the local Chiefs, it was difficult to exercise adequate control over them.²²⁴

Perhaps, if colonial officials had deployed pragmatic measures to address the concerns of the local populations who sought to build in controlled areas but could not afford the standards that were being demanded, such situation as is described above could have been contained.

Throughout the 1940s and beyond, colonial reports commended improvement in housing conditions in the mining areas, but also admitted the continuing presence of insanitary buildings and the persistence of overcrowding and deplorable insanitary conditions in many adjoining villages.²²⁵ The problem was an administrative lapse that related to a bigger challenge on how to deal with rural sanitation, generally. Whereas mining companies were made the responsible sanitary authority for mining areas, and government, for controlling the mining health areas, no provisions were made to address problems that could emanate from ancillary villages or emergent hamlets that were not gazetted as mining areas or mining health areas. In the absence of legislation, sanitary staff, financial means and the willingness of the government to deal with the sanitation of such villages their insanitary conditions often, worsened.

²²⁴ Ibid.

²²⁵ see GGC, 'Annual Report on the Gold Coast for the Year 1946'; GGC, 'Gold Coast Annual Report, 1950'.

This problem was succinctly elaborated by Selwyn-Clarke, the DDHS in 1936 when he explained to the DMS that:

Outside those areas that can reasonably be gazetted as mining and mining health areas, insanitary conditions are likely to be aggravated as time goes on owing to the lack of control. As you know, Sir, you and I have done our best in the past four years to endeavour to secure satisfactory legislation for rural areas in the Gold Coast and draft legislation has been before government for many months...until legislation of this nature is in force no effective steps can be taken to control rural health conditions and only incomplete control can be effected in townships in the colony proper through the emasculated Towns Ordinance.²²⁶

A close reading of the evidence also reveals the unwillingness of government to expend money on improving the sanitation of ancillary mining villages, and more generally, on rural sanitation. Indeed, whereas Selwyn-Clarke seemed to be acutely aware of the challenges that were giving rise to the insanitary conditions in villages surrounding mining areas he declared his unwillingness to approach the government for a special warrant to cover any additional cost that could extend sanitary services to rural communities. Perhaps, he was cautious, as he could anticipate what government position could be on such request. Because when the question was raised in 1936 about possible funding for sanitary work even in mining health areas that were ostensibly under government control, the response was that:

Once such a principle is conceded in the mining areas it must be conceded in other towns under the Towns Ordinance and the annual recurring expenditure which government must face in providing these fundamental services which ought surely to be furnished as they were before by chiefs and people themselves will be very considerable.²²⁷

It was, thus partly, the lack of commitment on the part of the government in improving the sanitation of rural communities more generally, that also affected the want of sanitary work in villages adjoining mining areas.

²²⁶ "From Deputy Director of Health (Selwyn Clarke) to the Director of Medical Services: Mining Areas, Insanitary Conditions of...", June 10, 1936, 2, CSO11/14/264, PRAAD, Accra.

²²⁷ "From the Director of Medical Service to Colonial Secretary," September 1936, 2, CSO11/14/264, PRAAD, Accra.

Conclusion

I have examined three major themes, viz, the management of shit, street cleaning and refuse disposal, and sanitation in rural and mining areas. Essentially, all these themes relate to how the colonial administration managed dirt in its various forms in different spaces with an intent to securing clean streets, neighbourhoods and homes in the various towns and villages where sanitary work was done. But, I also argue that the preoccupation with maintaining environmental sanitation also reflected an attempt to impose some form of order and control over the social landscape.

It has been argued that the kind of toilets that were constructed for use by the African population was primitive, inefficient, and their numbers inadequate. At the same time, the methods of removing and disposing of night-soil was also very primitive and ineffective. Thus, despite efforts to 'destroy' and reconstruct the toileting practices of the African population, the resort to primitive techniques only resulted in escalating the supposed unhygienic conditions that were targeted. In a similar vein, even while seeking to clear streets of filth, the use of badly constructed dust-bins, limited availability of incinerators, and inadequate labour to carry out scavenging activities impinged on the efforts to secure environmental sanitation. Furthermore, the lackadaisical attitude of the colonial state towards the sanitation of remote communities and mining camps ensured that, for most of the period examined, the sanitation of such areas improved but little.

Chapter Five

Health through Pipes: Towards Hygienic and Potable Public Water Supply, late 19th Century -1950

Introduction

One of the key sanitation problems that confronted the Gold Coast was the provision of potable water. In pre-colonial Gold Coast, water supply relied largely on the availability of natural surface waters including rivers, ponds, streams and dug-outs. These sources, as Veronica Fuest, has observed, were unreliable since they easily dried up during the dry season.¹ According to McCaskie, the Asante people have memorialised “nsu sa” (water wars), an urban folklore rooted in their long experience with water scarcity.² However, during the pre-colonial period, the quality of water could not have been an important concern. As Spencer Brown has argued, even in European societies where scientific research during the early 19th century had confirmed that surface water sources were prone to contamination, the quality of water was seldom considered “as long as the quantity...was adequate for their needs.”³

Yet, by the late 19th century, the connection between the lack of adequate water supply, sanitation facilities and diseases was firmly established in European aetiological thought.⁴ Scientist established that water could be bacteriologically impure and by the mid-century adopted a standard method of analysing water to detect germs.⁵ Thus, when the British formally colonised the Gold Coast, one of the earliest sanitary and health concern that found expression in official circles was the water supply situation. The existing water sources were generally held to be impure, unhealthy and unsuitable for human consumption.⁶

¹ Veronika Fuest, *Demand-Oriented Community Water Supply in Ghana: Policies, Practices and Outcomes* (Berlin: LIT Verlag Münster, 2006), 8.

² see Tom McCaskie C., ‘Water Wars in Kumasi, Ghana’, in *African Cities: Competing Claims on Urban Spaces*, ed. Francesca Locattelli and Paul Nugent, vol. 3, African-European Group for Interdisciplinary Studies (Leiden, Netherlands; Boston, MA: Brill, 2009), 136.

³ Brown, ‘Public Health in U.S. and West African Cities, 1870-1900’, 686.

⁴ see Philip D. Curtin, *Death by Migration: Europe’s Encounter with the Tropical World in the Nineteenth Century*, 1 edition (Cambridge: Cambridge University Press, 1989), 50–53.

⁵ see Brown, ‘Public Health in U.S. and West African Cities, 1870-1900’, 686.

⁶ see Bohman, ‘The Presence of the Past’, 140.

For instance, in 1886, the CMO observed that in Accra, not only was there an inadequate supply of wholesome water for human consumption, but also there was not good enough water even for bathing. The people, therefore resorted to dirty pools and ponds for their water supply. He observed that:

These dirty pools are both dangerous to life and health...that bathing in them must give rise to disease of various kinds is a fact which will be patent to anyone who will take the trouble to visit them and examine the water, which is of a vivid green, turbid and otherwise filthy...⁷

Thus, as McCarthy put it, "...for the want of water supply, the poor creatures are forced to wash their bodies in these stagnant ponds."⁸ But the presence of stagnant pools and ponds in Accra posed another challenge; they were potential breeding sources for mosquito larvae. As Gandy has noted, "water has a specific relationship with malaria."⁹ Indeed, the *Anopheles* mosquito, the vector for malaria, needs a water medium to breed larvae. Influenced by the prevailing epidemiological thoughts and believing that the stagnant pools and ponds in Accra were impure and injurious to health, McCarthy suggested to the government to: "give the people a water supply adequate to their wants...and fill up the ponds."¹⁰ The government took steps to remedy the situation. However, like other public health measures, the need for adequate and wholesome water supply remained one of the most enduring sanitary challenges in the Gold Coast throughout the colonial period.

This chapter discusses the provision of potable and piped water supply. I begin by examining the public water supply situation before the 20th century. I show that the technological and political arrangements that were adopted during the late 19th century to provide potable water in the Gold Coast, especially, in the principal towns were mostly inefficient. Early efforts to supply potable water during the late 19th century benefited mainly European colonial officials and few African elites. Nevertheless, influenced by the 19th century colonial ideology to transform Africans and African towns and compelled by the health imperative of supplying potable water, the colonial administration stepped up efforts during the 20th century to provide water through the

⁷ McCarthy, 'Enclosure 1 in No. 5: Sanitary Report on the Station of Accra for the Year Ending 31st December 1885', 108.

⁸ Ibid.

⁹ Gandy, *The Fabric of Space*, 84.

¹⁰ McCarthy, 'Enclosure 1 in No. 5: Sanitary Report on the Station of Accra for the Year Ending 31st December 1885', 108.

implementation of piped water supply schemes. I argue that the supply of potable water was as much a sanitary and public health measure as it was a part of the modernising agenda of the colonial administration.

Starting with Accra and Sekondi – the two most important towns in the Gold Coast at the beginning of the 20th century, the colonial administration took steps to extend piped water to other important townships and villages. By 1950, many important towns were either being supplied with piped water or schemes to provide them were ongoing. However, as it was with other public health measures, most rural communities remained neglected until the mid-1930s when the colonial administration, initiated schemes to provide wells and impounding reservoirs in villages and small towns. Yet, a mix of political and fiscal forces combined to impinge on the supply of potable water, both in urban and rural areas – so that by 1950, even though significant strides were made, a lot more remained to be done.

The Water Situation before 1910

Before the 20th century, no town or village in the Gold Coast had access to pipe-borne water. Most principal towns depended on rainwater, shallow wells, lagoons and ponds for their supply. In the rural areas, major sources of supply were from nearby streams and swamps. Without exception, these sources of supply were said to be polluted and disease-bearing.¹¹ In 1886 Dr Waldron, a colonial Surgeon for Keta, wrote that apart from one well, whose water when boiled and filtered was good enough to be used, all other wells in the town and surrounding villages were “highly impure”, although, used by the African population.¹²

¹¹ Addae, *The Evolution of Modern Medicine in a Developing Country*, 130; Bohman, ‘Framing the Water and Sanitation Challenge’, 62.

¹² GGC, ‘Sanitary and Medical Reports for 1886 and 1887’, 112.



Figure 6: Women Fetching Water from a Pond in Hausa Town, Sekondi. Source: Simpson, 'Report by Professor W.J. Simpson on Sanitary Matters', 112.

In a similar vein, Dr Eyles noted that in Cape Coast, the African population had no access to potable water. They, therefore, resorted to drinking “stinted and polluted water.”¹³ According to Addae, the domestic use of polluted water resulted in a high prevalence of intestinal diseases such as dysentery and parasitic infections such as anchylostomiasis and ascariasis that were common throughout the Gold Coast.¹⁴ Therefore, to reduce the incidence of such diseases and related water-borne infections, the colonial administration made efforts to provide potable drinking water.

As the logic of colonialism dictated, the official European population was privileged in the supply of potable water. In the principal towns such as Accra, Cape Coast, Sekondi and in all other administrative stations where Europeans were stationed, colonial officials were provided with metal tanks in which rainwater was stored.¹⁵ Few Africans, who could afford, also, stored their water in smaller tanks and

¹³ GGC, 'Sanitary and Medical Reports for 1886 and 1887', 115.

¹⁴ see Addae, *The Evolution of Modern Medicine in a Developing Country*, 130.

¹⁵ For example, in 1887 Cape Coast had a large subterranean water tank that supplied water to the government officials in the town. It was said to be “practically unlimited in quantity” except that without a buck-up tank to depend when it was emptied, it was difficult to keep it cleaned.

tubs. Most of the African population, was, however, left to store in vessels and pots in their compounds, water which they drew mostly from brackish ponds, swamps, shallow wells and lagoons.¹⁶ This discriminatory way of distributing potable water was a familiar feature of European colonial rule in Africa and other colonised territories. For instance, when in 1886, the French colonial administration introduced piped water to their settlement in Saint-Louis du Sènegal, it was confined mainly to the European part of the town. In a similar vein, the supply of piped water in the British part of Uganda during the second decade of the 20th century was limited to the part of Kampala where Europeans and Indians were settled.¹⁷



Figure 7: European Bungalow showing Metal Tanks that Collected and Stored Rainwater from the Roof. Source: Simpson, Report by Professor W.J. Simpson on Sanitary Matters, 110.

Some empathetic colonial health officials lamented the unfairness in the water supply situation. McCarthy, for example, complained in his 1884/85 report on Accra that:

¹⁶ Addae, *The Evolution of Modern Medicine in a Developing Country*; Simpson, 'Report by Professor W.J. Simpson on Sanitary Matters', 44.

¹⁷ see David Nilsson, 'The Unseeing State: How Ideals of Modernity Have Undermined Innovation in Africa's Urban Water Systems', *NTM Zeitschrift Für Geschichte Der Wissenschaften, Technik Und Medizin* 24, no. 4 (1 December 2016): 489, <https://doi.org/10.1007/s00048-017-0160-0>.

I cannot help remarking, and no one can deny, that our system here is an utterly selfish one with regard to the water supply. Whilst the official public are, and, as a rule, always have been, well supplied with pure water for all purposes, the wants of the general public in that respect have been comparatively ignored.¹⁸

He subsequently appealed to the government to, as a matter of fairness and justice, pay attention to the water supply needs of the African population. He stated:

As a constituted sanitary officer of this colony, however, and knowing as I do the evil effects in bodily health which accrue to the natives from drinking the foul ditch and brackish water which they do, I earnestly appeal to the Governor's sense of justice and humanity to deal promptly and in liberal manner with this important question.¹⁹

For McCarthy, "an abundant supply of good water..." was "the first sanitary necessity"²⁰. McCarthy's concern reflects a broader discourse during the 19th century that emphasised the need for the development of sanitary infrastructure including water. This discourse was constructed, *inter alia*, around the question of modernity and development and this resonated throughout the European colonial agenda during the 19th century and beyond.²¹

Either way, the supply of adequate water during this period remained a formidable challenge. Whereas rainwater remained largely unreliable and inadequate to provide the quantity that was needed to supply to everyone, Europeans and Africans alike, the lack of adequate storage facilities further complicated the situation. For instance, in 1885/86, it was noted that at Keta, the water tank could not store adequate water to meet all the needs of the European staff.²² Similarly, Governor Griffith describing the water situation in Christiansborg and Accra during the same period, complained to the Colonial Office that:

...The question of finding accommodation for that quantity of water is closely allied with being able to get the water, and if the experience of 1885 and 1886 so far is to be repeated, the rainfall will be inadequate to supply our wants...²³

¹⁸ McCarthy, 'Enclosure 1 in No. 5: Sanitary Report on the Station of Accra for the Year Ending 31st December 1885', 108.

¹⁹ Ibid.

²⁰ Ibid.

²¹ see Nilsson, 'The Unseeing State', 489.

²² see GGC, 'Sanitary and Medical Reports for 1886 and 1887', 106.

²³ Ibid., 104.

Compelled by the need to ensure regular, adequate and potable water supply to European officials in Accra, Griffith, in May 1886, initiated the construction of additional water tanks that could store two hundred and sixty-five thousand gallons of rainwater. And perhaps, in response to the appeal by McCarthy, Griffith also commissioned the construction of a reservoir that could store two million six-hundred and twenty-six thousand four-hundred and twenty-five gallons of water for the use by the African population.²⁴ The reservoir was completed and opened for use in September 1887.²⁵ In 1888, amidst protest from the African population, two unredeemable polluted ponds were closed and two new sources of supply, the Victoriaborg and Akimbo reservoirs were opened for the African population.²⁶ But these were “simply open ponds where people waded in and collected water in vessels. Pigs frequented them as were people, and they quickly became polluted.”²⁷ Besides, without sufficient rainfall to fill the reservoirs, their construction could not have been of any significant consequence.



²⁴ Ibid.

²⁵ GGC, 'Sanitary and Medical Report, September 1887', 51.

²⁶ Patterson, 'Health in Urban Ghana', 253.

²⁷ Ibid.



Figure 8: Victoriaborg Reservoir. Source: Simpson, Report by Professor W.J. Simpson on Sanitary Matters, 111.

Therefore, to solve the perennial water problems of Accra, the government, at various times during the late 19th century looked for alternative sources of water supply. For instance, in 1887, Accra's water supply was being supplemented with water from a rivulet in the village of Beulah located north-west of the town – and the government was considering the possibility of damming this rivulet.²⁸ In the meantime, the government instructed the Public Works Department to conduct a topographical survey of the rivers, Humo (Densu) and Insackey (Insakye) in the Aburi-Akropong range of hills to explore the possibility of bringing more water to Accra using pipes.²⁹ The MOH of Accra, Dr Easmon believed that this was “the most practical method which has presented itself to the Surveyor General.”³⁰ He noted that to be able to pump water to Accra from these areas was important “from a hygienic as from a socio-economic

²⁸ GGC, ‘Sanitary and Medical Reports, June 1887’, 12.

²⁹ *Ibid.*, 4.

³⁰ *Ibid.*

point of view.”³¹ The Densu River provided the most promising prospect as a source of supply to Accra. However, in 1895 the scheme was dropped because the quality of the water was not considered good enough for human consumption.³² The government was, therefore, compelled to consider other probable schemes and alternative sources of supply.

Subsequently, many proposals were considered. Among them included the proposal to construct an impounding reservoir at the back of Victoriaborg, the construction of artesian wells, and a scheme to pump water from the Adjamenta valley near Aburi.³³ The colonial government favoured the artesian well scheme.³⁴ Yet, probably because of cost, the government resorted to the boring of regular shallow wells. Many of the borings, however, proved unsatisfactory as the water that was obtained were reported to be mostly brackish. An observation by Simpson is instructive:

Much time was wasted on the artesian well scheme, the result being that there was never any attempt to make a deep artesian well because there was never any apparatus for the making of it. One bore well of a depth of 206 feet was made near the sea and seven bore wells of 30 to 114 feet were sunk in the valley some two miles north of Accra, and because the water was brackish, further boring was abandoned.³⁵

The problem was that the borings were never deep enough to obtain the quality of water that was required. This situation was known even to the Director of Public Works, Mr Anderson, whose suggestion for deeper borings was ignored.³⁶ Most probably, Anderson’s suggestion was disregarded because of the cost implication of boring deep artesian wells. As Gandy illustrates from his case studies of water supply in selected cities in the global North and South during the 19th century and beyond, “even when expert opinion had settled on a solution to the health-threatening effects

³¹ Ibid.

³² Quote in Simpson, ‘Report by Professor W.J. Simpson on Sanitary Matters’, 45.

³³ Adjamenta seems like a corruption of Adenta, a town North-west of Accra and close to Aburi. In any case, the Adjamenta valley scheme was abandoned because the water found there was found to be inadequate. See Patterson, “Health in Urban Ghana”

³⁴ These are wells that are dug to tap into a confined aquifer or in simple in terms porous and permeable rock that absorbs and store water and under natural pressure, water rises upward to the surface without pumping. See http://www.env.gov.bc.ca/wsd/plan_protect_sustain/groundwater/flowing_artesian_wells.pdf. Accessed on 12/06/2018.

³⁵ Simpson, ‘Report by Professor W.J. Simpson on Sanitary Matters’, 45.

³⁶ see *ibid*.

of inadequate infrastructure (in this case water), insufficient capital prevented such solutions from being implemented.” Gandy’s observation reflects the situation in the Gold Coast. Addae has suggested that in the Gold Coast, the colonial administration aimed for a modest water supply scheme that could be implemented at a lesser cost because of the limited availability of funds during the 19th century to support an elaborate water supply scheme.³⁷ Addae’s position is corroborated by Jonathan Roberts’ argument that the dictates of the colonial economy did impinge on funding for public health reforms in the Gold Coast in ways that were insensitive to the ordinary European population and Africans alike.³⁸

Apart from Accra, other towns and villages along the coast and further inland were also confronted with the lack of potable water. Health officials, were, therefore, often engaged in pressing the government to devise measures to ameliorate the situation and suggested possible schemes for consideration. For instance, in 1887, Dr Sullivan of Cape Coast suggested that water should be pumped from the river Kakum, a tributary of the Sweet River using windmill pumps to supplement the supply of the town. Sullivan had made the same suggestion in 1885 regarding Elmina. His proposal found resonance with other Assistant Colonial Surgeons such as Dr Rat who believed that the most practical method to get water to Elmina was to adopt Sullivan’s proposal.³⁹ In subsequent years, other medical officers continued to press the idea on the government, compelling Governor Griffith to in 1891, eventually consider the possibility of implementing the proposal. In a letter to Lord Knutsford in the colonial office that year, he gave the assurance that he hoped to implement the proposal when revenue improved.⁴⁰

However, it does not seem that this proposal was ever implemented, and the water supply situation of the African population in Cape Coast did not improve before the 20th century. For example, in 1888, while the European population was served by harvested rainwater stored in three metal tanks, the African population relied on wells that were sunk in different parts of the town for their water supply. The water from

³⁷ Addae, *The Evolution of Modern Medicine in a Developing Country*, 132.

³⁸ Jonathan Roberts, “Sharing the Burden of Sickness: A History of Healing in Accra, Gold Coast, 1677 to 1957.,” 2015, 166, <https://dalspace.library.dal.ca/handle/10222/56339>.

³⁹ GGC, ‘Sanitary and Medical Report, November 1887’, 46–48.

⁴⁰ Addae, *The Evolution of Modern Medicine in a Developing Country*, 132.

these wells was anything but potable as they were said to be often contaminated. Dr Waldron, the Assistant Colonial Surgeon for Cape Coast during 1888, reported that:

The water of the market well is brackish to drink and too hard for washing purposes. The Aboom and Kotokuraba wells are about a mile from the sea, and a quarter of a mile from one another by road. As there is no one to look after the wells, the water is contaminated with organic matter by the people, who wash their persons and their clothes around them.⁴¹

Similarly, in other important stations such as Ada, Keta, Sekondi, Axim, Winneba and other areas where some sanitary work was being done, there was hardly any improved water supply scheme before the 20th century. For instance, in Winneba wells and water from streams remained the major sources of supply for most of the period under consideration.⁴² In Axim, a dam was constructed in 1887, yet it could not supply potable water to the public because it was often contaminated and rendered useless for drinking purposes.⁴³

In Ada, neither the European officials nor the African population was properly served with clean and potable drinking water. Both the European and the African population relied on wells that were owned by private individuals. A report by the Assistant Colonial Surgeon of Ada in 1888 is instructive:

... In the absence of a Government tank for storing rainwater, I advised the sinking of a well for the special use of the District Commissioner and the Medical Officer, and other wells in the town for the general public. There is, at present, a well between the District Commissioner and the Medical Officer's quarters dug by the landlord of these quarters at his own expense. The well, being his private property, there is no control over it by the Government, and I have seen grown-up women, boys and girls going down into the well in a state of semi-nudity to recover buckets, calabashes, country cloths, &c. which may have dropped in; and besides, the rush of the people for the water makes the well supply an inconstant one. The natives bathe near the well at night, and when any remonstrance is made they allege that they have the permission of the landlord to use the well water. It is not used by me or the District Commissioner for drinking purposes and we have still to rely on the local merchants for our supply of drinking water. The inhabitants of the district are sadly in need of water and they have to go great distances for the well water of private individuals.⁴⁴

⁴¹ GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 57.

⁴² GGC, 'Sanitary and Medical Report, November 1887', 45.

⁴³ GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 4.

⁴⁴ *Ibid.*, 45.

Similarly, in Keta, good fresh water was said to be a rarity. There were few wells which did not supply sufficient quantity of good water.⁴⁵ In Sekondi, European supply at the beginning of the 20th century depended on rainwater. However, for most of the African population, their supply was from “various water holes” that were scattered in different parts of the town. These were usually not very deep, mostly without covers, and the water brackish. The only source of good supply was about a mile away in the outskirts of the town. A section of the lagoon in the town which had drinkable water and supplied the Hausa quarters was also reported to be often liable to pollution from the activities of the inhabitants, viz, washing too close to the lagoon, and commuters from adjoining villages, defecating in the bush close to the lagoon.⁴⁶

In Kumase, European supply remained of comparatively good quality. The Africans, however, obtained their supply from swamps, streams, and shallow wells, making intestinal worm infestation very common among them.⁴⁷ Thus, by the beginning of the 20th century, a solution to the water supply problem in the colony was yet to be found. Nowhere in the Gold Coast was the African population supplied with potable and clean water. And while the official European population seemed to be comparatively well-served, the colonial administration admitted that inadequate water supply was one major difficulty impinging on sanitation.⁴⁸

Towards the Provision of Clean and Potable Public Water Supply, 1910-1950

By 1910, only one town, Obuasi in Asante had pipe-borne water which was provided by the mining company operating there. However, in that year, steps at implementing comprehensive pipe-borne supply schemes were initiated. The first towns to benefit were Accra and Sekondi – undoubtedly, the two most important coastal towns during the early part of the century.

The Accra public water scheme was long time in maturing. Still struggling to find a suitable and reliable source of supply, the government, in 1907, revisited the Densu river as a probable source for public water supply to Accra. A scheme was

⁴⁵ Ibid., 65.

⁴⁶ see GGC, ‘Annual Medical and Sanitary Report on the Gold Coast Colony for the Year Ended 31st December 1901’, 31.

⁴⁷ GGC, ‘Medical and Sanitary Report for the Year 1902’, 18.

⁴⁸ see GGC, ‘Annual Report for 1898’, Annual, Colonial Reports - Annual (London: Darling & Son Ltd., 1899), 27.

subsequently designed and a cost of £123,000 was estimated and presented to the government. By 1909, subsequent investigations regarding the feasibility of the project had raised the cost of the project to almost £200,000.⁴⁹ This time, however, the quality of the Densu river water was favourably reported on by the analyst. The cost of the scheme relative to how many towns could benefit, however, raised concerns. For example, Simpson questioned the usefulness in implementing such a costly scheme which would serve only the people of Accra at the expense of the many towns and villages that were equally in need. He noted:

Whether a small town the size of Accra can afford such a scheme is for government to consider. There are other towns on the Gold Coast which require water schemes, and it will be impossible to spend over them similar sums of money...⁵⁰

Simpson, therefore, put the question to the government: "If there is no escape from a costly scheme, could it not be one that would supply more than one town?"⁵¹ Simpson was not convinced that the geological surveys that were conducted had "exhausted the possible sources of supply or have contemplated the possibility of providing other towns with the same water."⁵² Nevertheless, in 1910 the government decided on the Densu scheme. The public works department was subsequently tasked to execute the project at an estimated cost of £253,000.⁵³ Two impounding reservoirs and a pump house were to be constructed on the Densu at Weija (referred to as Weshiang in the colonial records), a town located to the South-west of Accra.⁵⁴

The scheme could store up to forty-five million gallons of water and could supply five-hundred thousand gallons per day.⁵⁵ The central government absolved the cost of the scheme since the Accra Town Council could not finance such a large-scale scheme.⁵⁶ By the latter part of 1913, while work was still in progress, the first supply of water was made to some sections of Accra. On 10 January 1914, Governor Hugh Clifford officially opened the general supply of water to Accra. Subsequently,

⁴⁹ Simpson, 'Report by Professor W.J. Simpson on Sanitary Matters', 47.

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Bohman, 'Framing the Water and Sanitation Challenge', 68; Patterson, 'Health in Urban Ghana', 253.

⁵⁴ The Densu river takes its source from the Atewa range in the eastern region and flows towards the Akwadum – Koforidua. From here, it changes course and flows in a southerly direction towards Weija.

⁵⁵ Bohman, 'Framing the Water and Sanitation Challenge', 70; Patterson, 'Health in Urban Ghana', 253.

⁵⁶ Bohman, 'Framing the Water and Sanitation Challenge', 68.

distribution mains were laid, public standpipes and taps erected, and connections to private homes, especially, bungalows of European officials, were commenced. By 1915, the Accra public water works scheme was fully operational.⁵⁷

The decision to implement the Accra public water works scheme, despite its high cost, rather than pursue an alternative scheme that could have yielded to the supply of potable water to many towns as was suggested by Simpson should be interpreted beyond the public health imperative. It reflects the colonial vision of building a 'civilised' and 'modernised' capital city for the Gold Coast, which at this period, was regarded by Britain as its model colony in British West Africa.⁵⁸ As Njoh and Akiwumi have argued, colonial development schemes that targeted the provision of "modern water and sanitation facilities in Africa" were part of the "modernisation initiatives of the colonial project on the continent."⁵⁹ For them, attempts by colonial authorities in Africa to promote western environmental design standards, complete with networked pipe-borne supply systems and sanitation formed part of a larger colonial initiative that aimed to replicate miniature versions of European cities and townships on the continent.⁶⁰

Along similar lines, David Nilsson has observed that it was the "pursuit of modern ideals" that goaded colonial officials and their supporting staff of urban engineers and planners to "import European water technology..." into Africa.⁶¹ Thus, by implementing the Accra piped water scheme, the colonial administration was as concerned about improving the public health as it was interested in creating the needed infrastructure required of a modern capital city befitting of a 'model colony.' According to Anna Bohman, British colonial administrators, generally "looked upon the African population as primitive and it was viewed as the white man's burden to provide a well-planned water and sanitation infrastructure" as part of efforts at transforming

⁵⁷ see GGC, "Gold Coast Report for 1913," Annual (London: Printed under the authority of His Majesty's Stationary Office by Barclay and Fry Ltd., 1914); GGC, "Gold Coast Report for 1914," Annual (London: Printed under the authority of His Majesty's Stationary Office by Barclay and Fry Ltd., 1915); Bohman, "Framing the Water and Sanitation Challenge"; Patterson, "Health in Urban Ghana."

⁵⁸ see John Parker, *Making the Town: Ga State and Society in Early Colonial Accra* (Portsmouth, NH; Oxford; Cape Town: Heinemann; James Currey; David Philip, 2000). 196.

⁵⁹ Ambe J Njoh and Fenda A. Akiwumi, "The impact of Colonization on Access to Improved Water and Sanitation Facilities in African Cities," *Cities* 28 (2011): 454.

⁶⁰ see *ibid.*

⁶¹ Nilsson, 'The Unseeing State', 482.

'native' lives.⁶² It was, thus, implicit in the British imperial ideological setting, Bohman has argued, that "bringing water and sanitary order into the [Gold Coast] colony" was part of the "Victorian civilising mission."⁶³ Stated differently, the provision of potable water as a sanitary measure provided a powerful link between improved public health and the colonial conception of modernity. Gandy considering the cultural and material significance of water has illustrated that water constituted part and parcel of the material culture of modernity, "ranging from the private spaces of the home to vast technological networks that enabled the growth of cities."⁶⁴

The manifest motivation for extending pipe-borne water supply to Sekondi, in 1910, however, seemed to reflect more of the public health agenda of the government. Nevertheless, it does also betray the tensions between the narrow self-interest and the wider public health ambitions of the colonial administration. Addae has observed that the selection of Sekondi as one of the first towns to benefit from the public pipe-borne water scheme was linked to the yellow fever outbreak in the town in 1910 which caused nearly a hundred per cent fatality amongst the European population. The Sekondi scheme, was thus, a manifest solution to halt European mortality from a disease whose cause could be linked to the lack of potable water, even if remotely. This was rather a global phenomenon during the 19th century which seems to have endured even beyond the 20th century. As Gandy has observed, in most cities, both in the global North and South, sometimes, it took the repeated occurrence of disease outbreaks, for urban administrations to take concerted action to provide water infrastructure.⁶⁵

The Sekondi waterworks was sited at Inchaban and its source of supply was the River Anankwan. The completion of the Sekondi scheme was delayed until 1916, two years after the Accra scheme was inaugurated. According to Addae, the delay was because of the outbreak of the First World War.⁶⁶ Faced with financial constraints and labour shortages arising from the outbreak of the war the colonial administration had to choose between the Accra and Sekondi projects, which one to complete first.

⁶² Bohman, 'The Presence of the Past', 140 Emphasis added.

⁶³ see *ibid.* Emphasis added.

⁶⁴ Gandy, *The Fabric of Space*, 2.

⁶⁵ see *ibid.*, 5.

⁶⁶ see Addae, *The Evolution of Modern Medicine in a Developing Country*, 133.

Accra being the colonial capital was given the first preference. However, challenges regarding the acquisition of suitable land on which to build the dam and the impounding reservoir also delayed the start of the Sekondi scheme significantly. Again, delays in the completion of ancillary works such as the construction of railway tracks to the Inchaban site also contributed to the stalled completion of the scheme.⁶⁷

As expected, the inauguration of the Accra and Sekondi water works afforded the consistent supply of water to the inhabitants of these towns. However, it did not result in the immediate improvement in the quality of water. Indeed, in 1914, the resident engineer of Accra remarked that:

As regards quality...it cannot be said that a safe drinking water has yet been produced, and analysis shows that the samples (taken at Weshiang) do not so far conform to those standards of purity which were guaranteed by the contractor.⁶⁸

An analytical chemist who was appointed in 1915 to conduct water analysis at Weija also concluded that the supply was bacteriologically impure.

By 1917, the problem persisted. It was, therefore, concluded, that the multiple filtration and aeration system (also known as the peuch-chabal system) which was used in treating the Densu water was incapable of producing the desired result. Subsequently, on the advice of Professor Simpson and Dr Houston on the need for further treatment, a local committee was formed to conduct experiments to ascertain the best means of purifying the water. The committee submitted its report in December 1918. The committee recommended that the best means of rendering the water pure was to adopt the *Excess Lime* method.⁶⁹ The committee noted that:

...the Excess Lime Process was capable of freeing the water supplied to Accra from bacillus coli and rendering it epidemiologically safe, whilst at the same time bringing it up to the standard required chemically and leaving little to be desired from the point of view of taste and visuality(sic).⁷⁰

⁶⁷ see GGC, "Gold Coast Report for 1911," Annual (London: His Majesty's Stationary Office, 1912), 41; GGC, "Gold Coast Report for 1913," Annual (London: Printed under the authority of His Majesty's Stationary Office by Barclay and Fry Ltd., 1914), 31.

⁶⁸ GGC, 'Medical and Sanitary Report for the Year 1914', 43.

⁶⁹ GGC, 'Medical and Sanitary Report for the Year 1918' (Waterlow and Sons Ltd., 1919), 29, BOA, <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.

⁷⁰ Ibid.

The method was adopted and applied in Accra. Subsequently, periodic bacteriological examination of water samples from the final filters and standpipes was instituted. And it was reported that "...the ability of the Excess Lime process to render the water epidemiologically safe was...beyond doubt."⁷¹ Unfortunately, while the Sekondi water supply had similar challenges, the same experiments could not be extended there immediately because of the unavailability of personnel and equipments.⁷² Instead, during the latter part of 1919, a committee was appointed to carry out separate experiments regarding the desired purification of the water supply. The committee then appointed a sub-committee comprising the Maintenance Engineer, the Inspector Chemist and the MOH to draw up a scheme. Having the benefit of the results of the experiments in Accra, the committee decided to focus on experimenting on the comparative effects of *Excess Lime* and of *Alum Sulphate* in purifying and decolouring water and on the sterilising effect of chlorine.⁷³ In the end, the chlorination process of purifying water was adopted and in 1920 and it was reported on favourably.⁷⁴ Curiously, by 1920, the *Excess Lime* process had started to produce an unsatisfactory result in Accra. Consequently, the health branch contemplated adopting the chlorination process that was in place in Sekondi. Chlorination in Accra, was, however, not adopted until 1929.⁷⁵

In the meantime, in townships and rural communities where pipe-borne water was yet to be extended, the colonial administration took steps to improve the quality of their water supply by implementing measures to prevent pollution, especially where there were wells. In this regard, some wells in principal towns were covered, cased with cement, and fitted with hand pumps.⁷⁶ The colonial administration made sure that the provision of more wells and pumps were featured in sanitary improvement programmes.⁷⁷

Yet, these efforts were piecemeal, and was thus, long in achieving the desired outcome. For instance, in 1910, there were only fifty-eight public wells in the colony

⁷¹ GGC, 'Reports on the Medical and Sanitary Department for the Year 1919', 17.

⁷² Ibid., 48.

⁷³ Ibid., 18.

⁷⁴ GGC, 'Report on the Medical Department for the Year 1920', 20.

⁷⁵ Patterson, 'Health in Urban Ghana', 254.

⁷⁶ see GGC, 'Medical and Sanitary Report for the Year 1910'.

⁷⁷ see GGC, 'Medical and Sanitary Report for the Year 1914', 43.

proper, Asante and the Northern Territories. By 1913, the number had increased by only seven, making the total number of wells in the entire Gold Coast sixty-five. In 1914, there were only sixty-six public wells. Many people, thus, depended on private wells and other sources for their water supply. The quality of water from these wells, public or private, could not be guaranteed. For example, in 1911, it was reported that:

Wells are so open to pollution that it is considered unreasonable to expect owners of private wells, who are mostly poor, to expend money on pumps. On the other hand, wells cannot be closed until some better supply of water is substituted; it is a serious problem.⁷⁸

Thus, during the first two decades of the 20th century, the water supply situation in most of the towns and villages remained a critical challenge. Indeed, in 1913, the health branch admitted that water supply to the Colony Proper and the Northern Territories constituted a significant challenge. This was particularly the case in towns and villages in the sea-board along the southern coast that relied on surface wells. These wells supplied mostly some non-potable brackish water during the dry season. In the Northern Territories, the nature of the soil being sandy, was not conducive for the construction of wells. Therefore, most of the wells that were bored, their sides not properly lined, caved in easily during the rainy season.⁷⁹ The result was that until piped water and more efficient boreholes and wells were extended to the Northern Territories, access to potable water remained a formidable challenge – the situation reaching unbearable levels during the dry season.

After World War I, however, the colonial administration stepped up efforts at extending potable water to various parts of the Gold Coast. This was part of broader efforts to invest in, and improve on, the social services. Such investments and improvements were undoubtedly motivated by the improved revenue of the colonial administration deriving from its expanding export trade, of which the chief export item was cocoa.⁸⁰ The improved revenue enabled the government to increase,

⁷⁸ GGC, 'Medical and Sanitary Report for the Year 1911', 197.

⁷⁹ GGC, 'Medical and Sanitary Report for the Year 1913', 28.

⁸⁰ see George Edgar Metcalfe, *Great Britain and Ghana: Documents of Ghana History, 1807-1957* (London: Published on behalf of the University of Ghana by T. Nelson, 1964), 575–604. Notable developments during this period, included the construction of the deep-water port in Takoradi, the extension of the railway network in the colony, the establishment of the Achimota College, expansion work on the Korle-Bu hospital, among others.

substantially, expenditure on social investments – and this included significant investment in sanitation, including the provision of potable water.

The Ten-Year development plan on economic and social development which was implemented during the Guggisberg administration (1919-1927) enabled varying degrees of development regarding public health more generally.⁸¹ In this regard, significant improvements were recorded in the existing water supply in Accra and Sekondi. Also, pipe-borne water was extended to other urban centres.⁸² For Guggisberg, the Gold Coast could only experience real progress if the government could spend “every penny” it could “justifiably afford” on improving the “...inadequate facilities for transport, education and sanitation.”⁸³ Guggisberg’s concern for improving social amenities, benign as it may seem, reflects the European “civilising mission” that sought to transform Africans in ways that could enable their incorporation into the global capitalist economy by providing them socio-economic amenities including public health services.⁸⁴

By investing in water supply, Guggisberg was not only concerned with improvements in sanitation and public health. Rather, he envisaged that any improvements in water supply will inure to an inestimable benefit in the long-term socio-economic developments and the general welfare of the people. Thus, during his tenure in office, every effort was made to improve existing water supply systems as well as the extension of potable water to other principal towns and villages. In 1921, schemes for extending piped water to Kumase and Winneba was being considered. The decision to extend piped water supply to Kumase, however, predates Guggisberg, yet any attempt to implement a water supply scheme for the town delayed until the late 1920s for reasons which will be discussed below.⁸⁵ However, in 1923, pipe-borne

⁸¹ For instance, in 1923, the colonial administration spent a sixth of the revenue of the colony on public health.

⁸² see Bohman, ‘Framing the Water and Sanitation Challenge’, 70; Metcalfe, *Great Britain and Ghana*, 594.

⁸³ Quote in Bohman, ‘Framing the Water and Sanitation Challenge’, 70.

⁸⁴ see Stephan F. Miescher, “‘Nkrumah’s Baby’: The Akosombo Dam and the Dream of Development in Ghana, 1952-1966.’, *Water History* 6, no. 4 (December 2014): 341–66

⁸⁵ Before a piped water scheme was implemented in Kumasi, the African population relied mostly on wells, streams and springs, and in few instances, on tanks for their water supply. In 1925, a scheme was developed to increase the number of tanks in European residential areas and for the pumping of water from public wells which was to be chlorinated before they could be drawn by the public. When completed, this remained the major supply to Kumasi until 1934 when a piped water scheme was completed for use as I discuss in more detail below.

water supply was inaugurated in Winneba.⁸⁶ In his 1924 address to the Legislative Council, Guggisberg lauded how the extension of piped water supply to Winneba was proving “a boon and a blessing to the inhabitants... who in the past” had “suffered much from the lack of pure, wholesome drinking water.”⁸⁷

In the same year, 1924, a decision was made to increase the capacity of the Accra water works as the existing supply could not meet the demands of the growing population. Subsequently, between 1925 and 1931 additional reservoirs were constructed and new plant installations were built in different parts of the town to improve supply.⁸⁸ By 1931 the health branch could report satisfactorily on developments regarding water supply in Accra noting that “In Accra, the new service reservoir has apparently overcome the deficiency in pressure, previously experienced in many parts of the town.”⁸⁹ In the meantime, in Cape Coast, efforts to provide piped water was started in 1923. In that year, “Kakum Su, a tributary of the Sweet River” close to the town, was selected as a dam site for “Raw Water Abstraction” to the town’s water supply. The water supply, was, however, not opened until December 1928.⁹⁰ According to Bohman, the delay was because of lengthy discussions concerning choices that had to be made regarding technical details on the building of the waterworks, materials to be used and methods of purification to adopt.⁹¹

Coincidentally, the completion of the Cape Coast water supply scheme marked the commencement of the Kumase waterworks scheme which had been on the drawing board since the early 1900s. In 1928, a scheme estimated to cost £250 000 was approved for Kumasi and the Owabi Su – located in a village by the same name, about seven miles to the north-west of the town was selected to be the main source of water supply. The development of the Kumase scheme had a long-winding and complicated history. Its beginnings date to 1914 when the colonial administration

⁸⁶ GGC, ‘Report on the Medical Department for the Period April 1923 - March 1924’, 15; GGC, ‘Report on the Medical Department for the Period January 1922 - March 1923’; Bohman, ‘Framing the Water and Sanitation Challenge’, 71.

⁸⁷ Metcalfe, *Great Britain and Ghana*, 594.

⁸⁸ Addae, *The Evolution of Modern Medicine in a Developing Country*, 134; see footnote 32 in Bohman, “Framing the Water and Sanitation Challenge,” 70.

⁸⁹ GGC, ‘Report on the Medical Department for the Year 1930-31’, 36.

⁹⁰ see GGC, ‘Report on the Medical and Sanitary Department for the Period 1928-1929’; Bohman, ‘Framing the Water and Sanitation Challenge’, 71.

⁹¹ Bohman, ‘Framing the Water and Sanitation Challenge’, 71.

commissioned Sir William Duff, a sanitary engineer who had experience in creating piped water schemes in Bombay and Nagpur, to do the same for Kumase. After inspecting the existing supply sources, Duff concluded that there was an urgent need for piped water in the town. He subsequently conducted topographical surveys of the lake Bosomtwe, the Offin and Oda rivers, as possible supply sources and judged that river Oda was the most suitable. He selected Esereso on the Oda, eight miles south of Kumasi as dam site. He estimated that when completed the Esereso scheme could provide Kumase with five-hundred thousand gallons of water a day and the total budget was estimated at £297, 000.⁹² The project was, however, shelved following the outbreak of the First World War. However, according to McCaskie, the government demurred at the scheme because of the cost involved.⁹³ In any case, the Esereso scheme was finally abandoned following a reassessment in 1917 which found the site to be unsuitable as the Oda river was found to experience heavy seasonal silting.

After the war, the colonial government, once again, initiated attempts to find a suitable site. This time, the search focused on the river Offin. Following a geological survey in 1920, Mprem on the headwaters of the Offin was discovered to have a better throughput of water flow. Mprem was therefore selected as the dam site. However, once again, this scheme was abandoned, not only because the estimated cost of £644,000 was found to be overly expensive, but also, because a second geological survey revealed that the Mprem waterbed could not sustain a dam.⁹⁴ Thus, when subsequent surveys eventually, identified in 1928, the Owabi river - a westward flowing tributary of Offin as a suitable source of supply, it was a welcoming news – not least, because the estimated cost of this scheme was, also, less compared to the two previous schemes.⁹⁵

The government approved the Owabi scheme and included it in the budget for 1930. Four years later, on 29 March 1934, the Chief Commissioner of Asante inaugurated the pipe-borne water supply for Kumase, the project having been

⁹² McCaskie, 'Water Wars in Kumasi', 137; William Sir Duff, *Report to the Governor on a Survey of Water Resources in Ashanti with Recommendations for Introducing a Piped Water Supply to Kumasi* (Accra: GGC, 1914).

⁹³ see McCaskie, 'Water Wars in Kumasi', 137.

⁹⁴ see *ibid.*, 138.

⁹⁵ see McCaskie, 'Water Wars in Kumasi'. Owabi is also the name of the village where the river is found.

completed at a cost of about £225,100, a little less than the initial estimated budget.⁹⁶ With an impounding reservoir that could hold up to one hundred and twenty-one million cubic feet of water, filtered and chlorinated, and an average production capacity of two-hundred and forty-thousand gallons daily,⁹⁷ the health branch was convinced that the scheme fulfilled “a long-want” that would “do much to safeguard the public health of this very important centre.”⁹⁸ Another important development in 1934 regarding water supply in Asante was the extension of piped water supply to Nsuta, Wawasi and the Zongo sections of Obuasi, courtesy the Obuasi Sanitary Board – a composite board on which both the government and the mining company were represented. The Ashanti Gold Fields Company also concluded plans to install additional filters and relay the supply mains to enable the extension of piped water to their staff bungalows and the mine hospital.⁹⁹

The development of the Kumase piped water scheme was to run concurrently with a similar scheme for the Northern Territories. However, no funds could be mobilised to start the scheme for the Northern Territories in 1930 as was done for Kumase. Instead, the colonial administration, considering the importance of Tamale, being the capital of the Northern Territories, sourced support from the Colonial Development and Welfare Fund to finance a water supply scheme for the town. The scheme, relatively small scale, which entailed impounding water in the head of the Jonduli valley, commenced in 1931 and was completed in 1932.¹⁰⁰

However, a detailed scheme for pipe-borne water supply to Koforidua that was developed in 1931 by the Senior Hydraulic Engineer could not be implemented because of lack of funds. Thus, by the third decade of the century, significant progress had been made in providing piped water in some principal towns. Yet, much remained

⁹⁶ GGC, ‘Report on the Medical Department for the Year 1933-34’, 31; GGC, ‘Report on the Medical Department for the Year 1934’, 19; Addae, *The Evolution of Modern Medicine in a Developing Country*, 134. The 1933/34 annual medical and sanitary report quote the total cost of the project as £225, 220.

⁹⁷ GGC, ‘Report on the Medical Department for the Year 1934’, 19.

⁹⁸ GGC, ‘Report on the Medical Department for the Year 1933-34’, 31.

⁹⁹ *Ibid.*, 32; Addae, *The Evolution of Modern Medicine in a Developing Country*, 134.

¹⁰⁰ see GGC, ‘Gold Coast Report for 1929-1930’, Annual (London: His Majesty’s Stationary Office, 1930), 35; GGC, ‘Gold Coast Report for 1930-1931’, Annual, Colonial Reports (London: His Majesty’s Stationary Office, 1932), 42; GGC, ‘Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1931-32’, Annual, Colonial Reports (London: His Majesty’s Stationary Office, 1933), 68. The feasibility studies and the draft scheme of the Tamale piped water works was completed in 1929. Two villages and a cattle market had to be moved to enable work to begin on the project.

to be done. Indeed, in 1934, the health branch reported that on account of not being able to implement a water supply scheme for Koforidua, the town “continued to derive its main water supply from a concrete tank filled by a polluted stream.”¹⁰¹ In similar vein, Salt Pond, a very important town in the Central Province, relied on rainwater stored in tanks, and on brackish wells for their water supply. A situation that caused the inhabitants to “suffer real hardships during the dry season.”¹⁰²

Like Koforidua, a scheme that was prepared to extend piped water to Salt Pond, and villages *en route* from the Cape Coast waterworks was suspended pending improvement in financial conditions.¹⁰³ And demands for water supplies for Nsawam, Larteh, Somanya, Akropong, Odumasi, among others were all shelved because of lack of funds.¹⁰⁴ By the beginning of the 1930s, the economic boom that characterised the colony in the 1920s was fast receding. The global economic slump of the 1930s hit the colonial economy badly. The price of cocoa, the leading export commodity, was halved, reducing the revenue of the colonial administration drastically. Attempts to sustain the economy by increasing income tax rather than reduce the budget for social services was vehemently resisted both within and outside the Legislative Council.¹⁰⁵ Consequently, the administration could hardly raise enough revenue to continue, on the same scale, the investments in social services, which it had commenced during the 1920s.

However, by 1935, the economy had started to show signs of a return to prosperity. This was due mainly to the stabilisation of the world market price of cocoa, the rapid developments in the mining industry, and its concomitant effect on railway and harbour revenues. As the revenue base of the economy improved, the government commenced, once again, its social investments. Consequently, in 1936, work commenced on the stalled project to extend piped water from Cape Coast to Salt Pond, Elmina, and villages and towns *en route*. In that same year, the initial phase of the scheme to supply water to Koforidua was, also, started. While the Koforidua project

¹⁰¹ GGC, ‘Report on the Medical Department for the Year 1934’, 19.

¹⁰² Ibid.

¹⁰³ see GGC, ‘Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1934-35’, Annual, Colonial Reports (London: His Majesty’s Stationary Office, 1936), 69.

¹⁰⁴ see Addae, *The Evolution of Modern Medicine in a Developing Country*, 134.

¹⁰⁵ see Metcalfe, *Great Britain and Ghana*, 623.

could not be completed until the end of World War II, the Salt Pond/Elmina scheme was completed in 1938. The health branch described its completion as a:

Public health measure of the first importance, for not only will it yield an excellent water supply to a large section of the population, but it should, by obviating the necessity for storing water in the houses, do much to diminish the breeding of domestic mosquitoes...¹⁰⁶

From 1935, the colonial administration took steps to improve water supply in rural communities which had been neglected until now. Initial efforts concentrated on conducting investigative and experimental work to ascertain the potential sources of supply to the Northern Territories. In this regard, a special water supply unit was established under the Geological Survey Department to undertake a comprehensive survey to explore the possibilities for water supplies to the more important stations in the Northern Territories. By 1936, the initial phase of the survey was completed and a proposal to form a Water Board for the Northern Territories was put forward for consideration.¹⁰⁷ The Board was formed, and it was mandated to control potable water supply in the region.

However, improvement in the water supply in the Northern Territories was a long time in maturing. Despite continuous investigations and experiments nothing concrete had been achieved by 1938. Inhabitants of the various districts of the region continued to suffer periodic water famine, especially during the dry season. The Health Branch continued to press the government on the urgency to provide adequate water supply in this region, noting that the “provision of an adequate water supply...” would “mean a revolutionary improvement in the well-being” of the inhabitants in the region.¹⁰⁸ Eventually, in 1939 two large impounding dams were completed in the region, one in Savelugu and the other at Yendi to supply water to the surrounding rural communities. Some villages were also supplied with new wells and existing ones, improved.¹⁰⁹

Apart from the Northern territories, geological surveys were also conducted in the Krobo, Akwapim and Shai areas of the Eastern Province to ascertain problems

¹⁰⁶ GGC, ‘Report on the Medical Department for the Year 1938’, 31.

¹⁰⁷ see GGC, ‘Report on the Medical Department for the Year 1936’.

¹⁰⁸ GGC, ‘Report on the Medical Department for the Year 1938’, 31.

¹⁰⁹ GGC, ‘Report on the Medical Department for the Year 1939’ (Gold Coast, Accra: Government Printer, 1940), 5, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>; Addae, *The Evolution of Modern Medicine in a Developing Country*, 134.

bearing on water supply. These areas, just like the Northern Territories, were confronted with acute water shortages, especially during the dry season. In 1937, the health branch observed that the perennial water shortages and the subsequent need to store water in homes in these areas had a “distinct bearing on the question of yellow fever prevention, for these areas all lie in the “hyper-endemic” yellow fever zone of the Gold Coast.”¹¹⁰ Yet, the water supply problem in this region was complex and did not lend itself to a simple solution. Geological surveys revealed that many of the towns and villages in the region had deficient natural supplies of water. Again, the unsuitability of the location of some villages and towns, made water supply to them impossible or where possible could, according to the colonial administration, involve “uneconomic expenditure of funds.”¹¹¹ Despite these defects, in 1938, the Director of Public Works formulated a scheme for the area and submitted it to the government for consideration. However, the outbreak of the Second World War stalled the implementation of the scheme until the 1950s.¹¹²

Indeed, the Second World War slowed progress in the water supply activities in almost every part of the Gold Coast. Throughout the 1940s, the Health Branch reported that difficulties regarding the acquisition of materials, the lack of funds and shortages of staff had impinged on the progress of water supply. Activities regarding water supplies were, therefore, limited to maintenance and repair of existing installations. In 1945, the health branch complained that:

In so far as this Department is concerned, progress has been slow. In the past, many small towns and larger villages, particularly in Ashanti, have been provided with simple, but much-improved water supplies. In recent years, owing to lack of staff and funds, the work has slowed down, and it has been difficult to effect even the maintenance of some of the existing supplies.¹¹³

These challenges notwithstanding, an important development occurred in the 1940s regarding rural water supply. Governor Allan Burns (1941-1947) took steps to institute an organisational structure to undertake systematic water supply projects to rural communities. In 1943, Burns wrote to the Colonial Office lamenting the “...lack of water throughout the country, and especially, in the Northern Territories” which he

¹¹⁰ GGC, ‘Report on the Medical Department for the Year 1937’, 27.

¹¹¹ Ibid.

¹¹² Addae, *The Evolution of Modern Medicine in a Developing Country*, 135.

¹¹³ GGC, ‘Report on the Medical Department for the Year 1945’, 12.

described not only as a serious matter but one that required the “greatest importance and urgency.”¹¹⁴ He, therefore, suggested the establishment of a temporary water supply department to oversee rural water supply with funding from the Colonial Development and Welfare Fund. He subsequently applied for £181,000 from the Colonial Development Fund to support the establishment of the department. After some initial hesitation, the Colonial Office approved both the scheme and the grant, enabling the establishment of the department in 1944.¹¹⁵

The department assumed responsibility for water supply to rural communities and small towns, which hitherto was handled by the health branch and the public works department. The department focused predominantly on sinking bore-holes, wells, reservoirs and maintaining existing supplies. Activities of the department, however, seemed to have been most intense from 1948 and most of its activities were concentrated in the Northern Territories.¹¹⁶ For instance, in 1948 alone, the department constructed four hundred and forty wells, and two impounding reservoirs in Tumu and Jirapa, all within the Wa and Dagomba districts in the Northern Territories.¹¹⁷ However, projects that were started in Bolgatanga and Pong-Tamale were deferred to the following year because of delayed delivery of materials. In a similar vein, a scheme to construct a water supply for Yendi was suspended because of the unavailability of essential materials. These latter projects were however completed in 1950. Outside the Northern Territories, the department also initiated supply projects in Ho and the British Togoland where many experimental bore-holes were sunk starting from October 1948. In the Bono area, the construction of a large impounding reservoir in Berekum was started in October 1948 and was expected to be completed in 1949.¹¹⁸

By 1950, the department had constructed eight hundred and eighty-nine village wells throughout the Gold Coast. Six hundred and fifty-eight of them in the Northern

¹¹⁴ Quote in Bohman, ‘Framing the Water and Sanitation Challenge’, 76.

¹¹⁵ *Ibid.*, 77.

¹¹⁶ Most likely, the late start was due to the unavailability of essential materials to work with during the immediate period after the war. Manpower shortages may also have been critical. See Bohman, “Framing the Water and Sanitation Challenge”, 78.

¹¹⁷ GGC, ‘Report on the Medical Department for the Year 1948’ (Gold Coast, Accra: Government Printing Department, 1949), 16–17, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>; GGC, ‘Gold Coast Annual Report, 1950’, 54.

¹¹⁸ GGC, ‘Report on the Medical Department for the Year 1948’, 16–17; GGC, ‘Gold Coast Annual Report, 1950’, 54.

Territories, one hundred and four in Asante, and one hundred and twenty-seven in the Colony Proper. Also, the department constructed many ponds, reservoirs and tanks and, also, advised Native Authorities on the construction of suitable water supplies. Indeed, under its supervision, between 1949 and 1950, Native Authorities constructed five hundred and eight wells – seventy-four in the Colony Proper, seventy-three in Asante and three hundred and sixty-one in the Northern Territories. In any case, in most instances, water supplies constructed by the department were entrusted into the care of Native Authorities.¹¹⁹

Thus, by the mid-century, significant improvements had been made in the supply of potable and clean water. Piped water was being provided in Accra, Kumasi, Tamale, Cape Coast, Sekondi-Takoradi, Kpong-Tamale, Yendi, Koforidua, Salt Pond, Winneba, and Elmina. Other schemes for Nsawam, Manya Krobo and Yilo Krobo were almost complete. Some of the existing schemes such as the Sekondi-Takoradi scheme had been expanded to provide water for the neighbouring towns of Shama, Aboadzi and Aboasi. The Accra scheme had also been expanded, its production capacity having doubled, and additional distribution mains laid to extend supply to other parts of the town. In 1950, plans were being developed to remodel the distribution systems of Accra, Kumase and Sekondi-Takoradi to allow for extension within the next thirty years. New treatment plants and trunk mains that were being installed for the three schemes were designed on this long-term basis. A scheme to extend the Koforidua supply was far advanced and construction work was expected to begin.¹²⁰ Certainly, improved water supplies proved an inestimable boon to the sanitation and health of the Gold Coast. Not only were water-borne diseases such as dysentery, diarrhoea, typhoid and guinea worm greatly reduced in urban areas, but also, the introduction of piped water certainly contributed to the development of urban centres.¹²¹

Now, as the provision of piped water progressed steadily during the 20th century, the colonial administration raised the question: whether it was appropriate to

¹¹⁹ Addae, *The Evolution of Modern Medicine in a Developing Country*, 135.

¹²⁰ see GGC, 'Gold Coast Annual Report, 1950', 54; Addae, *The Evolution of Modern Medicine in a Developing Country*, 136.

¹²¹ see Patterson, 'Health in Urban Ghana'; Bohman, 'The Presence of the Past'.

charge African residents in urban areas for their consumption of piped water?¹²² When the issue was first contemplated in the early 1920s, it raised an interesting debate between the colonial administration and the African population. The issue was whether Governor Clifford had committed the colonial administration never to levy the local population for their consumption of water. In a speech he delivered in October 1913 just before the inauguration of the Accra water scheme, Clifford is noted to have stated that, “rates will be charged for water supplied to houses but not for water drawn from street founts.”¹²³

Clifford’s statement cast in doubt the future financial obligation of the local population who drew their supplies from street stand-pipes. The question lingered until 1922 when Governor Guggisberg appointed a committee to investigate and advise on whether it was prudent to levy special rates on communities enjoying pipe-borne water. The committee recommended the imposition of a general water rate on property owners in Accra only. However, following protestations from the Ga Mantse, Tackie Yaoboi, that his subjects were promised exemption from any levy on water for agreeing to abandon their previous sources of supply, the committee’s recommendation was shelved.¹²⁴

However, in 1924, the debate was revisited. The colonial administration argued that the growing demand for piped water supplies and the consequent need to raise sufficient funds to develop and extend water supply systems in other urban centres required that the people paid for their water consumption.¹²⁵ This was captured in a report by a Committee on Pipe-borne Water Supplies in 1924 which noted that:

Demands are now rising from all important towns for pipe-borne water supplies and we consider that the people should become accustomed to the fact that if they want pipe-borne water they must be prepared to pay for it and not expect it to arrive as the manna from heaven.¹²⁶

¹²² This subject has been examined in detail by Stanley Shaloff, ‘The Gold Coast Water Rate Controversy 1909-1938’, *Institute of African Studies Research Review* 3 (1972): 21–34; Bohman, ‘Framing the Water and Sanitation Challenge’; Bohman, ‘The Presence of the Past: A Retrospective View of the Politics of Urban Water Management in Accra, Ghana’.

¹²³ As quoted in Shaloff, ‘The Gold Coast Water Rate’, 21.

¹²⁴ see Shaloff, ‘The Gold Coast Water Rate’.

¹²⁵ Bohman, ‘The Presence of the Past’, 143.

¹²⁶ PRO CO 96/682/10 as quoted in *ibid.*, 143; Bohman, ‘Framing the Water and Sanitation Challenge’, 72.

A proposal presented to the Legislative Council that year was, once again, withdrawn because of the unanimous African opposition against it. And an attempt to introduce a water ordinance in 1929 was, once more, thwarted by African opposition. In a petition written by Augustine Kojo Thompson on behalf of the Ga Mantse and his sub-chiefs and submitted to Governor Alexander Slater in July 1929, the petitioners argued that the bill, if allowed to pass, would be inimical to the interest and welfare of themselves and their subjects. The petitioners reminded the colonial administration that their enjoyment of the free use of water for domestic purposes since the opening of the Accra scheme was because of the promise made to them by government in consideration of their "...free gifts of land to the government for the construction of Railway from Accra to the plant at Wiedjian..."¹²⁷

The Gold Coast press also launched a bitter campaign to compel the colonial administration to withhold the passing of the bill. Eventually, after several vacillations, the colonial administration passed the Water Works Ordinance in 1934 amidst opposition from both within and without the Legislative Assembly. However, the implementation of the Ordinance was delayed until 1938 when a water rate of 2.5 per cent was imposed on owners of houses in Accra, Kumase, Sekondi and Cape Coast whose property had a rateable value of at least £6 per annum.¹²⁸ The government argued that the levying of a general water rate on property owners to pay for public standpipes, rather than impose an individual unit price on users would absolve the poor from paying for their consumption of water. In doing so, the administration contended that those who otherwise would have preferred to draw water from contaminated sources because of their inability to pay would now enjoy a free supply of treated water.¹²⁹

Thus, "...from a public health point of view" Bohman argues, "the colonial government viewed an extra tax for property owners, i.e. a general water rate, as the best alternative for financing water services"¹³⁰ for the poor masses. However, the local

¹²⁷ 'The Petition of Acting Ga Mantse and Sub-Chiefs of Accra and Christiansborg', 22 July 1929, 1-2, ADM11/1/290, PRAAD, Accra.

¹²⁸ Shaloff, 'The Gold Coast Water Rate', 29. The people of Winneba were already paying water rate which had been imposed since 1921. The inhabitants had reluctantly agreed to pay following threats by the colonial administration to suspend the construction of their water works if they refused to pay.

¹²⁹ PRO CO 96/682/10 Report on Kumasi Water Supply Owabi Scheme (1928) as cited in Bohman, 'The Presence of the Past', 144.

¹³⁰ Ibid.

population dissented. For them, if the provision of public standpipes was a public health measure, then, the government owed it a duty to provide it to the citizens of the Gold Coast for free.¹³¹ Even though the water rate was eventually imposed, the attempt by the African population to scuttle the water ordinance is telling. It reveals, as Shaloff has observed, the political potential of the masses to mobilise opposition to undermine colonial policies which they perceived to affect their interests adversely.¹³²

Conclusion

I have examined the efforts of the colonial administration to provide potable water in the Gold Coast. I started by examining the water supply situation before the 20th century. I demonstrated that during the late 19th century, except for European colonial officials who were supplied with comparatively clean rain harvested water, most of the African population accessed their drinking water from brackish ponds, shallow wells, rivulets and streams. And whereas, colonial officials were aware of the finite nature of the sources of water supply that was available and the health hazards it could pose, the measures adopted to improve water supply before the 20th century was not very progressive, and therefore, could not achieve any tangible results. The main issue as the colonial administration presented it, was inadequate funding. Thus, at the turn of the century, the provision of adequate supplies of clean potable water for the domestic use of the public remained one of the most urgent public health needs.

Nevertheless, I have argued that colonial aspirations to create replicas of modern European towns in their colonies combined with the need to maintain the public health inspired the implementation of piped water schemes after the first decade of the 20th century. Starting with the Accra and Sekondi piped water schemes in 1911, efforts were made throughout the 20th century to extend piped water supply to other important towns and villages. So that by 1950, most of the principal towns were either being supplied with piped water or works on schemes to supply them was underway. In rural communities, the colonial administration developed a scheme during the mid-1930s to supply village wells, particularly, in the Northern Territories where they were much needed.

¹³¹ Ibid.

¹³² see Shaloff, 'The Gold Coast Water Rate'.

However, I show that the efforts to provide potable water supply in the Gold Coast were not smooth. Sometimes, the colonial administration demurred at schemes because of the costs involved. At other times, the difficulties involved in finding appropriate dam sites and supply sources also frustrated the efforts at implementing public water schemes. Again, the colonial administration's attempt to levy a general water rate on urban residents to recover the cost for providing public standpipes presented a political conundrum as the African population mobilised concerted opposition to its implementation. Also, occurrences, such as the outbreak of the First and Second World Wars, significantly delayed measures that were in place to improve public water supply. Additionally, the dynamics of the colonial economy – such as the global economic recession of the late 1920s and the early 1930s, which caused a decline in the revenue of the colony, impinged on schemes to provide public water supply. Thus, even though, by the 1950s, significant strides had been made, a lot more remained to be done, especially, as the population kept increasing, the existing supplies were unlikely to meet the demands of both urban and rural populations.



Chapter Six

Anti-Mosquito Sanitation, Educational Prophylaxis and Domestic Hygiene

Introduction

This chapter examines two broad and chronologically overlapping themes. The first set of measures targets the materiality of malaria – bodies, streets, and households; the second targets sanitation and hygiene education. The first part discusses anti-mosquito sanitation measures that targeted the eradication of larvae in both private and public spaces. Such measures included sanitary segregation, sanitary inspection, drain construction, swamp and lagoon reclamation, the application of larvacides and the removal of weeds. The second part focuses on educational prophylactic, mainly, the teaching of hygiene and sanitation to school children and the public.

I draw these themes together to argue that notwithstanding their manifest aims, both measures served other related ends. Both sets of measures wittingly or unwittingly provided avenues through which the colonial administration could influence African practices, habits and attitudes in the domestic sphere and the public space. In other words, both the overtly anti-mosquito measures and the teaching of hygiene were as much about the public health as they were about sustaining colonial control. And not only did these measures overlap but also, they were mutually reinforcing. Implicit in these measures were also, colonial assumptions about modernising the ways of a supposedly “primitive” African population.

As one would expect these measures were influenced by late 19th and early 20th century Euro-Western medical theories. The contagion theory of disease – an offshoot of the bacteriological revolution that emerged during the late 19th century identified the individual as a disease vector. Subsequently, the social habits of individuals became the focus of preventive measures. In a similar vein, the discovery of the mosquito as the vector of malaria and yellow fever deflated the medical concept of acclimatisation which attributed the causes of European morbidity and mortality in tropical regions to climatic factors. In colonised territories, these discoveries were conflated with racial assumptions and colonial intentions. Colonised people and their

surroundings, therefore, became associated not only with vectors of diseases but also, with filth.¹ For instance, it was written of colonial Accra that:

Regarding domestic sanitation, there is little to be said, as although the native is personally cleanly his habitation is almost invariably the abode for the accumulated dust of ages. From this follows occasional outbreaks of Epidemic disease...²

This tendency to regard colonised people and their surroundings as a source of filth and contagion is what Maynard Swanson refers to as the *sanitation syndrome*.³ Thus, as sanitation issues coalesced into British official colonial policy, the colonial administration in the Gold Coast targeted the domestic habits of Africans as areas of control and surveillance. The colonial administration's anxiety about domestic hygiene and sanitation was, however, inextricably linked to the "medico-moral politics" in Europe which, among other things, emphasised hygiene and household cleanliness as central to the idea of making a modern home during the mid-19th century.⁴ As John and Jean Comaroff have argued, the notion of making a modern home in Europe and its implications for hygiene and sanitation was manifest in the colonial efforts at promoting domestic hygiene in Africa and other colonial enclaves. To them, therefore, the insistence on domestic hygiene by colonial administrators was "a simultaneous, mutually sustaining process of social reconstruction at home and abroad."⁵

Mosquito Control and Domestic Hygiene

In the Gold Coast and elsewhere in British West Africa, mosquito control formed the crux of sanitation policy starting from the late 19th century.⁶ The fight against mosquito targeted mostly African homes and surroundings. This was because, in line with theories of racial ecology, the colonial administration portrayed colonised subjects and their immediate surroundings as the nidus of diseases.⁷ This notion was fed by the misplaced scientific thinking that held that mosquitoes naturally preferred African

¹ see Swanson, 'The Sanitation Syndrome'; Burke, *Lifebuoy Men, Lux Women*.

² GGC, 'Annual Medical and Sanitary Report on the Gold Coast Colony for the Year Ended 31st December 1901', 17.

³ see Swanson, 'The Sanitation Syndrome'.

⁴ see Burke, *Lifebuoy Men, Lux Women*, 18; John & Jean Comaroff, *Ethnography and The Historical Imagination*, 1 edition (Boulder: Routledge, 1992), 268.

⁵ John & Jean Comaroff, *Ethnography and the Historical Imagination*, 1 edition (Boulder: Routledge, 1992), 268.

⁶ see Addae, *The Evolution of Modern Medicine in a Developing Country*.

⁷ see Moyes, 'The Making of the Everyday'.

blood.⁸ This assumption lent credence to the notion that African homes posed health hazards and therefore needed to be avoided and regulated. Such assumptions encouraged colonial administrators to focus sanitation initiatives targeting the control and elimination of mosquitoes on the domestic sphere and thus wittingly or unwittingly reinforced colonial domination of African households and everyday habits.⁹

Thus, in the Gold Coast as in other parts British West Africa, two sanitary initiatives that were critical, yet controversial in the fight to eliminate mosquitoes were residential segregation and household inspections. Other measures such as drain construction and swamp reclamation, removal of undergrowth, and the application of larvacides were also deployed to fight against the mosquito vector and to ensure general environmental cleanliness. In this section, I discuss sanitary segregation, household inspections, drain construction and swamps reclamation, the application of larvacides as well as the clearance of weeds.

The Mosquito and Sanitary Segregation

Segregating Africans from Europeans was first recommended in the Gold Coast by Farrell Easmon in 1893. He made this recommendation because of what Gale describes as the “hopelessly insanitary” conditions of Accra.¹⁰ Consequent to his recommendation, European officials in Accra were moved and settled in bungalows at Victoriaborg located midway between Accra and Christiansborg.¹¹ This was the first attempt ever at separating Africans from Europeans in any part of British West Africa before the early 1900s when colonial officials started to advocate segregation as an anti-malaria measure. Easmon’s suggestion might have been informed by his reading of British sanitary reforms in India – where during the 1870s and 1890s, permanent segregated residential areas were developed to separate British civilian officials and military officers from the “native” population.¹²

⁸ Curtin, ‘Medical Knowledge and Urban Planning in Tropical Africa’.

⁹ see Moyes, ‘The Making of the Everyday’, 19–20.

¹⁰ Gale, ‘The Struggle against Diseases in the Gold Coast’, 197.

¹¹ Gale, ‘The Struggle against Diseases in the Gold Coast’; Patterson, ‘Health in Urban Ghana’.

¹² see Curtin, ‘Medical Knowledge and Urban Planning in Tropical Africa’; John W. Cell, ‘Anglo-Indian Medical Theory and the Origins of Segregation in West Africa’, *The American Historical Review* 91, no. 2 (1986): 307–35.

Two developments during the late 19th century premised the introduction of sanitary segregation as official colonial policy in British West Africa. Firstly, the discovery in 1897 that the mosquito was the vector of malaria. Secondly, the solicited advice given by the Royal Society to Colonial Secretary, Joseph Chamberlain in 1898, to the effect that segregating Europeans from Africans was the most viable means to contain the spread of malaria to Europeans living in Africa.¹³ The discovery that the African was after all not immune to malaria as was previously perceived informed this advice. African children, especially, were recognised as potential carriers of malarial infection.¹⁴ European colonial officials were subsequently cautioned to avoid African quarters. The sanitary branch in the Gold Coast noted that:

Segregation is undoubtedly the most effective measure by which it is possible to guard against infection by mosquito-borne disease. It is true that officials and others while travelling on duty in the bush may get infected, but the possibility will get less when more attention is paid to the position and surroundings of rest camps, and the distance of these from Native villages...¹⁵

Yet, in implementing segregation, colonial administrators had other concerns other than just sanitation and health. As Oluwasegun has argued, the British sought to use segregation to achieve “racial othering” which formed a critical element in their “understanding of Africa as a continent that required Western Civilisation.”¹⁶ Africans as Indians were generally considered to be unhygienic. A “line of reasoning” which according to Oluwasegun “...tangled medical, cultural and speculative considerations” and “provided the colonial authorities with cunning moral grounds to begin the process of racial segregation of residential areas in India and later in Africa.”¹⁷ Thus, as Moyes argues, the colonial administration sought to use segregation to spatially designate the “European household as a safe site compared to African households.”¹⁸ And in doing so, reinforced racial claims to British cultural superiority.

¹³ see Thomas S. Gale, ‘Segregation in British West Africa’, *Cahiers d’Études Africaines* 20, no. 80 (1980): 495–507.; Julia M Wells, ‘Sun Huts, Sun Downers, and Tropical Hygiene: Managing Settler Bodies and Minds in British East and South-Central Africa, 1890-1939’, *African Historical Review* 48, no. 1 (2016): 68–91; Curtin, ‘Medical Knowledge and Urban Planning in Tropical Africa’.

¹⁴ Gale, ‘Segregation in British West Africa’; Wells, ‘Sun Huts, Sun Downers, and Tropical Hygiene’; Curtin, ‘Medical Knowledge and Urban Planning in Tropical Africa’.

¹⁵ GGC, ‘Medical and Sanitary Report for the Year 1913’, 22.

¹⁶ Jimoh Mufutau Oluwasegun, ‘The British Mosquito Eradication Campaign in Colonial Lagos, 1902-1950’, *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines* 51, no. 2 (2017): 222–23.

¹⁷ *Ibid.*, 223.

¹⁸ Moyes, ‘The Making of the Everyday’, 38–39.

Mary Douglas has illustrated that anxiety about dirt and contagion often arises from a concern not only about hygiene but also respect for the established order.¹⁹ This intent, wittingly or unwittingly, was subtly conveyed in colonial narratives regarding sanitary segregation in the Gold Coast. For instance, in 1915, it was stated in the annual medical and sanitary report that, “the discomforts and dangers which formerly attended residence within the native quarter are rapidly being exchanged for the peacefulness and comparatively safe seclusion of the segregation areas.”²⁰ Similarly, in 1918, the SSO noted that “...apart from the minor details of comfort, segregation may conceivably spell the difference between life and death to many residents [Europeans] on the coast.”²¹ Thus, in removing Europeans from Africans, the primary concern, was as much about avoiding diseases as it was about a desire to reorder both the social and physical environment to satisfy “anxieties of potential breaches of colonial social order.”²²

The instruction to implement sanitary segregation was, however, not readily adhered to in most colonies, both by governors and non-official European residents.²³ In the Gold Coast Governor Mathew Nathan’s attempt to enforce sanitary segregation on the premise that the Africans were unconcerned about improving their sanitary conditions, was frustrated because of non-compliance by the general European population.²⁴ For instance, in 1901, the PMO expressing concern about the lack of improvement in Cape Coast and Salt Pond lamented that:

...I cannot understand why the Europeans at such towns do not learn the actual value of segregating themselves from the Native community as far as their actual living quarters are concerned.²⁵

For the PMO, “No more radical improvement” in the health of the European population residing in the Gold Coast could be achieved without recourse to isolating

¹⁹ Douglas, *Purity and Danger*, 1–2.

²⁰ GGC, ‘Medical and Sanitary Report for the Year 1915’, 19.

²¹ GGC, ‘Medical and Sanitary Report for the Year 1918’, 29. Emphasis added.

²² Moyes, ‘The Making of the Everyday’, 39.

²³ Gale, ‘Segregation in British West Africa’. The only successful sanitary scheme that was completed in British West Africa before 1910 was the creation of Hill Station in Freetown.

²⁴ Ato Quayson, *Oxford Street, Accra: City Life and the Itineraries of Transnationalism* (Durham, NC: Duke University Press Books, 2014), 78.

²⁵ GGC, ‘Annual Medical and Sanitary Report on the Gold Coast Colony for the Year Ended 31st December 1901’, 13–14.

them “from zones infested with *anopheles* bearing the power of malarial infection.”²⁶ However, by 1903, the government had relocated only a few European officials in some principal towns to bungalows that were located away from African townships. And in 1907, the colonial administration having selected Tamale as the new capital of the Northern Territories was able to demarcate the upwind section from the African township to be reserved as segregated area.²⁷

Dealing with the segregation of European merchants presented a conundrum to the colonial administration. The European mercantile class avoided complying with the directive advising against living among the African population. In 1904, the PMO, W. R. Henderson, cautioned that “It is most important and desirable that mercantile firms and others should have the residences of their European employees removed as far away as possible from native quarters...”²⁸ In 1906, the acting PMO, P. J. Garland, re-echoed Henderson’s position noting that “the first point in the interest of the health of European community is segregation.”²⁹ He, however, noted that the European community was not enthused about segregation because it was “declared too expensive to be practicable.”³⁰

The continuing non-compliance of the European mercantile class frustrated the colonial administration, particularly, after a yellow fever outbreak in 1910. By 1918, the colonial administration was contemplating “whether segregation of Europeans should not be compulsory.” Without recourse to compulsion, however, J. M. Dalziel, the SSO admitted in 1920 that even though segregation was maintained in principal towns, “it cannot be said that it is fully adopted.”³¹ He observed that “...in no station” could “it be said that most of the non-official community are so protected.”³² In a similar vein, in 1922/23, A.G Lorena, the acting DDSS complained that the “...majority of European employees of mercantile firms continued to reside in the African townships, though space was available for them to build in healthier localities.”³³

²⁶ Ibid.

²⁷ see Curtin, ‘Medical Knowledge and Urban Planning in Tropical Africa’.

²⁸ GGC, ‘Medical and Sanitary Report for the Year 1903’, 15.

²⁹ GGC, ‘Medical and Sanitary Report for the Year 1906’, 10.

³⁰ Ibid.

³¹ GGC, ‘Report on the Medical Department for the Year 1920’, 20.

³² Ibid.

³³ GGC, ‘Report on the Medical Department for the Period January 1922 - March 1923’, 47.

It would take the outbreak of a second yellow fever epidemic in 1927 to induce a significant number of European merchants to acquire building plots in segregated areas.³⁴ Moyes has argued that the colonial administration's fixation with segregating non-compliant European residents is a testimony to the charge that the government was seeking to reorder social categories and thereby entrench the notion of cultural differences in the domestic sphere.³⁵ After all, the justification for sanitary segregation was premised on the need to safeguard the health of European colonial officials and not every European.

Apart from dealing with the non-compliance of European merchant residents, the question of segregation was one that pitched the sanitary and medical department on the one hand against the political officers on the other. In 1909, PMOs of British West Africa held a joint conference and outlined a common segregation policy. They unanimously agreed, among other things, that European residences should be located at least four hundred yards from the nearest African residence. Most governors including, William MacGregor of Lagos, Governor Denton of Gambia and in Ghana, John Rodger (1904-1910) resisted all pressures to implement this measure.³⁶ Gale has argued that their resistance was borne out of both humanitarian and economic considerations.³⁷ Indeed, in 1910, Roger wrote to the colonial office that "the compulsory segregation of Europeans from Natives is unknown in any part of the world, and I am certainly not prepared to advocate it in the Gold Coast."³⁸

Governor Roger was not alone in his opposition to segregation. In Colonial Lagos, Governor MacGregor argued that it was pointless to separate European residents from Africans. "I make no attempt to put these separatist principles in practice because to my mind they are impolitic, and unscientific...",³⁹ wrote MacGregor. He noted further that:

The presence of Europeans near natives would, theoretically, at least, be useful in educating the native on how to deal with malaria...Segregation from the

³⁴ see GGC, 'Report on the Medical and Sanitary Department for the Period April 1927 to March 1928'.

³⁵ see Moyes, 'The Making of the Everyday'.

³⁶ see Gale, 'Segregation in British West Africa'.

³⁷ Quote in *ibid.*, 499.

³⁸ *Ibid.*

³⁹ As quoted in Matthew Gandy, *The Fabric of Space: Water, Modernity, and the Urban Imagination* (Cambridge: The MIT Press, 2014), 87.

social point of view would be disastrous here. There is at present in this colony no racial question. It would be unwise to start one.⁴⁰

MacGregor's position, despite its progressive tenor, nonetheless, betrays the imperialist logic of the need to 'civilise' the 'primitive' African population by inculcating in them Euro-western notions of disease prevention.

However, despite Roger's reluctance to implement segregation in the Gold Coast, after his tenure, some progress was made in implementing segregation. In 1911, the sanitary department noted, "it is gratifying to be able to report that something has at last been done to secure segregation in the future."⁴¹ In September that year, a circular was addressed to presidents of all town councils prohibiting them from issuing permits to Europeans who wanted to build in African areas.⁴² Steps were subsequently taken to acquire land in various stations to build European residences. James Jamieson Thorburn (1910-1912), Roger's successor, however, protested, arguing that the acquisition of land for sanitary purposes was a subject of much discontent and that he was unwilling to "expropriate native landholders wholesale unless such a policy is declared imperatively necessary".⁴³ The colonial office overruled him. Subsequently, segregation areas were acquired in Kumase, Dunkwa, Sekondi, Tarkwa, Axim, Cape Coast, Saltpond, Winneba and Nsawam.⁴⁴

Gale has noted that Governor Hugh Clifford who replaced Thorburn in 1912 was, also, not enthusiastic about pursuing, with any seriousness, sanitary segregation. He sought to persuade the colonial office that segregation was expensive and impractical and, should, therefore, be abandoned. He could not understand why African taxes were being spent to protect the health of Europeans when the health of the Africans was neglected. He was similarly, dismayed that the Medical Department wielded so much power, which it often, abused.⁴⁵ By his actions and pronouncements, Gale is correct when he suggests that Clifford was segregation's greatest adversary.⁴⁶ Even so, by 1914, enough bungalows were ready in new reservation areas (as

⁴⁰ As quoted in Oluwasegun, 'The British Mosquito Eradication Campaign', 223.

⁴¹ GGC, 'Medical and Sanitary Report for the Year 1911', 63.

⁴² *Ibid.*, 63.

⁴³ quote in Gale, 'Segregation in British West Africa', 499-500.

⁴⁴ GGC, 'Medical and Sanitary Report for the Year 1911', 63; Gale, 'Segregation in British West Africa', 500.

⁴⁵ Gale, 'Segregation in British West Africa'.

⁴⁶ *Ibid.* Indeed, Clifford declined a decision approved by Roger in 1910 to relocate about two thousand Africans from the village of Esikado in Sekondi to a less pleasant area to make way for the settlement of Europeans.

segregated residences were sometimes called) to accommodate officials. The Colonial Office insisted that European officials were needed to develop Africa and unless health conditions improved, such officials could not be attracted to work in the colonies. They also downplayed the racial implications of sanitary segregation, arguing that Europeans were only moved away from infected Africans and the poor sanitation of their residence.⁴⁷

The reluctance of political officials to implement sanitary segregation demonstrate the tensions between scientific rationales and political expedience, but more so, the fractures in colonial attempts at hegemonic control. It also does reveal, in this regard, the order of preference between the concerns of political officials in the metropole and those of the political officers on the ground in the colony. But more importantly, it underscores Gandy's assertion that the epidemiological insights into malaria that justified segregation stemmed from a combination of cultural, political and scientific arguments that served contradictory interests, "underlining the fragility and illegitimacy of the colonial project itself."⁴⁸

The question of dealing with African labourers who worked as domestic servants for colonial officials further complicated the implementation of segregation in the Gold Coast. Male domestic servants could live in servants' quarters attached to bungalows in reservation areas. And few others were settled in villages close to the reservation areas.⁴⁹ However, because of the perception that African children were the prime focus of malarial infestation, servants were prevented from living with their children in residential areas. And for unexplained reasons servants' wives were not allowed to sleep in residential areas. However, the exclusion of servants' wives and their children from sleeping over in reservation areas could not be effectively implemented. MOHs often wrote to caution European occupants about allowing the children and wives of their servants on their premises.⁵⁰

⁴⁷ see *ibid.*, 500.

⁴⁸ Gandy, *The Fabric of Space*, 88.

⁴⁹ The Danyame village in Kumasi was, for example, purposely demarcated to accommodate labourers of European colonial officials.

⁵⁰ see for example, "Memo: From Medical Officer of Health to Occupier of Bungalow No. 48, Kumasi," 1931, ARG1/14/3/15, Ashanti Regional Archives, Kumasi.

Yet, such cautions did not stop servants from bringing in their wives and children to live in their quarters. Consequently, in 1935 the colonial administration decided to relax this rule and allow the wives of servants to live with their husbands' in reservation areas on condition that their presence would not lead to "insanitary overcrowding" and that mosquito nets would be provided for their use. European residents wishing their servants' wives to live in their premises, however, required permission from the local MOH.⁵¹ This decision to permit African servants to live in segregated areas, however, did not only undermine the core principle of the segregation policy, but it also betrays the spurious logic that underpinned segregation as a sanitary measure.

I must also remark that a closer reading of the records betrays what seemed like a deliberate attempt by the colonial administration to use segregation to mask their intentions to avoid responsibility for improving the general sanitation of the Gold Coast. For instance, in 1915, the SSO, D. Alexander, reporting on the difficulties that confronted colonial officials in commuting from reservation areas to their offices, argued that it was desirable to spend money on providing means of transportation for affected European officials than investing such money to improve unhealthy conditions in African towns.⁵² He was emphatic that:

...any funds which might be spent on the maintenance of a motor service or the grant of a transport allowance would be more than met by the ultimate improvement in the health of officials and by the saving of money which would otherwise have to be spent on rendering the unsegregated sites less unhealthy.⁵³

As Oluwasegun has argued, in British West Africa, it was "common for financial prudence to take precedence over the health of the African population." Colonial administrations were rather more committed to "finance official quarters segregated away from common people" than provide funding for public health infrastructure.⁵⁴ They often expected the provision of public health facilities, particularly, after World War I to be financed by the colonial fund. Yet, the Colonial Office was reluctant to fund

⁵¹ GGC, 'Report on the Medical Department for the Year 1935', 15.

⁵² GGC, 'Medical and Sanitary Report for the Year 1915', 20.

⁵³ Ibid.

⁵⁴ Oluwasegun, 'The British Mosquito Eradication Campaign', 227. Emphasis added.

such projects since it was expected that colonies had to be self-sufficient. In the end, expenditure on public health was often deferred to Town Councils that lacked the capacity to meet such expenses.⁵⁵

Sanitary Inspection and Domestic Hygiene

The emergence of sanitary inspection has been linked with the rise of the 'surveillance state' in Western Europe during the 18th and 19th centuries.⁵⁶ Whether practised in Europe or colonial Africa, sanitary inspection had a disciplinary rationale; it aimed to control and regulate the conduct of the population.⁵⁷ To that extent, sanitary inspection served both as a technique of intervention and as a means of surveillance. The sanitary inspector, acting as the agent of surveillance and intervention was, thus, given unrestrained access to the private abodes of individuals and empowered to subject one's behaviour to scrutiny.⁵⁸

In the Gold Coast, sanitary inspection emerged, primarily as a response to the question of dealing with the incidence of mosquito larvae, mostly in African households. Inspectors were deployed to African homes to search for larvae breeding and fine householders whose compound larvae were discovered. Sanitary inspectors were given wide-ranging powers to forcefully enter African homes and from the 1930s, European households from 6:00 am to 6:00 pm.⁵⁹ Subject to the provisions of the mosquito ordinance, larval offences could attract a fine of up to £5 or in default face prosecution.⁶⁰ Other sanitary offences could attract a fine not exceeding 40 shillings.⁶¹ Inspection as a method of searching households for larvae was pioneered by William Gorgas in the early 1900s and was later applied successfully to the Panama Canal Zone.⁶²

⁵⁵ see Oluwasegun, 'The British Mosquito Eradication Campaign'.

⁵⁶ see Tom Crook, 'Sanitary Inspection and the Public Sphere in Late Victorian and Edwardian Britain: A Case Study in Liberal Governance', *Social History* 32 (November 2007).

⁵⁷ Ibid.

⁵⁸ see Christopher Hamlin, "Nuisance and Community in Mid-Victorian England: The Attractions of Inspection," *Social History* 38, no. 3 (2013): 346–79.

⁵⁹ David Patterson K, "Health in Urban Ghana: The Case of Accra 1900-1940," *Soc. Sci. Med.* 13, no. B (1979): 251–68; Sylvester Gundona, "Coping with This Scourge: The State, Leprosy, and the Politics of Public Health in Colonial Ghana, 1900- Mid 1950s" (University of Texas, 2015), 140–41.

⁶⁰ GGC, 'Medical and Sanitary Report for the Year 1912', 96–97.

⁶¹ Gundona, 'Coping with This Scourge', 140–41.

⁶² Patterson, *Health in Colonial Ghana*, 40.

In the Gold Coast, the standard aimed at was the thorough inspection of all premises, at least, every seven to ten days.⁶³ However, the colonial administration conceded that this standard could not be attained except in “the largest centres, the ports and some of the more important but smaller towns and larger villages on the main trade routes.”⁶⁴ Suffice to say that inspections were mostly confined to areas where there was a considerable concentration of Europeans or where the colonial administration had an economic interest. By 1910, household inspections were being carried out in about thirty-three towns and villages.⁶⁵

Inspection was not limited to finding larvae; it was also employed as a mechanism to monitor the habits of the local population regarding domestic hygiene and to check the cleanliness of their compounds and or environments. To that extent, sanitary inspection could be viewed in Foucauldian terms as constituting a disciplinary technique that enabled the colonial state to control not only its subjects but also, their living spaces and to shape and recast people’s conduct. According to Foucault the emergence of modern European states meant that governmentality increasingly focused on techniques and tactics designed to create governable subjects through shaping and normalising people’s conduct.⁶⁶ These normalising techniques were latent in sanitary inspection. As John Morrissey has argued, the governmental techniques that Foucault associated with modern European states were also present in early modern colonial societies.⁶⁷

Household inspection in the Gold Coast was never a welcoming news amongst Africans. The African people viewed the Sanitary Inspector as some kind of vicious police officer who was given to issuing court summons and imposing arbitrary fines.⁶⁸ The local population complained that Sanitary Inspectors were “sometimes rude, dirtied household water, and allegedly planted larvae to trump up cases...”⁶⁹ An editorialist of the *Gold Coast Leader* complained that it was “monstrous” for Inspectors to throw out stored water on the pretence that it harboured larvae, when people lacked

⁶³ GGC, ‘Report on the Medical Department for the Year 1938’, 32.

⁶⁴ Ibid.

⁶⁵ GGC, ‘Medical and Sanitary Report for the Year 1910’, 55.

⁶⁶ see Michel Foucault, *Security, Territory, Population - Lectures at the College de France, 1977-78*, ed. Michel Senellart, trans. Graham Burchell (New York: Palgrave Macmillan, 2009).

⁶⁷ see Morrissey, ‘Foucault and the Colonial Subject’.

⁶⁸ see Moyes, ‘The Making of the Everyday’, 37–38.

⁶⁹ Patterson, ‘Health in Urban Ghana’, 256.

water supply.⁷⁰ As Paterson notes, many Gold Coasters regarded inspection as useless and self-serving. A 1912 editorial in the *Gold Coast Leader* is revealing:

The Yellow fever bogey has proven a fairly godmother to white doctors and to the class of men from whom the White Sanitary Inspectors are drawn; and so fast is the appointment of white Sanitary Officers increasing and so completely do they monopolise these appointments and jealously guard them against the admission of black doctors that people are led to believe that Sanitation is but a device for the white man to find jobs for himself, to humbug the natives by sanitary prosecutions and fines to levy irregular taxes on the people for the maintenance and upkeep of the sanitary show.⁷¹

Many in the Gold Coast remained sceptical about the role of the mosquito in the transmission of diseases and therefore, regarded larvae inspection and fines as a clever means by the colonial administration to raise revenue. The local population regarded the presence of the larvae in water as an indication that the water was not poisoned. Therefore, what was needed, according to a 1926 editorial in the *Gold Coast Independent*, was the education of the public and not the kind of coercion inspection entailed.⁷²

The sanitary department admitted that the sanitary inspector could be regarded “as a malignant type of police officer.”⁷³ However, they rejected claims that their inspectors were giving to wanton issuing of summons, arguing that their aim was to attract inspectors who could get the work done with the least number of court cases. However, it was stressed that “obstruction, apathy, and ...open hostility” had to be met with severe measures.⁷⁴ Colonial officials insisted that prosecutions and fines were desirable in the Gold Coast as in other places where western civilisation had existed for many years. Yet, they claimed that the health branch aimed to provide instruction on the causes of ill-health and the means of disease prevention rather than to rely on coercion.⁷⁵ It was stressed that “the presence and work of Sanitary Inspectors have themselves educational value...”⁷⁶

⁷⁰ *Gold Coast Leader*, 21 January 1903, 4. as cited in, Patterson, *Health in Colonial Ghana*, 40.

⁷¹ As quoted in *ibid*.

⁷² *Gold Coast Independent*, 24 July 1926, 800. as cited in *ibid*.

⁷³ GGC, ‘Medical and Sanitary Report for the Year 1911’, 64.

⁷⁴ GGC, ‘Report on the Medical Department for the Year 1937’, 28.

⁷⁵ GGC, ‘Report on the Medical Department for the Year 1934’, 25.

⁷⁶ GGC, ‘Reports on the Medical and Sanitary Department for the Year 1919’, 18.

The colonial administration made every effort to reinforce the claim that household inspection was in the interest of the public health. Consequently, they insisted that in the training of sanitary inspectors, they ought to be instructed to “constantly teach those amongst whom they work the elementary principles of tropical hygiene and never to serve a notice or take out a summons without carefully explaining to the accused the true nature of their offence.”⁷⁷ It was stressed that persons recruited to be inspectors should be those of “probity and intelligence, and capable of exercising an educational influence upon those with whom their work brings them into contact with.”⁷⁸ It was hoped that if these were done, the local people would develop a positive attitude towards inspectors and inspection “so that they will be willing to listen to and carry out the advice given by Sanitary Inspectors, and the need for working the deterrent expedients of prosecutions, fines and imprisonment will become less.”⁷⁹

Yet, the educational component of household inspections was hardly executed efficiently. Indeed, in 1910, the SSO admitted that “education of the native as to the vital importance of the mosquito and other insects in conveying disease”⁸⁰ required more attention than it had received in the past. He subsequently suggested that:

If funds are available to make the subject a more interesting one, and to print simple pamphlets in the commonest native languages for general distribution, in addition to the instruction given in schools, then perhaps some headway might be made.⁸¹

Perhaps, it was in response to this suggestion that in 1912, the sanitary department issued for the use of the African population a pamphlet containing guidelines on how to avoid prosecution by sanitary inspectors. In this pamphlet, the sanitary department explained why the mosquito was a danger to the people and why there was the need to keep them away from households and compounds. It was stated that:

Mosquitoes cause Fever and other diseases, which cause the deaths of half of your children, therefore, if you and all who live in the house wish to enjoy good health do what you can to keep your house free from mosquitoes. Mosquitoes lay their eggs on the water contained in chatties, tanks, barrels, and in the water

⁷⁷ GGC, ‘Medical and Sanitary Report for the Year 1911’, 64.

⁷⁸ Ibid., 63.

⁷⁹ Ibid., 64.

⁸⁰ GGC, ‘Medical and Sanitary Report for the Year 1910’, 56.

⁸¹ Ibid.

contained in old tins, pots, and bottles lying about the compound. From the eggs the little wrigglers are hatched out and these after a few days turn into mosquitoes...if you wish to keep your house free from mosquitoes take the following simple measures to prevent mosquitoes laying their eggs in, and so introducing wrigglers into the water vessels in your house or compound.⁸²

The pamphlet spelt out directives to Africans to follow if they wanted to avoid mosquito-breeding in their households and subsequently avoid prosecution. They were required to keep water tanks and barrels mosquito-proof, keep gutters clean of stagnant water, and ensure that the compound was free of empty tins, bottles and old pots. The pamphlet concluded by cautioning its readers that:

The Sanitary Inspector does not want to trouble you by taking you to court, but he knows that if there are wrigglers in every compound soon the town will be full of mosquitoes then there will be much sickness, perhaps even an epidemic and quarantine. Try to help the Sanitary Inspector by taking a little trouble to do the simple things you have been asked to do and so prevent court proceedings, sickness, epidemics and quarantine.⁸³

It must, however, be pointed out that in a colony where much of the population were illiterates such educational literature written in English could only appeal to a few.

By the 1930s, the intensity of household inspection had increased and was considered as a routine activity which every health officer of the sanitary department was obliged to undertake.⁸⁴ To appreciate the level of intensity during this period some statistics will suffice. In 1929/1930 eight-hundred and forty-thousand, seven-hundred and twenty-five households were inspected during the year.⁸⁵ This figure is substantial when compared with 1912 and 1913 when the total number of houses inspected was four-hundred and twenty-six thousand one-hundred and ninety and four-hundred and fifty-two thousand nine-hundred and four respectively.⁸⁶ By the middle of the 1930s, the sanitary department was recording over a million household inspections yearly.⁸⁷ In the key towns, such as Kumase, Cape Coast, Accra and Sekondi, the efforts of the

⁸² GGC, 'Medical and Sanitary Report for the Year 1912', 186.

⁸³ Ibid.

⁸⁴ see GGC, 'Report on the Medical Department for the Year 1931-32', 34.

⁸⁵ GGC, 'Report on the Medical and Sanitary Department for the Year 1929-1930', 41.

⁸⁶ GGC, 'Medical and Sanitary Report for the Year 1913', 54. This is the first time when the number of houses inspected was recorded.

⁸⁷ For instance, in 1931/32, the sanitary department recorded 1,309,651 household inspections. In 1932 the figure was 1,590,647. The number increased in 1933 to 1,735,501 and in 1934 1,929,507 households were inspected. In 1935 the figure rose to 2,262,565. These figures are substantial given the limited availability of inspectors for most of these periods. See section on sanitary inspectors in chapter three above.

sanitary branch was sometimes complemented by voluntary organisations such as the Gold Coast League for Maternal and Child Welfare (GCLMCW). Indeed, during the early 1930s, the GCLMCW was conducting bi-weekly household visits in Cape Coast, Accra, Sekondi and Kumasi.⁸⁸

It is interesting, however, to note that even when throughout this period colonial officials continued to present household inspection as an important method of educating the people on the need for, and objects of environmental and household sanitation, the coercive element was never diminished. Household inspection continued to involve some amount of coercion through warning notices, followed by summons, prosecutions and fines when advice on important health matters was ignored.⁸⁹ In this respect, the Gold Coast was not an unusual case. In colonial Lagos, even when colonial administrators claimed that summons was only issued as a measure of last resort, Oluwasegun argues that the amount of summons that was issued proved otherwise.⁹⁰ Thus, the colonial administration used household inspections to veil the desire to force compliance with European sanitary norms and to exert control over practices in African households.⁹¹ And the sanitary inspector was the conduit for achieving this. As Patterson has observed, in colonial Accra “one of the most frequent contacts between ruler and ruled” were sanitary inspectors.⁹²

Thus, as Paterson notes, “education may have been lacking, but coercion was not.”⁹³ The deterrent effect of prosecutions and fines remained a key component of household inspections, not only in the Gold Coast but in other British West African colonies where inspection was instituted. In the Gold Coast, colonial authorities reckoned that:

Whilst sufficient emphasis cannot be laid on the desirability of limiting prosecutions as far as possible, where it has become necessary to resort to legal action after all efforts at suasion and the issue of notices have proved fruitless, it is obviously necessary that fines should be of such a nature as to

⁸⁸ GGC, ‘Report on the Medical Department for the Year 1931-32’, 34.

⁸⁹ Ibid.

⁹⁰ see Oluwasegun, ‘The British Mosquito Eradication Campaign’, 228.

⁹¹ see Moyes, ‘The Making of the Everyday’.

⁹² Patterson, ‘Health in Urban Ghana’, 256.

⁹³ Patterson, *Health in Colonial Ghana*, 40.

act as deterrents. Inadequate fines result in a contempt of the law and a disregard of the duties of citizenship.⁹⁴

Again, in a rather paradoxical statement, a SSO J. M. Dalziel stressed that while:

The work and personal influence of the Sanitary Inspectors is an important factor in the spread of knowledge of the ideas underlying sanitation...it is also obvious that prosecution for offences against sanitary laws is likely to remain for long the most educative measure amongst the illiterate population.⁹⁵

It is obvious from these pronouncements that even though education was trumpeted as a key component of inspection, there was no desire to drop the coercive elements which the African population resented.

From 1910, the sanitary department undertook many yearly prosecutions in places where Inspectors were stationed. The graph below shows the enormity of yearly prosecutions, convictions, and fines for some years for which statistics are available.⁹⁶ The variance in the amount realised in fines relative to convictions for some of the years as shown on the graph was dependent on how many people were convicted and fined for larvae offences. Larvae offences attracted higher charges than other offences. So, in years when more people were fined for larvae offences relative to the total number of convictions, the amount in fines was higher.

⁹⁴ GGC, 'Report on the Medical Department for the Year 1931-32', 29.

⁹⁵ GGC, 'Report on the Medical Department for the Year 1921', 20.

⁹⁶The data used for the graph were abstracted from the annual medical and sanitary reports from 1910-1937. I have omitted the number of houses inspected because for most of these periods information provided excluded the number of houses visited. It was from the late 1920s through the 1930s that such statistics is available. Even so such statistics also excludes in most cases, the number of people prosecuted and those fined.

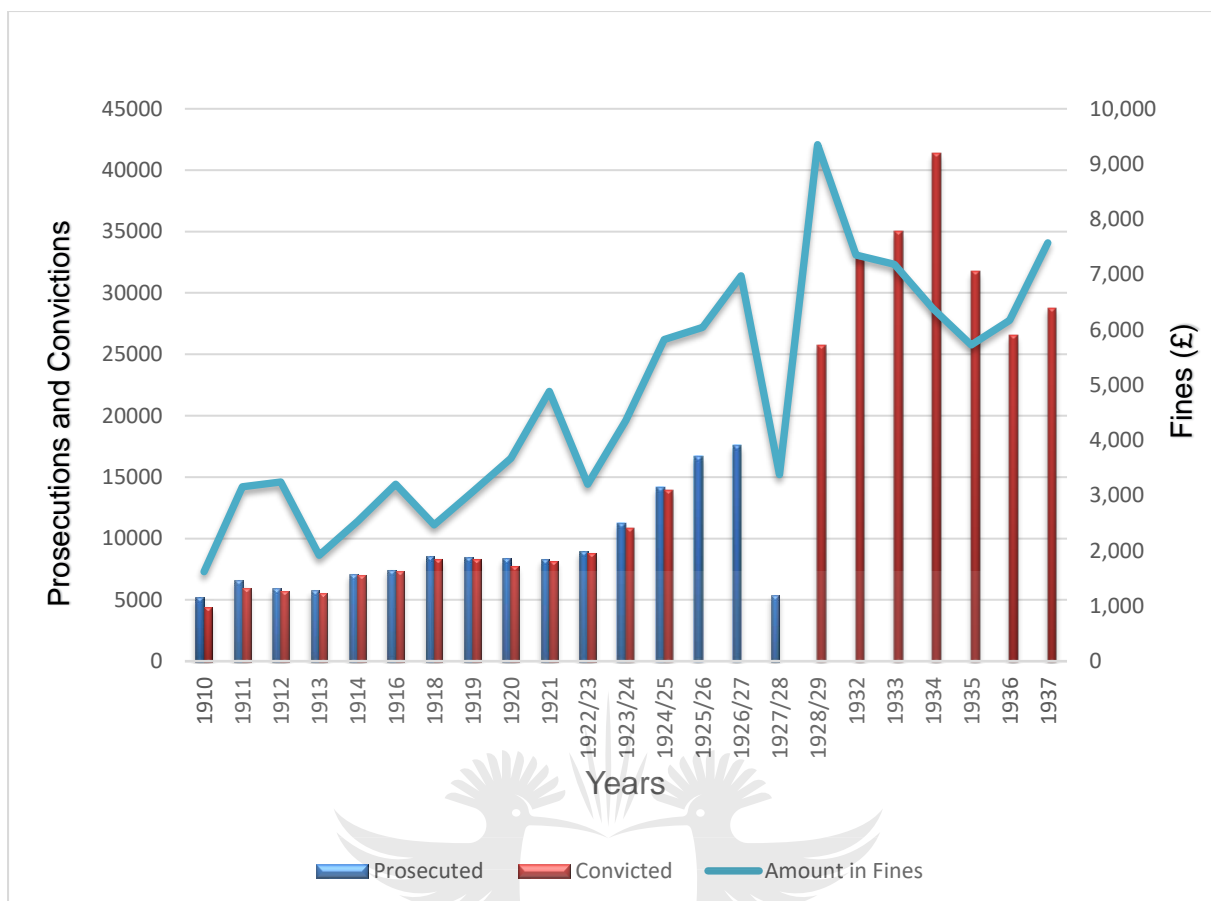


Figure 9: Graph Showing Prosecutions, Convictions and Fines for Sanitary Offences, 1910-1937. Source: Extracted from Annual Medical Reports.

The sanitary department was not alone in prosecuting sanitary offences. For some African chiefs, particularly in the central province, the trial of sanitary cases became a much-coveted enterprise and sometimes a subject of intense lobbying. For instance, in 1932, the Ohene of Ajumako in the central province wrote to the District Commissioner of Winneba persuading him to permit the trial in his tribunal sanitary cases arising in surrounding villages.⁹⁷ In a similar vein, in 1943, Aduku Ababio, the Omanhene of Mankessim in the central province wrote to the District Commissioner of Saltpond to request that all sanitary cases within his jurisdiction should be transferred to his Native Tribunal for trial to “enhance the revenue of the Mankessim Treasury.”⁹⁸

⁹⁷ ‘Minutes of Meeting No. 6/32 of the Sanitary Committee Held at the District Commissioner’s Office, Winneba on Thursday 16th August 1932’, 1932, 2, ADM23/1/368, Central Regional Archives, Cape Coast.

⁹⁸ ‘From Omanhene of Mankessim to the District Commissioner, Saltpond.’, 20 August 1943, PRAAD/ADM23/1/987, Central Regional Archives, Cape Coast.

In another instance, the Omanhene of Ayanmaim, wrote to the District Commissioner of Saltpond in 1945 in a very patronising tone to request him to allow the adjudication of sanitary cases in his Native Court B.⁹⁹ And when in 1944 the sanitary superintendent proposed to transfer the trial of sanitary cases from the Native Tribunal of the Omanhene of Ayan Denkyira he protested vehemently.¹⁰⁰ It would seem that some of these chiefs were interested in adjudicating over sanitary offences because it could potentially enrich their treasuries. It could also be that the trial of sanitary cases provided them with opportunities to leverage their authority. But more importantly, it underscores Cooper's contention that sometimes indigenous 'elites' – in this case chiefs – exploited the colonial hegemonic project to their own advantage.¹⁰¹ In this instance, chiefs turned sanitary improvement into revenue mobilisation.

Sanitary inspection and prosecution may certainly have improved the general sanitation in the Gold Coast. This was the sentiment expressed in the 1929 Medical and Sanitary report, when it was stated that, "there can be no doubt that the sanitary condition of premises in towns subject to the constant supervision of officers of the sanitation branch has undergone a very considerable improvement..."¹⁰² However, the extent to which inspection and prosecution contributed to eliminating the mosquito vector is difficult to determine. What can be observed from the available data is that household inspections increased from few hundreds in the early 1900s to millions during the 1930s and beyond, and the larval index was, except in 1930, often under 1%. Whereas this trend could be interpreted to mean that household inspections reduced the incidence of mosquito breeding in households, it would not support a claim that, inspection as a tool to eliminate the mosquito vector was an unmitigated success.

The graph below shows the number of household inspections and the corresponding percentages of compounds harbouring larval index for the years 1922, 1930, 1943, 1948, 1949 and 1950, for which data is available. As illustrated in the

⁹⁹ 'From Omanhene Ayanmaim to District Commissioner, Saltpond', 29 August 1945, PRAAD/ADM23/1/987, Central Regional Archives, Cape Coast.

¹⁰⁰ 'From Hammah III to the Ag. District Commissioner, Saltpond', 13 June 1944, PRAAD/ADM23/1/987, Central Regional Archives, Cape Coast.

¹⁰¹ see Cooper, *Decolonisation and the African Society*.

¹⁰² GGC, 'Report on the Medical and Sanitary Department for the Year 1929-1930', 41

graph, in 1922, out of four hundred and fifty-three thousand five-hundred and twenty-two households inspected the percentage of compounds harbouring larvae was 0.89%.¹⁰³ In 1943, of a total of three million one-hundred and ninety-seven thousand seven-hundred and thirty houses inspected, the percentage of compounds harbouring larvae was a measly 0.33%.¹⁰⁴ In 1948, the percentage of compounds harbouring larvae was 0.25% out of three million one-hundred and ninety-eight thousand nine-hundred and eighty-six households inspected.¹⁰⁵ The percentage in 1949 of houses harbouring larvae was 0.55% out of a total number of three million four hundred and forty-four thousand, four hundred and three households inspected.¹⁰⁶ In 1950, the larvae index was 0.35% out of a total of two million one-hundred and seventy-six thousand one-hundred and seventy-four households inspected.¹⁰⁷



¹⁰³ GGC, 'Report on the Medical Department for the Period January 1922 - March 1923', 48.

¹⁰⁴ Gold Coast Colony, 'Report on the Medical Department for the Year 1943' (Accra: Government Printing Department, 1944), 6, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹⁰⁵ GGC, 'Report on the Medical Department for the Year 1948', 16.

¹⁰⁶ GGC, 'Report on the Medical Department for the Year 1949' (Gold Coast, Accra: Government Printing Department, 1950), 13, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹⁰⁷ GGC, 'Report on the Medical Department for the Year 1950' (Gold Coast, Accra: Government Printing Department, 1952), 13, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

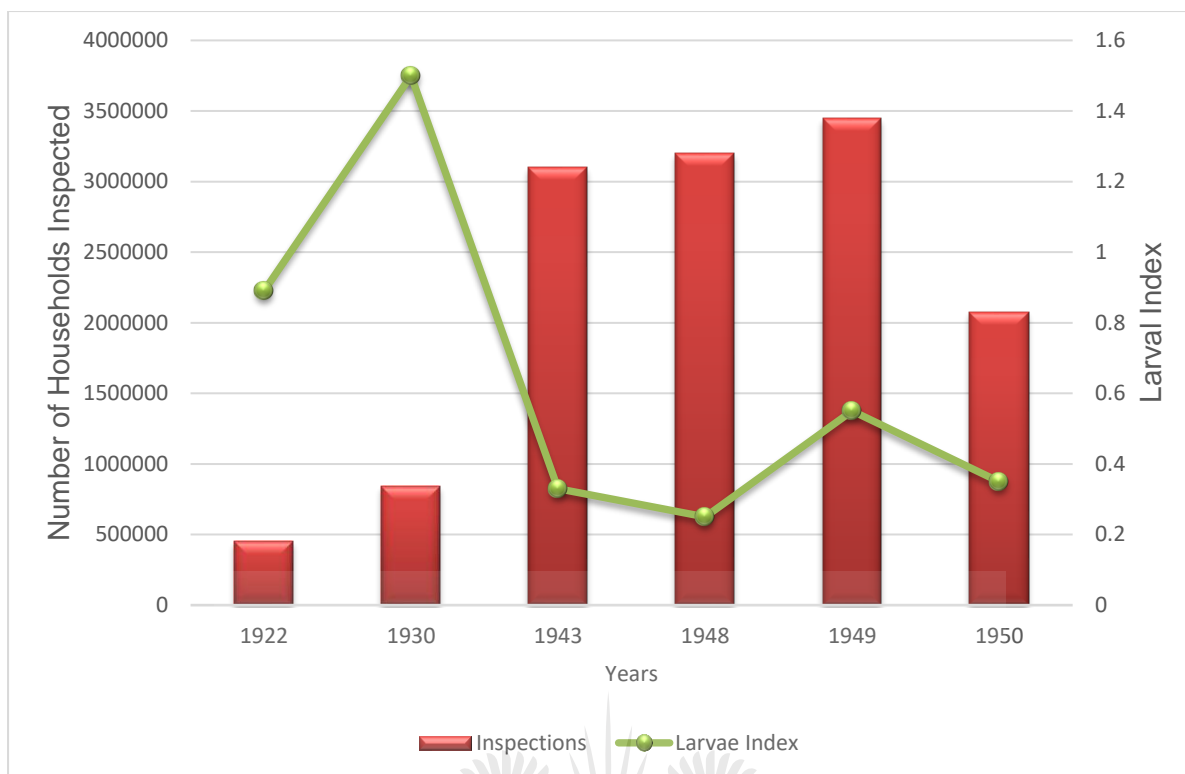


Figure 10: Graph of Household Inspections Showing Larvae Index for Selected Years. Source: Extracted from Annual Medical Reports.

The declining larvae index, however, cannot be taken to mean the diminishing presence of the mosquito. This could be the case if the decline in the larvae index reflected positively in the reported cases of malaria. As shown in the graph below, there was a steady rise in the reported cases of malaria even as inspection reports indicated a reduction in mosquito breeding. This suggests that the decline in the larvae index was by no means an indication of a triumph in the fight to eliminate the mosquito vector. Two interpretations can be inferred. Firstly, it is either Inspectors did not do due diligence for which reason they could not identify larvae even when they were present. Secondly, the health branch did not seem to attach the same level of importance to preventing the breeding of mosquitoes in other places other than in households. Thus, granted that household inspections reduced the incidence of larvae breeding in homes, the presence of conditions outside households that were conducive to the breeding of mosquitoes impinged on the fight to eliminate the mosquito vector.

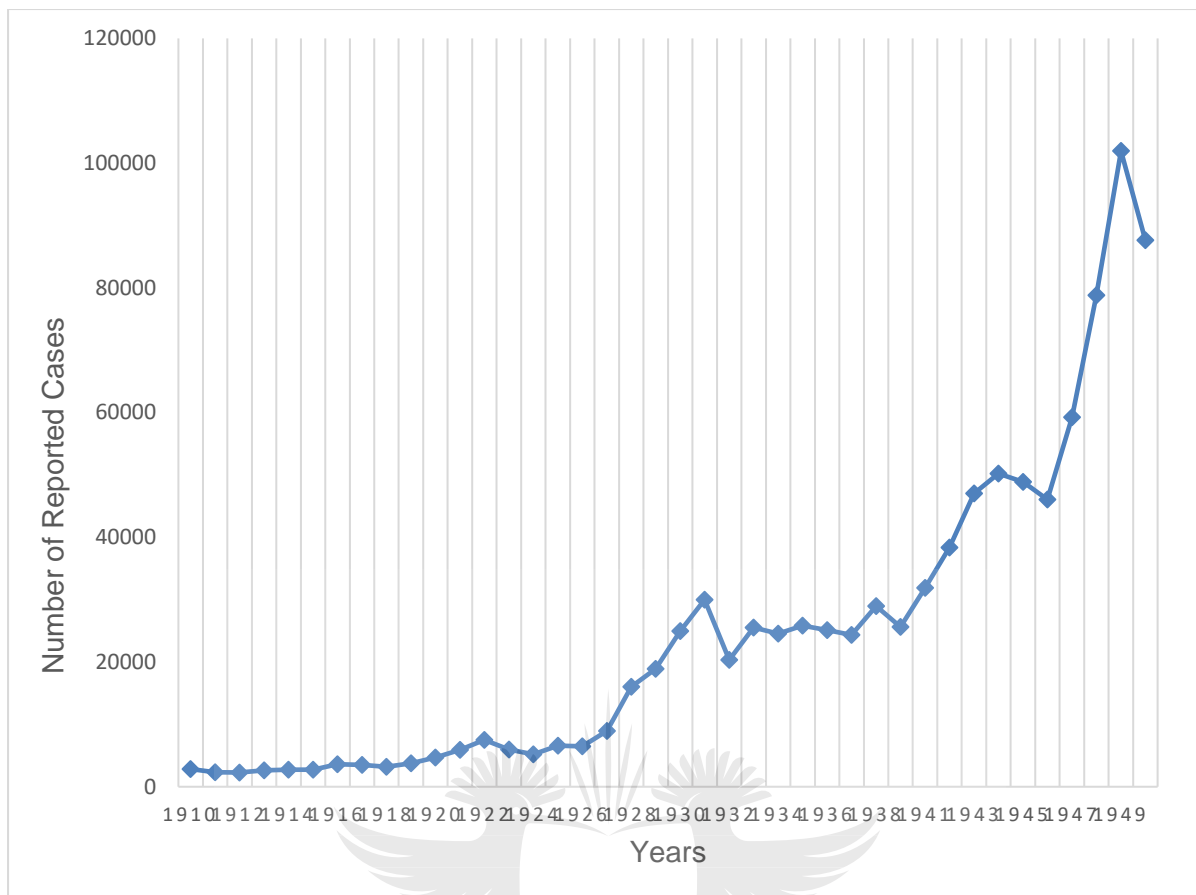


Figure 11: Graph of Reported Cases of Malaria, 1910-1950. Source: Data used for plotting the graph was taken from Addae, *The Evolution of Modern Medicine in a Developing Country*, 485

Household inspection presented the colonial administration with a conundrum. Whereas most of the African population complied with inspections to avoid prosecutions and fines, they were nevertheless not always passive to such invasions of their privacy which inspections involved.¹⁰⁸ Inspections could, as Patterson observed, “produce collisions between rulers and the ruled.”¹⁰⁹ Colonial officials recognised the potential for such collisions. Indeed, the SSO in 1912 observed that:

The enforcement of the provisions of the mosquito ordinance under which fines up to £5 can be inflicted for larval offences upon superstitious and illiterate people most inevitably arouse hostility, especially when it is remembered that they are used largely against domestic mosquito larvae found in tubs, and chatties and within their houses and compounds to which the Sanitary Inspectors have the right of entry...¹¹⁰

¹⁰⁸ see Moyes, ‘The Making of the Everyday’.

¹⁰⁹ Patterson, *Health in Colonial Ghana*, 20

¹¹⁰ GGC, ‘Medical and Sanitary Report for the Year 1912’, 96–97.

This statement was made against the background of a disorderly demonstration that was organised by some African women in Accra in January and February 1912 against the imposition of a fine of £1 for larval offences. These women argued that “there was no water that did not contain mosquito larvae, and that they were being punished for what was virtually an act of God.”¹¹¹ Yet, the colonial authorities claimed that resistances of such nature were borne out of bad faith arising out of the shared belief among the African population that the larval campaign was targeted primarily “against yellow fever, to which they are themselves comparatively immune...”¹¹²

In other instances inspection was violently opposed, such as in Cape Coast where it was reported in 1901 that the people frequently assaulted sanitary inspectors and other workers of the sanitary department.¹¹³ In another instance at Anloga, near Keta, the DC was reported to have toured the town in 1939, and having found its environs dirty, instructed the Inspector to ensure that the place was cleaned up. The Inspector requested police escort to enable him execute the Commissioner’s order because “the people were obstructive and threatened him.”¹¹⁴ When the DC decided to accompany the Inspector, he was dismayed to realise that the houses to be inspected were locked and “a large crowd looked on, refusing to identify the owners....”¹¹⁵ The DC had to apply some minimal force by breaking down doors to the houses whose premises were to be inspected to achieve compliance.¹¹⁶ In another incidence, the Bantamahene in Kumase was reported in 1942 to have refused two Inspectors entry to the section of his premises where females of his household lived.¹¹⁷ The acting DC of Kumase reprimanded him and cautioned that while medical officers loathed prosecuting a person of his standing, his outfit was unwilling to tolerate any such obstruction from him in the future.¹¹⁸

¹¹¹ Ibid., 96; Addae, *The Evolution of Modern Medicine in a Developing Country*, 129.

¹¹² GGC, ‘Medical and Sanitary Report for the Year 1912’, 96–97.

¹¹³ GGC, ‘Medical and Sanitary Report for the Year 1902’, 17–18.

¹¹⁴ Patterson, *Health in Colonial Ghana*, 20.

¹¹⁵ Ibid., 20–21.

¹¹⁶ Ibid., 21.

¹¹⁷ ‘From the Medical Officer of Health, Kumasi to the District Commissioner, Kumasi, 12 May 1942’, 1942, PRAAD/ARG6/14/3, Ashanti Regional Archives, Kumasi.

¹¹⁸ ‘From the District Commissioner to the Bantamahene, Kumasi, 14th May 1942’, 1942, PRAAD/ARG6/14/3, Ashanti Regional Archives, Kumasi. The Bantamahene was and still is a very prominent chief in Asante. For him to have refused inspectors access to his premises could be interpreted as a sign of great insubordination given that the support of chiefs of his kind was often solicited by the colonial administration in the sanitary administration of the colony. Yet the Bantamahene denied any wrong doing. His response to the DC was that

Sometimes, literate Africans and some educated chiefs also used the medium of the press or the writing of petitions and memorandums to express their resentment. For instance, in 1913, a correspondent of the *Gold Coast Nation* contended that the colonial administration had neglected fixing water pumps for Cape Coast, yet they were busy “Chasing imaginary mosquitoes” which “seems to absorb all the time and attention of Sanitary Inspectors....”¹¹⁹ In a damning, yet incisive memorandum sent to the governor in 1933, the Omanhene and people of Akim Abuakwa, while requesting of the government to allow them to take control of the sanitation of their towns and villages, noted that:

Though the government have not, in the past, devoted such attention as is necessary towards the health conditions of the people of this state, we do not propose to suggest today that Government’s expenditure be increased in this regard. We feel that it is our place to do what we can to help. We, therefore, beg to suggest that the present system whereby a sanitary headman or officer is stationed in a town under the Towns ordinance with one or two scavengers for the sole purpose of summoning people before the police magistrate or District Commissioner’s court for alleged sanitary offences be modified. The existing system is not educative. It is rather harsh, coercive and punitive and the people gain nothing thereby. The handful of scavengers or sanitary labourers cannot, and do not, do the sanitary work of the town. Yet, fines imposed on people found guilty of alleged sanitary offences imposed on people found guilty of alleged sanitary offences which are in a good many cases heavy go into the General Revenue and not spent for the benefit of such particular town.¹²⁰

Though such open confrontations and scathing criticisms did not stop household inspections, it does point to the potential of the African population to sometimes undermine the colonial administration’s claim to authority regarding the enforcement of sanitary measures.

Apart from the opposition encountered, colonial health officials also highlighted inefficient supervision, ineffective training of African Inspectors, and sometimes, the shortage of sanitary staff as some of the key hindrances to household inspection. This

he allowed the inspectors access to his premises except his stool room, which he was forbidden to open to strangers in line with native custom. see “From Bantamahene to District Commissioner, 15th May 1942,” 1942, ARG6/14/3, Ashanti Regional Archives.

¹¹⁹ quoted in Moyes, ‘The Making of the Everyday’, 42.

¹²⁰ ‘Extract from Memorandum Submitted to His Excellency the Governor by the Omanhene, Chiefs, and People of Akim Abuakwa at the Durbar Held on the 28.12.1933’, 28 December 1933, 1, CSO11/14/205, PRAAD, Accra.

was particularly the case during the first two decades of the 20th century. For instance, it was reported in 1913 that “careful supervision over Sanitary Inspectors is unfortunately very necessary and in stations where the medical officer has to do a certain amount of travelling continuous supervision is difficult...”¹²¹ In the following year, the SSO stressed that “Over Native Sanitary Inspectors, as a class, a good deal of supervision is still necessary.”¹²² Young Inspectors were particularly targeted as needing a more systematic supervision and training. Yet, the colonial administration claimed that the limited availability of funds often forestalled the provision of such training timeously.

The shortage of sanitary staff often affected the scale and quality of inspection. Shortages were acute during the onset of the First World War in 1914, and for most periods during the 1930s and 1940s. For instance, in 1915, the SSO reported that:

Shortage of European Staff has interfered sadly with the work of sanitary inspection, and in the Northern Territories, where whole districts have been shut down as far as sanitary work is concerned, sanitary inspection has come to a standstill.¹²³

Indeed, during the war, most towns where sanitary work was being done were deprived of their full staff of inspectors and this was because some of these inspectors, both European and African were drafted into the war.¹²⁴ The impact of the shortage of inspectors and the subsequent reduction in the scale of inspection on the fight against mosquito during this period was immense. For instance, the cumulative total of household inspections for the Colony Proper, Asante and the Northern Territories decreased from 466,691 in 1914 to 347,092 in 1915. Consequently, the larval index rose from 0.75 % in 1914 to 1.35 % in 1915. In Keta, it was reported that the removal of the sanitary staff in the town had caused the larval index to rise to 12.26%.¹²⁵

¹²¹ GGC, ‘Medical and Sanitary Report for the Year 1913’, 30.

¹²² GGC, ‘Medical and Sanitary Report for the Year 1915’, 47.

¹²³ *Ibid.*, 19.

¹²⁴ See section on Sanitary Inspectors in Chapter three above.

¹²⁵ GGC, ‘Medical and Sanitary Report for the Year 1915’, 19.

Swamp and Lagoon Reclamation, Drainage Construction and Weed Control

The construction of drains, the drainage of swamps and lagoons, and the filling of low-lying areas, the removal of undergrowth, and the application of larvacides were some of the ancillary anti-mosquito sanitation measures that were adopted in The Gold Coast. These techniques were pioneered in the USA and they were among the measures which William Gorgas, the Chief Sanitary Officer of the Panama Canal Commission relied on to eliminate the mosquito in Panama and Cuba.¹²⁶ Gorgas's success, according to Curtin, raised "false hopes for mosquito control in Africa."¹²⁷ However, in the Gold Coast, Raymond Dumett has suggested that Ronald Ross influenced the resort to these measures.¹²⁸ Ross subscribed to Gorgas's approach and was a known advocate of anti-mosquito sanitation that targeted the elimination of the larvae from its source and the prevention of conditions that were conducive for its breeding.¹²⁹ To Ross, therefore, the construction of drains and the application of larvacides on swamps (that could not be drained easily) were critical if the mosquito vector was to be contained.

Perhaps, Ross's influence on anti-mosquito sanitary measures in the Gold Coast could be traced, firstly, to his visit with an entourage from the Liverpool Tropical School of Medicine (LTSM) in 1901.¹³⁰ And secondly, to what seems to be a personal relationship and a regular correspondence between himself and Governor Mathew Nathan.¹³¹ Indeed, by 1902, it was reported that Dr Logan Taylor, a protégé of Ross from the LTSM, was in the Gold Coast assisting and supervising the medical department.¹³² Taylor instructed sanitary officers in proper methods of filling small holes with cement and treating large collections of stagnant water with kerosene.¹³³ By 1905, the medical department had issued a circular instructing all Inspectors and district

¹²⁶ See Amina Issa, 'Malaria and Public Health Measures in Colonial Urban Zanzibar, 1900–1956', *Hygiea Internationalis* 10, no. 2 (2011): 35–36.

¹²⁷ Curtin, 'Medical Knowledge and Urban Planning in Tropical Africa', 600.

¹²⁸ see Dumett, 'The Campaign against Malaria'.

¹²⁹ see *ibid.*; Spitzer, 'The Mosquito and Segregation in Sierra Leone'.

¹³⁰ see GGC, 'Annual Medical and Sanitary Report on the Gold Coast Colony for the Year Ended 31st December 1901'.

¹³¹ Dumett, 'The Campaign against Malaria', 168.

¹³² GGC, 'Medical and Sanitary Report for the Year 1902'; Dumett, 'The Campaign against Malaria', 168.

¹³³ Dumett, 'The Campaign against Malaria', 168.

officers to regularly fill or drain small depressions, clear bush that could potentially conceal stagnant water, and recruit teams to apply larvacides on large accumulations of stagnant water. These instructions were in line with the advice received from the team from the LTSM.

Progress in this direction, however, appeared to be slow during the first decade of the 20th century. Drainage construction, for example, did not receive much attention until after the first decade of the century. For instance, in 1906, the Medical Officer of Sekondi, H. Carlaw, lamented that “The drainage system here is almost useless... the drains lead the water from the upper end of the town to the lower, where it collects and forms a swamp in the wet season.”¹³⁴ In Tarkwa, it was observed that even in European quarters, the drainage system was very bad. There was only one good cement drain, and all the others were simple gutters. The main street of the town had a cement drain; however, it had an earth bottom which was not graded and therefore retained wastewater instead of running it off.¹³⁵ In Kumase, drain construction was only started in 1908 and even so, not much progress was made that year.

A beginning was, however, made in 1910 following the establishment of the sanitary department, and funds were voted annually towards the exercise. For instance, in 1910, a little over eight-thousand six hundred and eight lineal yards of masonry drains were constructed and six thousand forty-one yards of ditches, and or gutters were dug and graded in the principal towns and villages where sanitary work was being undertaken.¹³⁶ Addae has observed that in 1910, out of the eighteen towns and villages where sanitary work was being done only nine had concrete drains.¹³⁷ However, in that year an extensive plan was conceived to develop drainage schemes in Accra and Sekondi.¹³⁸ Progress was, however, slow. The colonial administration was aware that the provision of surface drains needed to be tackled urgently if the sanitary question was to be addressed sufficiently. Yet, the administration contended that the large number of towns that needed drainage systems inhibited speedy

¹³⁴ GGC, ‘Medical and Sanitary Report for the Year 1906’, 22.

¹³⁵ Ibid.

¹³⁶ GGC, ‘Medical and Sanitary Report for the Year 1910’, 54.

¹³⁷ Addae, *The Evolution of Modern Medicine in a Developing Country*, 129.

¹³⁸ GGC, ‘Medical and Sanitary Report for the Year 1910’; Addae, *The Evolution of Modern Medicine in a Developing Country*.

progress.¹³⁹ Therefore, attention was focused rather on the principal towns such as Accra, Sekondi and Cape Coast where it was reported in 1913 that considerable progress was made in providing surface drainage.¹⁴⁰

The difficulties of raising revenue, importing construction materials among other adverse effects of World War I further derailed the efforts at constructing drains. Indeed, the colonial administration pleaded the lack of funds as the key impediment to the provisioning of drains in stations other than Accra, Sekondi, and Kumase.¹⁴¹ Thus, for most of the period during the War attention was focused on repairing the few existing open drains rather than providing new ones. After the War, however, efforts were made to construct some additional drains. Even so, much of the work was still confined to principal towns. For example, in 1920, six thousand six hundred and eighty-four) linear yards of drains were completed in Accra, One thousand four hundred and forty-four linear yards in Cape Coast, one thousand eight hundred and thirty-two in Sekondi, two thousand one hundred and fifty-one in Axim and one thousand eight hundred and forty-nine in Kumase. In other towns, it was reported that "...important additions were made to previously properly constructed drains."¹⁴² And whereas in subsequent years, concrete drains continued to be provided in all stations where sanitary work was being done, these were mainly of the surface type.

No sub-soil drainage existed in any part of the Gold Coast by 1926.¹⁴³ And not many concrete drains could be constructed in the 1930s because of the financial constraints imposed by the 1929/1930 global economic recession. Similarly, in the 1940s, attention was rather focused on maintaining and repairing existing concrete drainage systems which were falling into disrepair because of the financial and logistical constraints imposed by World War II and the economic depression that preceded it.¹⁴⁴ Thus, the attempt to provide drains to contain the breeding of mosquitoes and to keep the environment clean was anything but impressive.

¹³⁹ GGC, 'Medical and Sanitary Report for the Year 1913', 28.

¹⁴⁰ see GGC, 'Medical and Sanitary Report for the Year 1913'.

¹⁴¹ GGC, 'Medical and Sanitary Report for the Year 1915'.

¹⁴² GGC, 'Report on the Medical Department for the Year 1920', 20.

¹⁴³ see GGC, 'Report on the Medical and Sanitary Department for the Period April 1925 - March 1926', 19. In Kumase, the main drain of the town which was called the Insubin (Zubin) drain was almost complete by 1927. But of course, it was the surface water drainage type.

¹⁴⁴ see Addae, *The Evolution of Modern Medicine in a Developing Country*, 129.

Yet, it does appear that the attitude of the African population towards the use of these drains, also, undermined the purpose for which they were constructed. Colonial officials, often, lamented that drains were put into objectionable use as the inhabitants found them as convenient avenues for the disposal of refuse of varying kinds.¹⁴⁵ For instance, J.M. Dalziel, a SSO lamented in his 1921 annual report that the existing drains “require constant attention, in order to be kept in a sanitary condition, as they are apt to be misused by the people who do not appear to understand their purpose.”¹⁴⁶ In a similar vein, in 1930, the regent of Upper Town, Salt Pond, Mr Pyne complained about the objectionable odour emanating from drains in the town as a result of residents emptying their chamber pots and other waste substances into them.¹⁴⁷ Addae is, thus, correct when he suggests that the maintenance and upkeep of the existing drains alone, “taxed to the utmost the available labour force”¹⁴⁸ of the sanitary department.

If the efforts at providing surface water drains in towns and villages did not produce the desired result, dealing with lagoon and swamp reclamation was even a more difficult undertaking, the result of which was equally unimpressive. Many towns, particularly those along the coast were dotted with “sluggish streams, swamps, and pools whose drainage often presented considerable difficulties.”¹⁴⁹ Even in the interior, where most towns were sited in well-drained areas, there were equally low-lying areas and depressions that accumulated stagnant water of varying levels.¹⁵⁰ Measures to deal with swamps, lagoons and depressions in the early 1900s were mostly *ad hoc* and small scale. For instance, while in 1913, it was recognised that two large swamps in Kumase formed by the east and west Insubin streams were breeding grounds for *Anopheles* mosquitoes, the Medical Officer only instructed for it to be drained by means of an open ditch.¹⁵¹

¹⁴⁵ see GGC, ‘Medical and Sanitary Report for the Year 1915’, 17.

¹⁴⁶ GGC, ‘Report on the Medical Department for the Year 1921’, 19.

¹⁴⁷ ‘Minutes of Meeting of the Salt Pond Sanitary Committee Held on Monday 3rd November 1930’, November 1930, 2, ADM23/1/2436, Central Regional Archives, Cape Coast.

¹⁴⁸ Addae, *The Evolution of Modern Medicine in a Developing Country*, 1929.

¹⁴⁹ *Ibid.*, 129.

¹⁵⁰ see Addae, *The Evolution of Modern Medicine in a Developing Country*.

¹⁵¹ GGC, ‘Medical and Sanitary Report for the Year 1913’, 19.

In many towns, small depressions, borrow pits and swamps were in most cases filled with incombustible materials and sometimes the ashes from incinerated refuse.¹⁵² In areas where there were no incinerators, refuse of varying kind was dumped in swampy and or low-lying areas, and then covered with a top dressing of sand. This method was recognised to be effective in dealing with the incidence of mosquito-breeding, yet, it was also said to be objectionable to many people because of its potential to breed flies and serve as a harbourage for rats. The bad odour that was produced from the decomposition of organic matter in the refuse deposited without prior effective incineration was also resented. Consequently, during the late 1920s, this method was abandoned.¹⁵³

The most comprehensive effort to deal with the sanitation of swamps and lagoons was started in the late 1920s. Yet these were still confined to the principal towns. For instance, the filling of the Ejisu road swamp in Kumase was started in 1929 and by the end of 1930, about one-third of the area was reclaimed. In addition, the permanent drainage of a swamp close to the European residence in Kumase was begun in 1929 and by the close of the year about three-hundred and eighty yards of concrete drain was completed. In the same year, the Korle-Lagoon reclamation project in Accra was started.¹⁵⁴

The Accra scheme was the most ambitious and comprehensive of any reclamation scheme ever started in the Gold Coast. Colonial officials justified the need for the scheme on the grounds of the nuisance caused by the smell from the lagoon, and most importantly, its notoriety as the worst source of mosquito breeding in Accra. In 1927 the acting DDSS, and the DMSS agreed to prioritise the Korle-Lagoon reclamation scheme among other sanitary works to be undertaken in Accra. However, this was subject to the availability of funds.¹⁵⁵ The political authorities supported the

¹⁵² see GGC, 'Report on the Medical and Sanitary Department for the Period April 1926 - March 1927', 28.

¹⁵³ see GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929', 30.

¹⁵⁴ The claim by Stephen Addae that the project was started by Army Service Engineers does not seem to be supported by the available evidence. His source which is p. 20 of the Annual medical report does not mention army service engineers as those working on the project. Army Service Engineers, however, got involved in 1943, at a time when the project had been abandoned by the colonial administration for want of funds.

¹⁵⁵ 'A Report on the Service Control Scheme at Accra and Takoradi, May 1945', May 1945, 1-2, PRAAD/ADM5/3/46, PRAAD, Accra This report contained a history of the Korle-lagoon reclamation scheme prior to 1945.

need for the scheme. Indeed, Governor A. Ransford Slater (1927-1932), in a letter to the Secretary of State dated 7 May 1929 argued that:

For the years past, in furtherance of the campaign against malaria and yellow fever, measures have been taken to destroy mosquitoes by attacking their breeding places, but the lagoon, which is by far the worst source of trouble has been subjected to only such palliative treatment as has been possible with the limited funds available, and in my opinion and that of the sanitary authorities it is time that these necessarily haphazard and disjointed efforts should be replaced by a programme of work designed to secure a definite result.¹⁵⁶

The colonial administration stressed that:

This scheme will have a far-reaching effect upon the general health and comfort of the people of Accra and at the same time will result in the acquisition of hundreds of acres of parkland and additional building sites.¹⁵⁷

The entire project was to last for six years and it was estimated to cost £195000. A budget of £27700 was approved for the first phase which appeared to have been completed in the early 1930s.¹⁵⁸ Yet, for various reasons, key among them being financial stringency, the remaining part of the project was never completed, and worse, the section that was completed was not properly maintained.¹⁵⁹ So that by the early 1940s, the lagoon had silted up and filth of varying degrees had been allowed to accumulate on the mouth of the various drains entering the lagoon.¹⁶⁰

The arrival of British and American military personnel in Accra during the Second World War once again revived interest in sanitising the Korle-Lagoon. In 1942 the Inter-Allied Malaria Control Group (IAMCG), an *ad hoc* group of British and American scientist were brought together to fight against malaria in Accra. This was part of efforts to protect allied troops stationed in Accra against malaria infestation.

¹⁵⁶ This letter was reproduced in *ibid.*, 1.

¹⁵⁷ GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929', 30. The suggestion that the project could result in the availability of more land, however, betrays the latent intention of the colonial administration. That is even if the manifest intention of colonial reclamation projects was to control the breeding of mosquitoes, an additional motivation which fed into the colonial agenda was the acquisition and control of land.

¹⁵⁸ see 'A Report on Service Control Scheme'; Roberts, 'Korle and the Mosquito'.

¹⁵⁹ see Addae, *The Evolution of Modern Medicine in a Developing Country*; 'A Report on Service Control Scheme'.

¹⁶⁰ 'A Report on Service Control Scheme', 2.

The IAMCG took over the Korle-lagoon reclamation project between 1942 and 1945.¹⁶¹ After the war, the project once again, run into a halt. And by 1950, the lagoon had once again silted up. Addae remarks, the drainage was turned into another artificially created grounds for mosquito breeding.¹⁶²

It is interesting to note that a scheme like the Korle-Lagoon reclamation project, which was devised in Sekondi-Takoradi in 1942 by the IAMCG and completed in 1943 suffered a similar fate as that of the Korle-Lagoon reclamation project. Indeed, as early as 1944, the health department complained that it could not maintain the scheme because of the shortage of staff and the cost of maintenance.¹⁶³ Thus, it does appear as Jonathan Roberts has argued, that the colonial administration simply lacked the resources to permanently eliminate the local population of the *Anopheles* mosquito in the Gold Coast. Indeed, “While they did briefly remove mosquito larvae from the Korle watershed, they could not afford to re-engineer the lagoon in a manner that would impose their vision of urban health”¹⁶⁴ on the city of Accra. The same is true of the Sekondi-Takoradi scheme. To that extent, it can be argued that dealing with swamps, lagoons, depressions of varying kinds, and stagnant pools was yet another sanitary failure of the colonial administration.

Other swamps and lagoons that could not be easily drained were treated with larvicides. Kerosene was mostly used during the early part of the 1900s. By 1911, larvicide application had become a routine activity of the sanitary department which was executed by mosquito brigades.¹⁶⁵ However, the relevance and effectiveness of this larvicide application were in doubt even amongst colonial officials, particularly, officials of the sanitary department who did not seem to appreciate the impact of larvicide application on mosquito control. For example, in 1915, the question was

¹⁶¹ “A Report on Service Control Scheme”; Jonathan Roberts, “Korle and the Mosquito: Histories and Memories of the Anti-Malaria Campaign in Accra, 1942–5,” *The Journal of African History* 51, no. 03 (2010): 343–365. In 1941, when Allied troops fighting in North Africa were cut off from receiving supplies via Mediterranean supply routes, the Allied forces were forced to send supplies to their troupes by air through West Africa and Accra became the stop over point for British and American aircrafts but also the staging base for troops recruited from the colonies.

¹⁶² Addae, *The Evolution of Modern Medicine in a Developing Country*, 130.

¹⁶³ see GGC, ‘Report on the Medical Department for the Year 1944’.

¹⁶⁴ Roberts, ‘Korle and the Mosquito’, 364.

¹⁶⁵ Mosquito brigades comprised the more intelligent scavengers who were grouped together under the supervision of a headman for purposes of searching for mosquito larvae and collecting all portable articles which could potentially serve as breeding spaces for mosquitoes.

raised by the SSO as to "...whether oiling though a good larvicidal measure in certain cases, and under strict supervision is a political undertaking."¹⁶⁶ The SSO observed that:

For economic reasons it quite fails to deal with some of our lagoons and larger pounds. And in the case of smaller and more amenable collections of water oiling is often adopted as a palliative where more radical treatment should and could be attempted.¹⁶⁷

Such remarks from a senior officer of the sanitary department does reveal the sometimes-unspoken tensions that existed between the political authorities and the medical officials regarding the best way to solve the sanitation problem in the colony.

The African population also resented the application of larvacides on the swamps, pools, and ponds, especially because some of the ponds and stagnant pools served as sources of water supply. Thus, whereas the colonial administration presented the application of larvacides as a sanitary measure, the African population viewed it as a source of contamination. Some educated Africans sometimes stirred up resentment against the colonial administration by accusing the sanitary branch of putting carbolic acid into their sources of water supply. An incident recorded in 1902 is worth noting:

...in one of the chief towns of the colony, in which everything possible to improve sanitation is being done by Government, kerosene was being used to destroy mosquito larvae, and the people were told by a native medical man (holding qualification from a British university) that it was not kerosene that was being put on the water but carbolic acid, and not to allow it to be done.¹⁶⁸

To the colonial administrators, the behaviour of the African elite was mischievous and contemptuous. However, his action does reveal the tensions and distrust that characterised the relationship between the colonial administration and the African population. Even so, the use of larvacides continued deep into the 20th century. By 1928/29, "Paris Green" a chemical substance that was mostly used in the United States of America (USA) and some parts of Europe to control mosquito breeding in

¹⁶⁶ GGC, 'Medical and Sanitary Report for the Year 1915', 13.

¹⁶⁷ Ibid.

¹⁶⁸ GGC, 'Medical and Sanitary Report for the Year 1902', 17.

swamps was being applied on large scale in the Gold Coast. And it was said to be producing effective results.¹⁶⁹

The presence of bushy surroundings in most towns and villages was seen to be a great nuisance that could undermine the fight against the mosquito. Bushy surroundings were seen to conceal numberless thrown out tins, bottles, old calabashes, snail-shells and other related materials that could potentially retain water and serve as ideal nurseries for mosquito larvae.¹⁷⁰ The colonial administration, therefore, aimed not only to have the interior of towns and villages cleared of bush but also to have their entire outskirts also well cleared to the extent of at least 100 yards.¹⁷¹

Bush clearance was started in 1910 following the outbreak of the yellow fever epidemic. In 1910 alone about 4,531,743 square yards of bush was cleared.¹⁷² In subsequent years a special budget was set aside for this exercise. For example, in 1911, an amount of £1,200 was allocated for the clearance of government lands. This was increased to £2,400 in 1912.¹⁷³ Clearance of weeds in a town or village could be done multiple times in a year, but this depended on the availability of funds and labour. But in most cases clearance occurred either quarterly or twice in the year.¹⁷⁴

In the colony proper, chiefs, headmen, and all persons inhabiting towns and villages where the Towns Ordinance was applicable were required by regulation to keep open spaces in their towns/villages and its surroundings free from bush and refuse or anything that could conduce to the breeding of mosquitoes or contribute to insanitary conditions. Chiefs/headmen who failed to adhere to these regulations were prosecuted and fined if found guilty. In Asante and the Northern Territories rules regarding bush clearance were made and applied in townships and small villages. Occupants of households were required to clear their surroundings of bush to the extent of twenty yards from their premises. Failure to do so attracted a fine not below 40 shillings. In communities where this rule was not applicable chiefs/headmen were

¹⁶⁹ GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929', 20.

¹⁷⁰ GGC, 'Report on the Medical Department for the Year 1936', 28.

¹⁷¹ GGC, 'Medical and Sanitary Report for the Year 1910', 55.

¹⁷² Ibid.

¹⁷³ GGC, 'Medical and Sanitary Report for the Year 1911'; GGC, 'Medical and Sanitary Report for the Year 1912'.

¹⁷⁴ see GGC, 'Medical and Sanitary Report for the Year 1914', 70.

required to cause to be made and maintained a clearing of fifty yards in depth around the village.¹⁷⁵ However, in 1931/32 it was observed that:

Practically speaking this clearing is frequently neglected and efforts to secure compliance with this...not infrequently end in failure, since the feeling of responsibility for sanitary state of their towns and villages is with a small number of brilliant exceptions – conspicuous by its absence.¹⁷⁶

In townships where the government was directly responsible for the cost of bush clearance, farming was encouraged on open spaces around the margins of the European residential areas since this reduced the expenditure involved in hiring clearing gangs. This was, however, contingent on the availability of adequate supervision and if the rainfall pattern permitted. Again, this 'privilege' was accorded only to persons who were willing and able to maintain their farmed area free from tins, bottles, refuse, excrement.¹⁷⁷ Also, not every crop was allowed. The acceptable crops were cassava and groundnuts. Others such as plantain, banana, and pineapple were excluded because of their water retaining properties.¹⁷⁸

During the 1930s through to the 1950s, perhaps owing to the lack of funds and labour, the leasing of open spaces for farming became a preferred option and most open spaces were leased for controlled farming. And this was not yielding satisfactory results.¹⁷⁹ W. M. Howells, a senior health officer observed that:

The maintenance of a well-cleared zone round rural townships and villages is one of the greatest difficulty. If an area of 50y yards is cleared, the tendency is to plant crops right up to the compound walls. Owing to the fouling of this area for a series of years it probably produces the richest crops...cover is afforded for tins and bottles. Water retention inevitably results in the rains, and ideal facilities are offered for the propagation of *Aedes aegypti*. This factor discounts to some extent the value of a larval index in such areas. Houses and compounds are often free of larvae, but right up against the compound fence there may be long grass or tall crops covering deposits of tins and bottles, the majority of which contain water and many of them, larvae.¹⁸⁰

¹⁷⁵ see GGC, 'Report on the Medical Department for the Year 1931-32', 28.

¹⁷⁶ Ibid., 29.

¹⁷⁷ Ibid. It is interesting to note that initially the privilege to farm in open spaces was not allowed in African neighbourhoods.

¹⁷⁸ GGC, 'Report on the Medical Department for the Period January 1922 - March 1923', 30.

¹⁷⁹ see GGC, 'Report on the Medical Department for the Year 1936'.

¹⁸⁰ GGC, 'Report on the Medical Department for the Year 1932-33' (Accra: Government Printer, 1933), 30, GH/PRAAD/ADM5/1/128.

It would thus, seem that the preference for controlled farming over continuous clearance was economically beneficial to the colonial administration. But this was not in the least beneficial to keeping towns and villages cleared of bush, which the colonial administration purported to achieve with this measure.

Even so, the government applauded this exercise during the early phase of implementation, as one of the most satisfactory of all the general preventive measures, because it achieved for them so many desirable objects at the same time. In 1915, it was observed that the exercise had ensured that in larger towns "...a good deal of land had been won permanently for the purposes of town extension schemes and recreation."¹⁸¹ Thus, while serving as a preventive measure, bush clearance also facilitated the acquisition and control of land and, could thus, potentially further the urban spatial design ambitions of the colonial administration.

The Teaching of Hygiene and Sanitation

It is probably through the rising generation alone that one can hope to raise the general standard of knowledge and to improve the present unhygienic manners and habits. A capable sanitary organisation and a vigilant staff can do much to check epidemics and to reduce the incidence of infective disease associated with unclean conditions, but these can only become fully effective when attained by a higher standard of life on the part of the individual quite as much as by the larger measures of public health administration.¹⁸²

J. M. Dalziel, a Senior Sanitary Officer in the Gold Coast made this statement in 1921. He was commenting on the progress in the teaching of sanitation and hygiene to school children and the need to intensify efforts in this regard. Despite its characteristic condescending tenor, the statement betrays the crucial role that the colonial authorities envisaged for the education of the African child, to play in propagating knowledge about sanitation and hygiene. As Burke illustrates, in Africa education provided the space for colonial discourse about cleanliness and manners.¹⁸³ It was the considered opinion of colonial administrations in most parts of Africa that the teaching of hygiene was necessary to inculcate in African children better habits and healthier ways of living. It was also considered to be dangerous to leave the colonised ignorant of protective measures against contagion and epidemics since the

¹⁸¹ GGC, 'Medical and Sanitary Report for the Year 1915', 17.

¹⁸² GGC, 'Report on the Medical Department for the Year 1921', 21.

¹⁸³ see Burke, *Lifebuoy Men, Lux Women*.

outbreak of diseases would also affect the European population.¹⁸⁴ To that extent teaching sanitation and hygiene to the African population was essential not only because it might influence their supposed insanitary habits, but because it was necessary if the health of European colonial officials was to be protected.

The provision of sanitation and hygiene education in the Gold Coast was first raised in 1888 by Farrell Easmon. Easmon observed that the problems of practical sanitation in the Gold Coast was similar in scope to those experienced in India and, therefore, recommended that addressing these should follow the lines of the “Indian Solution” – which was the education of the ‘Native.’¹⁸⁵ Drawing copiously on an editorial in the *Indian Medical Gazette* published in 1888, Easmon argued that:

The advantage of general education which implies a raising of the standard of living, a progress from savagery to refinement, is no doubt the cardinal condition of appreciation of the need, use, advantage, and comfort of sanitation. Special education in the laws and requirements of health is also highly useful as impressing on the young the fundamental maxims of hygiene. But the most promising and practical method of sanitary education is the demonstration of the utility and luxury of sanitary arrangement and requirements...It is not enough that the people should be told and taught to know what is good for them in this respect. This kind of knowledge is excellent in its way, but it is infinitely better that the people should be taught to feel by experience how much sanitation contributes to render life more agreeable and secure.¹⁸⁶

To that extent, he suggested that education on sanitation and hygiene should proceed conterminously with the provision of sanitary amenities. As he correctly observed, “A man who has tasted clean water and breathed an atmosphere kept habitually pure by proper drainage and conservancy is not likely to rest with content with foul drink and faetid (sic) air.”¹⁸⁷

The institutionalisation of the teaching of sanitation and hygiene was delayed until 1905 when a scheme for teaching Elementary Hygiene in government and assisted schools was inaugurated.¹⁸⁸ This was in line with directives to all colonial administrations in the British Empire during the early 1900s to ensure the teaching of

¹⁸⁴ see A. A. Jaques, ‘Teaching of Hygiene in Native Primary Schools’, *Journal of International African Institute* 3, no. 4 (1930): 501–5.

¹⁸⁵ see GGC, ‘Gold Coast Sanitary and Medical Report for 1887 and 1888’, 33.

¹⁸⁶ *Ibid.*

¹⁸⁷ *Ibid.*

¹⁸⁸ GGC, ‘Medical and Sanitary Report for the Year 1907’, 10.

hygiene and sanitation in schools.¹⁸⁹ By 1909, the subject had been made compulsory in standards II to VI in all government and assisted schools throughout the Gold Coast.¹⁹⁰ By 1911, the Director of Education could report that the pupils in the upper grades were beginning to demonstrate intelligent knowledge of the subject.

The colonial administration did not desire for the pupils to acquire only theoretical knowledge of sanitation and hygiene. Rather they wished for the teaching of the subject to reflect the realities of the sanitation problems in the Gold Coast in a manner that could influence the daily habits and practices of the African population. It was hoped that after acquiring the appropriate scientific knowledge and experience the pupils would transmit and apply the knowledge to their homes and villages.¹⁹¹ The Sanitary Department, therefore, suggested some practical methods to guide teachers in their teaching. For example, teachers were encouraged to place larvae in a bottle full of water in the classroom, the top covered with gauze and inspected until the imago emerged from the water.¹⁹² The sanitary department was optimistic that through this experimentation, the teachers could demonstrate to the pupils that mosquitoes breed in water.¹⁹³

The mosquito-proofing of barrels was also to be demonstrated to pupils, and on the walls of classrooms, large pictures of the mosquito in its various stages of growth from egg to imago, pictures of typical *anopheles* pools and insanitary compounds, among others were to be displayed.¹⁹⁴ Furthermore, to demonstrate the

¹⁸⁹ see Burke, *Lifebuoy Men, Lux Women*, 37. By 1903, Zimbabwe had already introduced instruction in hygiene in elementary schools and so was Lagos. The teaching of hygiene in the Gold Coast hit an initial snag – which concerned the lack of literature on the subject and teachers could, therefore, not acquire enough information on the subject to “enable them, with any reasonable hope of success, to transmit it to the pupils.” To mitigate this challenge, the Medical Department consulted with the Director of Education in 1907 and devised an organised and systematic course of training for teachers. Arrangements were made at eleven selected stations where reasonable number of teachers could attend regular courses of lectures which was given by Medical Officers. The Medical Department encouraged voluntary participation by other interested persons other than teachers. And such persons were awarded with certificates of proficiency. To ensure uniformity in instruction, the Medical Officers offering lectures to the teachers were encouraged to use Dr Prout’s book on tropical health as the basis of their lectures. The teachers were to be examined by a board of medical officers and proof of proficiency was a precondition for taking the rest of their examinations (GGC, Medical and Sanitary Report for the Year 1907, 10).

¹⁹⁰ GGC, ‘Medical and Sanitary Report for the Year 1909’, 12.

¹⁹¹ Sandra E. Greene, *Sacred Sites and the Colonial Encounter: A History of Meaning and Memory in Ghana*, 1st Edition (Bloomington: Indiana University Press, 2002), 74.

¹⁹² GGC, ‘Medical and Sanitary Report for the Year 1911’, 65.

¹⁹³ see GGC, ‘Medical and Sanitary Report for the Year 1913’, 83.

¹⁹⁴ GGC, ‘Medical and Sanitary Report for the Year 1911’, 65.

proper ways of building to conform to sanitary and hygienic principles the department recommended that “a model of a simple type of sanitary house should be provided and regular demonstration given, to illustrate the provision of cubic space, light and ventilation area, compound space etc.”¹⁹⁵

These recommendations seemed to have caught on well with some schools. In 1913, the education department expressed satisfaction that the teaching of the subject had departed from theoretical concerns and emphasis was laid more on the practical aspects. Pupils’ were instructed, for example, not just about the desirability of pure water, but also, “the fact that the straining of water through a cloth will, at least, remove the impurities in suspension and that boiling” could “nullify the chances of contracting Guinea-worm.”¹⁹⁶ Again, the overemphasis on the scientific explanation of the evolutionary processes of the mosquito was downplayed and attention was rather focused on the necessity for removing the breeding places of the mosquito.¹⁹⁷ It was also noted that teachers demonstrated the necessity for ventilation through appropriate experiments. An acting Director of Education, P. Mayall, wrote in 1914 that:

Many of the teachers have begun to understand that the teaching of hygiene means more than the delivery of scientific names and facts and have endeavoured to make the children understand the practical, everyday value of what they teach.¹⁹⁸

In this regard, some teachers appeared to have demonstrated ingenuity in adopting sophisticated teaching techniques. In one recorded instance, a teacher employed the technique of dramatisation to demonstrate the value of hygiene to his pupils. It was reported that:

The teacher made the children model in clay a native village having the usual native defects in sanitation. Under his supervision, the children also modelled a village constructed under proper sanitary conditions. Then one boy acted the part of the chief of the village; a second boy acted the part of the chief of the village; a third boy acted as interpreter; a fourth boy as Sanitary Inspector and the rest of the children formed a chorus of villagers. The sanitary Inspector through the interpreter explained to the chief in the presence of the villagers

¹⁹⁵ Ibid.

¹⁹⁶ GGC, ‘Medical and Sanitary Report for the Year 1913’, 83.

¹⁹⁷ Ibid.

¹⁹⁸ GGC, ‘Medical and Sanitary Report for the Year 1914’, 101.

how defective his village was, and having combated all the chief's objections, produced the model of the correctly planned village and showed the chief all the advantages to be derived from a village so laid out.¹⁹⁹

For the director of education, such an advancement in teaching was an indication of the growth in the peoples' appreciation of sanitation.²⁰⁰

To facilitate a more efficient teaching Strachan's *Elementary Hygiene*, considered to be a more appropriate textbook was adopted in 1914 to replace Mrs Deacon's *Lectures on Hygiene*, which was the basic textbook for teaching in schools.²⁰¹ Additionally, an award scheme was instituted and prizes were awarded to schools for clean and hygienic upkeep of premises and compounds, and teachers for a like maintenance of their houses.²⁰² In a similar vein, prizes were awarded to teachers who were adjudged to have made their teaching practical oriented and illustrated their lessons with experiments.²⁰³

Nonetheless, sometimes, colonial officials expressed conflicting opinions about the teaching of hygiene and its impact on the lives of the people. For example, in 1909, whereas the Director of Education reported that fair progress had been made in the teaching of the subject, an acting director from the same Department expressed the opinion that there was general difficulty due to the failure of teachers to show practical examples to their pupils. And in a characteristically condescending slant, the acting PMO, P.J. Garland corroborated the acting Director, noting that "I am personally of the opinion that one of the last matters of interest to the Native mind is the consideration of even simple sanitary principles."²⁰⁴ He further expressed an uncanny pessimism about the possibility of the teaching of hygiene to improve sanitation in the colony. He noted that:

There is very little advancement to show for either the oppressive measures or the teaching of elementary hygiene and sanitation and we cannot anticipate more than a very gradual improvement, as long as native families and their retainers live under the existing conditions with the wide divergencies (sic) in

¹⁹⁹ Ibid.

²⁰⁰ see GGC, 'Medical and Sanitary Report for the Year 1914'.

²⁰¹ However, by 1919 the use of textbooks for teaching the subject in primary schools was generally discouraged, since it was felt that its use could result in the subject being too mechanical and theoretical.

²⁰² GGC, 'Medical and Sanitary Report for the Year 1914', 101.

²⁰³ see GGC, 'Report on the Medical Department for the Year 1920', 23.

²⁰⁴ GGC, 'Medical and Sanitary Report for the Year 1909', 12.

intelligence and habits...Generally speaking neither comfort nor health considerations appear to be of much importance.²⁰⁵

In another instance, in 1913, the Director of Education, J. D. Oman observed that in spite of the progress made in the practical teaching of the subject, most pupils continued to regard the subject as belonging “to the book and not their daily lives.”²⁰⁶ In a rather patronising tone, he stated that “this is only natural, for it cannot be expected to change the lifelong habits, or to remove the innate prejudices of a people, in the course of a generation, however vital the subject and however expert the teacher.”²⁰⁷ Seven years later, a SSO, J. M. Dalziel expressed a similar sentiment, though not in the same tenor as Oman. Dalziel stated that:

A change in the attitude of the people and any proper appreciation of the meaning and objects of sanitary measures is scarcely to be expected in the present generation, but the great importance attached at present to education in general, quite apart from special instruction in health matters encourages the hope that the conversion of public opinion will progress more rapidly than in the present.²⁰⁸

In a not so different tone, he noted further that:

“Knowledge comes but wisdom lingers”, and although a knowledge of the main facts as to insect-borne diseases, and an understanding of the reasons underlying the importance of cleanliness can be conveyed through instruction in schools and indirectly through sanitary work, it may take generations to alter appreciably the attitude and opinion of the people in general, a conversation which is essential to progress.²⁰⁹

Yet, some other officials expressed satisfaction with both the teaching of the subject and its outcomes. For instance, in 1914, the acting Director of Education, P. Mayall remarked that there was noticeable improvement among teachers and pupils regarding their sanitation and that they had taken pride in their houses and premises – a development which educational managers also made efforts to reinforce. Mayall, however, admitted that his observations were limited to boarding schools. He was, however, hopeful that in future the same keenness demonstrated in the “big” schools

²⁰⁵ Ibid., 13.

²⁰⁶ see GGC, ‘Medical and Sanitary Report for the Year 1913’, 183.

²⁰⁷ Ibid.

²⁰⁸ GGC, ‘Report on the Medical Department for the Year 1920’, 23.

²⁰⁹ GGC, ‘Reports on the Medical and Sanitary Department for the Year 1919’, 18.

would be replicated in smaller schools and have a permanent influence on village life.²¹⁰

Four years later, the sanitary department reported that:

The seed that to all appearances was being sown on strong ground is now beginning to show fruit: Education in hygiene and simple sanitation is part of the curriculum of the schools, and the knowledge which at least the more intelligent of the applicants for posts as Sanitary Inspectors possess on presenting themselves for employment is creditable to the teaching...²¹¹

Whatever, the disagreement about the outcomes of the teaching of the subject, it continued to be a significant component of the school curriculum. By 1920, it was being taught to dispenser pupils, probationer nurses and students in the teacher training colleges as well as some missionary seminaries such as the Scottish Mission Seminary at Akropong in the Eastern Province.²¹² The subject was also made compulsory in Junior Trade Schools where it was studied throughout the four-year duration of the course.²¹³ However, from the 1920s, formal instruction in hygiene in most schools begun in Standard IV (that is half-way through the school career). Even so, immediately upon entering school, pupils were taught among other things, personal cleanliness, the need to refrain from unguarded spitting, and how to keep the school compound clean.²¹⁴

To reinforce the teaching of the subject the sanitary department organised routine inspections during the 1920s to schools to inspect premises, buildings, sanitary conveniences as well as the medical conditions of pupils, and, where necessary, recommended improvements to prevailing conditions.²¹⁵ However, during the 1930s, this exercise became erratic due to limited staff.²¹⁶ Even so, teachers were tasked to

²¹⁰ GGC, 'Medical and Sanitary Report for the Year 1914', 101.

²¹¹ GGC, 'Reports on the Medical and Sanitary Department for the Year 1918', 29.

²¹² At the Accra Training College, the first government teacher training college in Ghana, instruction in hygiene was generally given by European masters. During the first year, the syllabus for primary schools formed the basis of instruction. In the second year, an advanced course was offered and Dr Prout's Lessons on elementary hygiene was used. In 1925, ordinance no. 21 was passed which made the attainment of the minimum standard of proficiency in hygiene education a prerequisite for the registration of teachers.

²¹³ see GGC, 'Reports on the Medical and Sanitary Department for the Year 1919', 18–19; GGC, 'Report on the Medical Department for the Year 1920', 20.

²¹⁴ see GGC, 'Reports on the Medical and Sanitary Department for the Year 1919', 19.

²¹⁵ Reports on the conditions of schools were not always pleasant. Common cases reported on included overcrowding, lack of adequate ventilation, and inadequate and or the lack of latrines.

²¹⁶ see GGC, 'Report on the Medical and Sanitary Department for the Period April 1925 - March 1926'; GGC, 'Report on the Medical Department for the Year 1932-33', 1933.

subject pupils in infant classes to daily inspections of their hands, nails, hair, and clothes. Teachers were tasked to ensure that pupils were made responsible for keeping their classrooms clean and tidy. Older children were, similarly, subjected to periodic inspections and tasked to keep their classrooms and the compound clean. Older boys in rural schools were assigned the task of constructing latrines and incinerators for their schools.²¹⁷ All of these were done to ensure that the pupils would internalise and practice the knowledge that they had acquired in their hygiene lessons. Certainly, the teaching of hygiene was concerned to build character and stimulate the energies of the pupils to be conscious of healthy living, and more importantly, to assimilate European notions of hygiene and sanitation.

In the propagation of knowledge about hygiene and sanitation, the colonial administration saw the teacher as a veritable tool. The potential influence of teachers over their pupils and the community at large was in no doubt and the colonial administrators exploited this fully. One Senior Health Officer, W. M. Howells wrote that:

...The teaching profession in the Gold Coast is rightly looked up to and respected by the general public. A school child returning home and informing his elders that spitting is a filthy, indecent and dangerous habit and that is teacher told him so, will even now carry great weight in the homes...²¹⁸

Starting from the 1920s, officers of the Sanitary Department collaborated with the Education Department to publish in simple language and for the benefit of teachers and the reading public, several pamphlets on topics bearing on sanitation. For example, in 1923, the department published pamphlets treating topics such as *Our Enemy the Rat*, *Our Enemy the Fly*, *Personal Hygiene*, etc. Staff of the Sanitary Department also wrote on other topics including *Hygiene in the Home*, *Elementary Anatomy and physiology* – and these were awaiting publication for dissemination.²¹⁹

From the 1930s and beyond, the *Teachers' Journal* became the conduit for the dissemination of knowledge about hygiene and sanitation among teachers and the reading public. The Journal was published quarterly and was widely circulated.²²⁰ The

²¹⁷ GGC, 'Report on the Medical Department for the Year 1931-32', 33–34.

²¹⁸ W M Howell, 'This Spitting Habit', n.d., 4, PRAAD/ARG6/14/2, Ashanti Regional Archives, Kumasi.

²¹⁹ GGC, 'Report on the Medical Department for the Period January 1922 - March 1923', 49.

²²⁰ see GGC, 'Report on the Medical Department for the Year 1932-33', 1933, 34.

usefulness of this journal was aptly articulated by J.D. Mackay, the DDSS in 1938 when he remarked that:

The *Teachers' Journal* with its large circulation is an excellent medium for health propaganda, and its pages have, as in the past, generously been made available for several important articles by members of this department dealing with health subjects.²²¹

Wide-ranging articles on hygiene and sanitation were often published in the journal. For example, volume 4 of 1933 contained diverse themes such as *Hygiene: A life to be lived, Cleanliness and the Prevention of Disease, Our Teeth: How to Lose and How to Keep them*, etc.²²² A perusal of the copies of the Journal available to me suggests a careful selection of themes that had a direct bearing on the sanitation problems in the Gold Coast. The wording of articles, mostly prescriptive, was carefully tailored to instruct both the teacher, the student and the general reader to adhere to basic principles of hygiene. There also seemed to have been a deliberate emphasis on personal and domestic hygiene.

The intent was clear – to influence the habits and practices in African homes along lines regarded as sanitary and hygienic. An extract from an article written by Dr H. O'Hara May which was published in 1933 will suffice:

Diseases carried by mosquitoes – The mosquito causes malaria, yellow fever, elephantiasis and dengue. The mosquito is a clean insect living on fruit and on an occasional meal of blood. Nevertheless, cleanliness enters very considerably into the prevention of all mosquito-borne diseases. The mosquito dislikes sunshine, fresh air, wind and light. It hides in dusty dark corners, until dusk, when it starts to bite. Consequently, the more sunlight, ventilation, and fresh air in your houses, the fewer mosquitoes you will have. The mosquito lays its egg on water. These eggs cannot develop into mosquitoes unless there is some sort of dirt in the water to feed the larvae. Therefore, if your water containers are kept clean, and if you use clean water, you will breed no mosquitoes and you can snap your fingers at the sanitary inspectors. Thoroughly clean and dry your containers once a week and you will breed no mosquitoes.²²³

In the same article, O'Hara instructed that:

The body should be washed in warm water twice daily. Warm water dissolves dirt better than cold; it opens the pores of the skin and lets the dirt out. The

²²¹ GGC, 'Report on the Medical Department for the Year 1938', 39.

²²² See *the Teachers' Journal*, Vol. 4. 1933.

²²³ H. O'Hara May, 'Cleanliness and Prevention of Disease', *The Teachers' Journal* 4 (1933): 204.

mouth and teeth should be washed immediately on rising and just before going to bed and, also, immediately after each meal. The hands should be washed before meals, before preparing or touching the food and after doing or touching anything dirty. Nails should be kept short and clean...underclothes should be changed at least daily – oftener if the body becomes hot and sweaty. Other clothes should be changed as soon as they become soiled and dirty.²²⁴

By the 1920s, the propagation of knowledge about sanitation and hygiene was no longer confined to schools. Activities were designed to teach the subject to the wider public. An important activity in this regard was the institution of health weeks and health days. The first of its kind was held in 1925 in Accra and other principal stations and it continued throughout the 1930s and beyond. During health weeks, “demonstrations were given to instil into the minds of the general public what sanitation and cleanliness really meant.”²²⁵ Other activities during health weeks included public lectures, exhibition of sanitary materials, baby shows, anti-rubbish campaigns, essay competition among school children, inter-school cleanliness campaign, and marching and physical exercises competition.²²⁶

Health weeks were said to provide “ready means of spreading the knowledge of hygiene to the general population in a palatable form.”²²⁷ As far as practicable, all sections of the community including clerks, storekeepers, soldiers, police officers, labourers, chiefs, and members of the mercantile community were persuaded to participate in the activities of health weeks. Cooperation of school children was always sought by organisers of health weeks to help with clean up exercises in their communities.²²⁸ By this, a sense of communal hygiene was being promoted.

During the late 1920s and the early 1930s, some principal towns had advanced beyond annual health weeks and were organising monthly health days. For example, in 1928/29, monthly health days were held in Accra and Ho and the results were described as “satisfactory.” In 1930/31, many of the principal towns were reported to have held monthly health days. For instance, in Cape Coast, the health department chose a special subject each month for a discussion with teachers and school children.

²²⁴ Ibid., 205.

²²⁵ GGC, ‘Report on the Medical and Sanitary Department for the Period April 1925 - March 1926’, 17.

²²⁶ see W M Howell, ‘Health Week, Kumasi: From 24th to 30th November 1929’, 1929, PRAAD/ARG6/14/1, Ashanti Regional Archives, Kumasi.

²²⁷ GGC, ‘Report on the Medical Department for the Year 1931-32’, 34.

²²⁸ GGC, ‘Report on the Medical and Sanitary Department for the Period April 1926 - March 1927’, 34.

In the same year, it was reported that during health months, Medical Officers in Cape Coast, Sekondi, Nsawam, and Koforidua gave lectures and demonstrations to tribunal registrars, and or chiefs, and police officers. In Kumase the MOH gave lectures during health days to the Infant Welfare Clinic, teacher trainees at Wesley College and other government schools.²²⁹

Beside Health weeks and health days, officers of the sanitary department occasionally gave informal talks on hygiene to community members during their routine house to house and community visits. For instance, in 1928/29, it was reported that:

Friendly talks on hygiene, personal and communal, took place between the MOH, Winneba, and the omanhene, his sub-chiefs and citizens of the town. In Ashanti, the officers of the department supervising village sanitation and layouts took every opportunity of bringing home to the people of the villages the value of healthy houses and surroundings.²³⁰

Other colonial officials were generally encouraged to act as missionaries of hygiene both by precept and by example. They were entreated to among other things, "spread among natives the knowledge of those measures and precautions that conduce to good health."²³¹ European travelling officials were particularly admonished to "...when travelling ...show example by leaving his rest camp in an orderly and tidy condition, and by looking after his personal sanitation and that of his servants and labourers."²³² This way, it was hoped that the African population would learn from their examples, to appreciate the desirability of keeping their homes and immediate surroundings clean of filth.

By 1934, the health department was involved in delivering public lectures on health topics, sometimes illustrated by magic lantern and cinematography to chiefs, tribunal registrars, and the public, and school pupils and their teachers. By 1938, the health branch was contemplating the adoption of cinematography as the key medium for executing large-scale health propaganda and education. To this end, a committee was constituted to deliberate on the matter and advice the government.²³³ Yet, there

²²⁹ GGC, 'Report on the Medical Department for the Year 1930-31', 42.

²³⁰ GGC, 'Report on the Medical department for the Year 1928-29, 36

²³¹ see GGC, 'Medical and Sanitary Report for the Year 1914', 48.

²³² GGC, 'Medical and Sanitary Report for the Year 1913', 30.

²³³ GGC, 'Report on the Medical Department for the Year 1938', 39.

is no evidence to suggest that cinematography was generally adopted during public health lectures before the 1950s.

The government was not alone in its efforts to propagate health education. Voluntary organisations such as the junior section of the Red Cross Society which comprised fifty-four links by 1938 also assisted the health department in educating the youth in health matters, and through them, the adult population.²³⁴ Selwyn-Clarke, the Deputy Director of Health Service in 1934 remarked that:

...The formation of 22 Junior Red Cross links in various large schools and training institutions since the Red Cross Movement in this colony was founded in April 1932, has contributed in no small fashion to the study of hygiene, first aid and welfare work.²³⁵

The Red Cross Society and the GCLMCW were notable for the printing and distribution to the public, large numbers of popular pamphlets on health-related issues such as air, water, food, night-soil disposal, refuse disposal, malaria, rabies and tuberculosis.²³⁶

Notwithstanding these efforts, during the 1940s and the 1950s, the popularity of preventive health generally, and health education declined considerably. The likely causes related to staffing challenges, financial constraints, and the popular clamour of the African people as well as colonial administrators for curative as opposed to preventive health services.²³⁷ Whereas the teaching of hygiene continued in schools, other activities such as health weeks and health days were not regularly organised. The periodic school inspections which were a routine activity of the health department in the 1920s had almost collapsed. The medical and sanitary report of 1943 stated that “school medical services had broken down.”²³⁸ In the same report, it was observed that in areas like Asante and Northern Territories where health officials continued to conduct school inspections, it was done only twice in a year – and even that was limited to few schools.²³⁹

²³⁴ see *ibid.*

²³⁵ GGC, ‘Report on the Medical Department for the Year 1934’, 25.

²³⁶ *Ibid.*, 26.

²³⁷ see Patterson, *Health in Colonial Ghana*, 21.

²³⁸ Gold Coast Colony, ‘Report on the Medical Department for the Year 1943’, 6.

²³⁹ see *ibid.*

Indeed, by the late 1930s, the language of the colonial administration towards health education was changing. There were talks about persuading the African to take responsibility in matters concerning their health, rather than depending on the government for such services. A statement made by J. D. Mackay in 1938 is instructive:

A good deal has been and is being done towards the education of the general public in health matters. Much more, however, is required. If future advance is to be possible, the people require to be taught that they must help themselves and not wait for everything to be done for them. A sense of responsibility, of concern for the well-being of others, of civic pride, and of self-help, an organising capacity and the faculty of sustained effort require to be implemented, fostered and maintained.²⁴⁰

Perhaps, this changing attitude towards health education and preventive health more generally, had to do with a change in government priorities. During the 1940s, the government focused attention on building hospitals and providing curative health services rather than investing in preventive and environmental health. Indeed, in the 1940s, when faced with financial constraints, the colonial administration retrenched staff of the sanitary branch, but not the medical department which was providing curative services.²⁴¹ Perhaps, this was politically expedient, given that during this period, "...both administrators and the public were much more impressed with the visible and immediate results of clinical medicine than the humdrum and almost imperceptible work of the public health officer."²⁴²

Conclusion

I have examined two broad themes, viz anti-mosquito sanitation and educational prophylaxis. I have attempted to link the two themes together by a common strand of argumentation, which relates to how both the fight against the mosquito and the teaching of hygiene and sanitation were intended, consciously or unconsciously to recast practices, habits, manners and attitudes of the African population in the domestic sphere. That is not to say that the manifest reasons for such measures were abandoned. But rather to suggest that in conceiving these sanitary measures, the colonial administration had other latent motives.

²⁴⁰ GGC, 'Report on the Medical Department for the Year 1938', 40.

²⁴¹ see Patterson, *Health in Colonial Ghana*, 21.

²⁴² Ibid.

Sanitary segregation, sanitary inspection, drain construction, swamp and lagoon reclamation and the removal of weeds were all anti-mosquito measures deployed manifestly to contain the *anopheline mosquito*. However, the extent to which these measures inured to the benefit of the sanitation campaign and public health by dealing decisively with the eradication of the *anopheline* mosquito and hence reducing the incidence of mosquito-borne diseases cannot be deduced easily. Certainly, logistical and financial challenges constrained the implementation of these measures and therefore, impinged on their outcomes. I have also highlighted some of the opposition that the colonial administration encountered from the African population and sometimes from amongst the European population, both official and non-official to suggest that the power to impose sanitary measures was never a monolithic one. It could be subverted by the African population who were at the receiving end or by some European officials and merchants who were not keen about some of these measures.

I have argued, among other things that in adopting these anti-mosquito sanitary measures, the colonial administration had other concerns apart from fighting the mosquito menace. For instance, by designating African homes as unhealthy, dirty and dangerous to justify sanitary segregation, the colonial administration wittingly or unwittingly created not only a paradigm of difference in which the African was cast as the diseased other but also did to some extent, sought to entrench the perception of European cultural hegemony. In a similar vein, sanitary inspection served not only as a tool for checking the breeding of mosquitoes in the domestic sphere but also as a mechanism through which African homes were brought under the inspectorial gaze of the colonial administration. It, therefore, provided a convenient avenue through which the colonial administration could control practices, manners and habits in African homes. Similarly, even while serving as anti-mosquito measures, swamp reclamation and the removal of bush also served latently as an avenue for the colonial administration to increase its land holding.

I have also examined the teaching of hygiene and sanitation to school children and the public. I have shown that the teaching of hygiene and sanitation was envisaged to, in the first instance, inculcate in African children European notions of hygiene believing that their knowledge and experience gained could potentially shape and condition the habits and practices of the broader community. Later, when this

education was extended to the public, it was designed to change attitudes, habits and practices of the Africans that were regarded as insanitary and unhygienic, and therefore, impinged on the public health.



Chapter Seven

Sanitation or Re-ordering Public Spaces? A Colonial Approach to Sanitation and Public Hygiene, Late 19th Century -1950¹

Introduction

Pre-colonial African societies developed their understanding and social practices regarding the use of space and the built environment. Societies spatially organised their communities to achieve not only their physical health but also, their spiritual well-being. Writing on the Anlo, an ewe-speaking people located mostly in the south-eastern coastal plains of modern Ghana, Sandra Greene observes that:

Prior to the mid-19th century, Anlo perceptions of their built environment were based on the notion that their homes, the physical layout of their villages and towns, and the placing and spacing of the dead served many purposes and had multiple meanings. Houses provided shelter and comfort and symbolised one's social status...priorities that informed Anlo ways of organising their towns and villages were ...based on both practical and religious concerns, through which the physical and the spiritual were intertwined as to be inseparable.... efforts to maintain one's health and wealth within the many homes and towns and villages of Anlo also influenced the way the residents used their houses and spatially organised their communities.²

Such understanding of the use of space and the spatial organisation of African communities would, however, be altered significantly during the colonial period. Colonial authorities introduced into their colonies their vision and understanding of how to spatially organise towns and villages to achieve sanitation and health. Yet, the use of space would also become a vehicle through which colonial authorities flexed their power. As Debra Pellow has argued British colonisation and exercise of political power in the Gold Coast was not just symbolic, but was also, expressed in the spatial characterisation of their administration and the spaces they assigned to local people.³ According to Njoh, the use of spatial policies within the context of urban planning

¹ A compressed version of this chapter under the same title was presented in the African Studies Association of the UK biennial conference that was held at the University of Birmingham from 11 – 13 September 2018.

² Sandra E. Greene, *Sacred Sites and the Colonial Encounter: A History of Meaning and Memory in Ghana*, 1st Edition (Bloomington: Indiana University Press, 2002), 61.

³ Deborah Pellow, 'The Power of Space in the Evolution of an Accra Zongo', *Ethnohistory* 38, no. 4 (1991): 414–50.

constituted part of a carefully and multifaceted crafted agenda through which colonial administrations sought to reinforce their control over colonies in Africa.⁴

Thus, British colonial administrations in Africa, did not only succeed in controlling the local people and their environment but also used the need to protect the public health, and related social welfare concerns to justify and design spatial policies which strengthened the powers of the colonial administration and, therefore, helped to reinforce effective social control in their colonies.⁵ Indeed, by the late 19th century issues bearing on disease and medicine had merged with those of law and order as colonial officials worked to reshape the cultural, social and political space of urban centres.⁶ According to John Parker, during the 1870s "...sanitation and "order" became linked by an emerging imperial ideology in which the new concern with tropical medicine contained a variety of encoded messages about wider social control."⁷ Such encoded messages about wider social control were to some extent implied in measures that were designed to bring about sanitation and public hygiene in towns and villages in the Gold Coast.

This chapter examines the creation of cemeteries, the planning of towns, the regulation of the building of dwelling houses, the erection and control of market sheds and slaughterhouses, and the regulation and control of bakeries and restaurants. The colonial administration presented these as sanitation and hygiene measures that targeted the protection of the public health. Yet, a close reading of the evidence reveals that the colonial administration used such measures also to achieve other latent motives. Therefore, I argue that the colonial administration's regulation and sanitary policing of burials, the regulation of the construction of dwelling houses, the remodelling of towns/villages, the erection and control of market spaces, slaughterhouses and the regulation of bakeries and public eateries were as much about the public health as they were about engineering some form of wider social control. The colonial administration sought through these measures to impose a Eurocentric vision of what constituted acceptable sanitary and hygienic manners and

⁴ Ambe J Njoh, 'Urban Planning as a Tool of Power and Social Control in Colonial Africa', *Planning Perspectives* 24, no. 3 (2009): 301–17.

⁵ *Ibid.*, 311.

⁶ see Curtin, 'Medical Knowledge and Urban Planning in Tropical Africa'; Parker, *Making the Town*; Patterson, 'Health in Urban Ghana'; Patterson, *Health in Colonial Ghana*; Chakrabarti, *Medicine and Empire*.

⁷ Parker, *Making the Town*, 99–100.

practices regarding the use of such spaces. And in doing so, sought to transform and modernise what they perceived as primitive practices of the African population regarding their understanding and use of such spaces. I also argue that the appropriation and control of such spaces had some latent economic motivation. I show that the implementation of such public health initiatives and space control was not always smooth. It presented a conundrum to the colonial administration.

Sanitary Burials or re-engineering the Geo-space of the Dead?

Information about the burial practices of the Gold Coast before the 19th century is patchy. It would seem, however, drawing from available European accounts about the 19th century that most cultural groups practised home burials. Brackenbury and Huyshe wrote in 1873 that “intramural sepulchre ... in the Gold Coast seems to have reached its climax. Corpses are buried in the basements of dwelling-houses” – a situation which they described as “most pernicious condition fatal to health.”⁸ Writing a year later, Alexander Gordon confirmed that the practice of home burials existed in most coastal settlements and beyond.⁹ Rattray in his ethnographic study of the Asante suggests the practice of home burial in pre-colonial Asante, and so does McCaskie in his historical study of the meanings of death and mortuary rituals in Asante.¹⁰

In a similar vein, A. W. Cardinal recorded in his account of the customs, religions, and folklore of the Northern Territories the practice of home burials.¹¹ And before the mid-19th century, the Anlo were also noted to bury their dead in their homes and so were the Ga.¹² Indeed, Isert wrote that in 18th century Accra “every single Black” was “buried in the room of the house where he died.”¹³

⁸ Brackenbury and Huyshe, *Fanti and Ashanti*, 106.

⁹ Gordon, *Life*, 45.

¹⁰ see R S Rattray, *Ashanti* (London: Oxford University Press, 1923); Thomas C McCaskie, ‘Death and the Asantehene: A Historical Mediation’, *Journal of African History* 30, no. 3 (1989): 417–44.

¹¹ see A W Cardinal, *The Natives of the Northern Territories of the Gold Coast: Their Customs, Religion and Folklore* (London; New York: George Routledge & Sons Ltd; E.P. Dutton & Co., 1891), 108.

¹² see Greene, *Sacred Sites and the Colonial Encounter*; John Parker, ‘The Cultural Politics of Death and Burial in Early Colonial Accra’, in *Africa’s Urban Past*, ed. David M Anderson and Richard Rathbone (Oxford: James Currey, 2000), 205–21.

¹³ Parker, ‘The Cultural Politics of Death’, 209. It must be noted that not everybody who died was buried in the room of the house where he died. Slaves, pawns, children, debtors, and people who died “unnatural death” such as through accidents, during wars, during child birth, etc. were buried outside in the bush of the town boundary. The same was true of the Anlo. See Greene, *Sacred Sites and the Colonial Encounter*.

Thus, during the late 19th century, the people in almost every part of the Gold Coast practised some form of home burial. The colonial administration and its medical advisors, influenced by the epidemiological thought of the period, regarded home burials as insanitary and detrimental to health and therefore needed to be stopped. It was widely held during the late 19th century that miasma – that is effluvia produced from decaying organic matter – under certain climatic conditions could cause epidemic outbreaks. Therefore, inhabiting the same space with a decomposing human body buried some few feet below the surface of the earth was regarded as dangerous to health as the surface of graves were said to emit noxious gases. This concern was captured in the 1886/87 annual medical and sanitary report. The report noted:

The old and pernicious practice of burying the dead in the midst of towns is now condemned all the world over as insanitary, for it has been proved by chemical analysis that morbidic exhalations are constantly given off from the surface of graveyards.¹⁴

The administration believed that home burial was a principal cause of the ill-health of Europeans who were permanently settled among the African population. However, for the African population, it was said that the difficulty in obtaining data “on the vital statistics of the nature of the population” eliminated any possibility of gauging “the effects of this pernicious custom on their health.”¹⁵

For this reason, the government was determined to create public cemeteries and discourage home burials. Greene suggests that the government passed the first ordinance abolishing home burials in 1878.¹⁶ When in 1883 the Native Jurisdiction Ordinance was passed Chiefs were mandated to create cemeteries and regulate burials in their towns and villages. The most effective legislation banning home burials was, however, enacted in 1888 (Ordinance No. 7). This Ordinance made cemetery burials mandatory and specified penalties and sanctions for those who disobeyed.¹⁷ The ordinance was modelled on the 1852 and 1853 Burial Acts of Britain, which empowered local authorities to establish public cemeteries. In 1891 an amendment to the 1888 ordinance was passed. This amendment sought to clarify the difference

¹⁴ GGC, ‘Sanitary and Medical Reports for 1886 and 1887’, 109.

¹⁵ Ibid.

¹⁶ Greene, *Sacred Sites and the Colonial Encounter*, 71–72.

¹⁷ Francesco Pellizzi, *Res: Anthropology and Aesthetics, 55/56: Absconding* (Harvard University Press, 2010), 105–6.

between public and private cemeteries. It also sought to reinforce punishments for people who evaded interment in cemeteries.¹⁸

By the end of the first decade of the 20th century, laws regulating burials had been extended and applied to almost every part of the Gold Coast.¹⁹ Both the colonial government and private entities, especially, missionary societies created and maintained cemeteries. Whereas missionaries created cemeteries for only their members, government cemeteries were opened to both religious and non-religious people. All cemeteries were to be created outside town boundaries and were to be at least 300 yards away from the village or town boundary.

Yet, these pieces of ordinances were applied unevenly and were of little effect before the 20th century. For instance, in 1886/87, it was reckoned that at Accra, "...the disgusting custom of domiciliary sepulture[sic] is still carried on",²⁰ and that:

...A far greater volume of poisonous gases emanates from the native hovels... than would be found to arise from many a native town ten times its size where this abominable custom does not prevail.²¹

Similarly, the Assistant Colonial Surgeon for the Ada district, Sylvester J. Cole, reported in 1888 that:

Intra-mural sepulchre still continues in this district. There is a small private cemetery belonging to the Basel Mission Society and in which none, but Christians are interred. It is well known the number of Christians is very small and therefore the majority of natives are buried anywhere in the bushes and houses. There being no public cemetery, the provisions of Ordinance No. 7 of 1888 to provide for interment in cemeteries and to prohibit intra-mural sepulchre cannot be enforced.²²

In Cape Coast, there was a government cemetery for Europeans in 1888 but none for Africans. The Africans consequently buried their dead where they could.²³ The persistence of home burials in some stations related to the uneven application of the burial ordinance and therefore, the non-existence of public cemeteries in most

¹⁸ Ibid., 106.

¹⁹ Greene, *Sacred Sites and the Colonial Encounter*, 71–72.

²⁰ McCarthy, 'Enclosure 1 in No. 5: Sanitary Report on the Station of Accra for the Year Ending 31st December 1885', 109.

²¹ Ibid.

²² GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 46.

²³ Ibid., 58.

stations. For instance, in 1886, the CMO J.D. McCarthy suggested that the people of Accra should be provided with a “walled cemetery for their own special use” as the passing of an ordinance was awaited. He observed that, “until the people are given decent burial ground of their own, it would be useless making any effort to carry the provisions of such an ordinance into effect...” By 1887, there was still no public cemetery in Accra and the excuse was that “because of other commitments of the Public Works Department, nothing had been done about the provisions of cemeteries by the end of 1887.”²⁴ The only cemetery in Accra was created for use by hospital patients, paupers, and prisoners. This was located behind the government hospital, but it was closed because it was said to be closely sited to a public water reservoir.²⁵

It was in 1888 that finally, land was acquired and cleared for the creation of a municipal cemetery at Christiansborg in Accra. To ensure that the cemetery would be patronised, the Governor, William Griffith called a meeting of Ga chiefs, European and African Churchmen, and leading merchants in Accra and explained to them the sanitary benefits of cemeteries. Despite such efforts, the practice of home burials was not easily stopped and as it turned out, Griffith is recorded to have remarked in later years that “despite assurances of Ga chiefs house burials continued unabated” in Accra.²⁶

The lack of public cemeteries in most stations caused the CMO and his subordinates to appeal persistently to the government for their creation. Eventually, in 1889 the Colonial Secretary wrote a circular to all District Commissioners whose districts were in want of cemeteries to work in conjunction with medical officers to acquire the most suitable land conducive to serving as cemeteries. In anticipation of likely opposition from the Chiefs and their people, the Colonial Secretary advised that:

If the advantages to be derived from setting aside a proper place for the burial of the dead and the wishes of her Majesty’s Government on the subject are properly explained to the Chiefs, and they are given sufficient time to think over the matter, I have some hope that you will have no difficulty in accomplishing the object in view.²⁷

²⁴ GGC, ‘Sanitary and Medical Reports, June 1887’, 5.

²⁵ Ibid.

²⁶ see Parker, ‘The Cultural Politics of Death’, 219.

²⁷ GGC, ‘Gold Coast Medical and Sanitary Report for 1889’, 71.

By the close of the 19th century, most of the important stations in the Gold Coast, especially, those along the coastal stretch had public cemeteries. In 1895, three cemeteries, all of them private, namely, Basel Mission, Wesleyan Mission, and Mohammedan cemeteries, respectively, were in use at Accra. In Cape Coast, there were five, two of them belonging to missionary societies and the remaining belonging to the colonial government. The Saltpond district had the highest number of cemeteries in 1895 - there was a total of forty-three cemeteries, yet all of them were private, belonging to missionary institutions. The Axim district also had six cemeteries, however, it was not stated whether these were privately owned or public. And in Winneba there were four cemeteries, two private (one belonging to the Wesleyan Mission and the other belonging to Ghartey, the king of Winneba), and the remaining, were owned by the Government. Apam, Mumford, and Bereku had two cemeteries each – and in each case, one of them was privately owned. In Akuse, there was a cemetery which belonged to the “Natives” yet this was said to be in very bad shape. In Keta, there were four cemeteries, three of them belonging to Missionary Societies.²⁸

More public cemeteries were opened during the 20th century. In 1913, there was a total of eighteen public cemeteries in the entire colony.²⁹ In 1914, three kinds of cemeteries were recognised. These were Public Cemeteries, Chiefs’ Cemeteries, and Private Cemeteries. Public Cemeteries were those declared to be so by an order of the Governor in Council and controlled and maintained by the government. Public cemeteries were found in Accra, Labadi, Christiansborg, Cape Coast, Axim, Sekondi, Elmina, Tarkwa, Saltpond, Winneba, Addah, Keta, Akuse, Aburi, Dodowa, Dunkwa, Kpong, and Kumasi. For each of these areas, a Deputy Registrar was appointed to be in charge of births and deaths who also acted as a sexton. Chiefs’ cemeteries existed in every town or village where there was no public cemetery, and the chiefs were responsible for their maintenance. Cemeteries designated as Private were those kept by groups that were referred to as non-official sections of society, mainly European groups, such as Missionary Societies, and Mining Companies. However, such kinds of cemeteries were becoming obsolete and new ones were not being created. Instead,

²⁸ Registrar of Deaths’ Office, ‘Report on the Public and Private Cemeteries of the Colony for 1895’ (Gold Coast, Accra, 1896), 71, BOA, <https://boa.microform.digital/documents/7348/public-cemeteries-1895-1907>.

²⁹ GGC, ‘Medical and Sanitary Report for the Year 1913’, 30.

more efforts were being made to acquire land for the creation of more public cemeteries as new sites for Chiefs' cemeteries were also being selected.³⁰

By the end of the second decade of the 20th century, almost every important town and village in the Gold Coast had a cemetery. Sextons were appointed to take care of cemeteries in the principal stations and fees were charged for burials in cemeteries that were under government control. For instance, the annual returns in fee of burials from all out-stations for 1901 was £121,11/6 and that of 1902 was £141,1/6. In 1903, the fees for burials from all out-stations amounted to £157,12/3., and for 1906, £127, 12/6.³¹ It does seem that by the end of the second decade of the 20th century home burials were no longer a major sanitary concern. Neither the annual medical reports nor the general annual reports capture anything substantial about home burials; neither are concerns raised about the creation of cemeteries as a challenge anymore. What was sometimes mentioned was the maintenance of existing cemeteries.

Yet, for most of the 20th century the colonial administration continued to extol the advantages of cemetery burials while discrediting home burials. For instance, sanitary burials featured prominently as a topic in the textbook for teaching hygiene. Henry Strachan's book, *Lessons in Elementary Tropical Hygiene*, which was the prescribed text for teaching in the Gold Coast in 1913, stressed the following regarding burials:

Air contains a certain amount of water-vapour...also the nasty sulphureted hydrogen we smell in the horrible odour given off by swamps and cesspits and sewers [and] badly made graves...from what you have learned about poisonous gases that come up from graves and the equally poisonous stuff that passes from them into the soil and so, by the groundwater, into wells near them, you will see how bad it is to have graveyards in towns and especially how bad is the custom prevailing in some parts of Africa of burying bodies in houses where people live. This is very wrong, and you know why it is so.³²

The colonial administration believed that by teaching such knowledge to school-pupils, it could be transmitted to the rest of society.

³⁰ GGC, 'Medical and Sanitary Report for the Year 1914', 48.

³¹ see GGC, 'Medical and Sanitary Report for the Year 1902'; GGC, 'Medical and Sanitary Report for the Year 1903'; GGC, 'Medical and Sanitary Report for the Year 1906'.

³² Quote in Greene, *Sacred Sites and the Colonial Encounter*, 72–73.

However, the abolishing of home burials and the imposition of the British notion of what constituted the sanitary and hygienic way of burying the dead was not received by the African population without some resistance. However, the resistance was often covert. For instance, in 1895, it was recorded in the annual reports on cemeteries for Salt Pond and Anomaboe that:

Except as regards cemeteries attached and belonging to the Government or some religious institutions, all endeavours to obtain any account of the sepulture[sic] during the year 1895 have been unavailing. No returns have been sent in by the chiefs and kings, and I certainly consider any return they might furnish would be absolutely unreliable.³³

Certainly, what is being implied here is that the African population with the support of the chiefs resisted burying their dead in the cemeteries through some form of subtle avoidance of such spaces. This form of resistance appeared to be common in other parts of the Gold Coast. Parker notes, that the application of the burial ordinance in Accra, was resisted deeply into the 20th century. He contends that resistance assumed mostly a covert character and reflected what he described as “evasion” and “innovation”.³⁴ To evade cemetery burials, the bereaved families often made efforts to conceal their grief and buried their dead without alerting the colonial administration. Thus, “...demonstrative displays of public grief – so essential in managing the smooth passage of the deceased suddenly disappeared from public view.”³⁵ In a similar vein, during the early decades of the 20th century, many Anlo rural communities outmanoeuvred the authorities regarding burials by burying empty coffins in the cemeteries and then secretly interring the dead in their homes.³⁶ Again, Parker notes that during the mid-1890s, Ga leaders innovated a new mortuary practice in response to interment in public cemeteries. To avoid burial in government cemeteries, Ga rulers followed the lead of the Akan and chose to be interred in specially constructed mausoleums on the outskirts of town.³⁷

Despite these resistances, Sandra Greene is correct when she notes that by the 1950s, the government, partly through regulations and partly through educational

³³ Registrar of Deaths’ Office, ‘Report on the Public and Private Cemeteries of the Colony for 1895’, 27.

³⁴ Parker, ‘The Cultural Politics of Death’, 214.

³⁵ Ibid.

³⁶ see Greene, *Sacred Sites and the Colonial Encounter*, 72.

³⁷ Parker, ‘The Cultural Politics of Death’, 214.

propaganda, had succeeded in getting the African population to accept interment in cemeteries as the most sanitary way of burying the dead. And cemeteries were established throughout the Gold Coast. However, Parker notes that “Crucially, the changing nature of death and burial shaped – and was shaped by – patterns of conversion to Christianity.”³⁸ Drawing on the work of Carl Reindorf, Parker illustrates that the elderly in Ga society avoided interment in public cemeteries by converting to Christianity. Converts were certain to be interred in church cemeteries and not in public cemeteries when they died. For the Ga, interment in public cemeteries was tantamount to being cast unburied in the bush.³⁹

The acquiescence to cemetery burials, however, did a lot to reconfigure the thinking of the African population not only about their notions about health and disease, but also some aspects of how they conceptualised their identity and their understanding of the nature and uses of space. Parker reckons, for example, that for the Ga of Accra, “intramural sepulchre underpinned the role of the “daeboo shia”⁴⁰ as embodying – literally – the historical identity of each Ga lineage, an identity formerly rooted in the cultural order of urban space.”⁴¹ Similarly, for the Anlo:

...By burying the aged in the floors of their own homes, by building one’s house on the foundation of ancestors dwelling, by establishing the boundaries of towns and villages and then disposing the bodies of those who died in war at the edge of the settlements in shallow graves, they could maintain relations with the dead, who in turn were able to influence both the physical and spiritual health of their families and communities.⁴²

Certainly, the intervention of the colonial state into the intimate social affairs of the African population through the abolishing of home burials altered their beliefs about health, identity, and space. In doing so, the spatial practices of the colonial administration and their notions of the health risks of home burials were upheld. And as Greene puts it “...in embracing the health benefits of cemeteries” the African

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ This refers to ancestral/clan household

⁴¹ Ibid., 209.

⁴² Greene, *Sacred Sites and the Colonial Encounter*, 61.

population “managed “modernity” by effecting their own displacements of meaning”⁴³, and to add, the displacement of the geo-space of the dead.

Creating Sanitary Towns/Villages? Sanitation, Street Layout and ‘Modernised Houses’

European visitors to the Gold Coast before formal colonisation were unanimous in their condemnation of African townships and villages as insanitary and the nature of their houses as primitive.⁴⁴ At the beginning of colonial rule, the nature and arrangement of houses and the composition of towns and villages were still held to be insanitary. For instance, in 1883 Accra was described as a town,

...built on the most insanitary conditions that ingenuity for that purpose could devise. The mud huts – for they are very nearly all mud – are huddled together in the greatest confusion...⁴⁵

Three years later, J. D. McCarthy, stated that in Accra, “the native hovels are allowed to be built in such close proximity that a wheelbarrow could hardly pass through some of the narrow, foul-smelling alleys intersecting them...”.⁴⁶ To this, the MOH of Accra, Dr Farrell Easmon added that “no one who has not seen this town can form the remotest idea of the frightful condition it is in...the lanes which intersect it are an average 4 to 6 feet wide, some less.”⁴⁷ It was reckoned that:

Regarded purely from the health point of view, the system of overcrowding of individuals and compounds of huts which generally obtains as a direct result of their social system is deserving of most serious consideration...⁴⁸

Conditions in other out-lying towns/villages were described in similarly disparaging terms as those in Accra. Ada, for example, was said to be overcrowded, its houses made of swish, thatched roofs, small, ill-ventilated and thickly peopled, with no streets. Few houses, though, were said to be properly constructed because they were built on European style.⁴⁹ The MOH for the Keta District, B. W. Quartey-Papafio, wrote in 1888 after having toured the interior of the district that, “...any enlightened person visiting these places could not help observing the unsubstantial structure of the

⁴³ Ibid., 80. The emphasis is mine.

⁴⁴ See chapter two above.

⁴⁵ Quote in Addae, *The Evolution of Modern Medicine in a Developing Country*, 114.

⁴⁶ GGC, ‘Sanitary and Medical Reports for 1886 and 1887’, 109.

⁴⁷ GGC, ‘Sanitary and Medical Reports, June 1887’, 32.

⁴⁸ GGC, ‘Gold Coast Sanitary and Medical Report for 1887 and 1888’, 31.

⁴⁹ Ibid., 42.

so-called houses” and “want of streets...”⁵⁰ Colonial officials reckoned that the overcrowding in Accra and elsewhere in the Gold Coast, the poor conditions of their buildings and the improper planning of their towns and villages were important contributors to the high morbidity and mortality rates. Farrell Easmon noted that:

The population is congested to a most alarming extent...And to the manner in which this population and for that matter of the population of almost every town on the coast, is packed together, may be attributed a very large percentage of the sicknesses and mortality which exists amongst them when unseasonably meteorological conditions occur...⁵¹

The colonial administration argued further that the apathy of the African population to transform the insanitary nature of their townships (i.e. lack of streets, poorly constructed houses, etc.), as well as financial stringency were the major drawbacks to sanitary reforms in the Gold Coast. For instance, McCarthy wrote in 1887 that:

...In a country where public spirit is an unknown quantity in the social problem, rapid progress in matters of sanitary reform must not be looked for. Even were the people imbued with a healthy desire to assist the government in carrying out sanitary measures, the irregular and confused manner in which the great mass of the houses are huddled together in the towns together with difficulties of economic nature will practically always tend to frustrate the attainment of anything approaching a standard of sanitary excellence in the towns of the Gold coast.⁵²

The reasoning of the colonial administration and its medical officials regarding the composition of towns/villages and the nature of African houses reflected prevailing European epidemiological theory that connected defective architecture and dirt with diseases.⁵³ It was generally held that infectious diseases thrived in filthy overcrowded spaces. The idea of a pathogenic city animated in Western Europe both spurious and real state of popular panic that inspired a medical discourse on urban morbidity that advocated for the placing under surveillance of a range of urban developments including construction.⁵⁴ To counteract diseases, therefore, many preventive measures that were advocated in,

⁵⁰ Ibid., 64.

⁵¹ GGC, ‘Sanitary and Medical Reports, June 1887’, 32.

⁵² GGC, ‘Gold Coast Sanitary and Medical Report for 1887 and 1888’, 20.

⁵³ see Crook, ‘Sanitary Inspection and the Public Sphere in Late Victorian and Edwardian Britain’, 377.

⁵⁴ see Foucault, ‘The Politics of Health in the Eighteenth Century’, 282.

for example, Victorian Britain, emphasised the need for building spacious neighbourhoods, well-ventilated houses, decongestion and general cleanliness.⁵⁵

This understanding of re-ordering built spaces to protect the public health in Victorian Britain was imported into the Gold Coast by the colonial administrators and their health advisors. As Farrell Easmon put it, the remedy to the insanitary conditions in Accra, is "...to open up the town by wide streets and compel the natives to build their houses in some kind of regular order."⁵⁶ "...The question of ventilation of the town by the limitation of overcrowding is now the subject of absorbing interest..."⁵⁷, Easmon noted.

Early measures to improve the sanitation of towns included the demolishing of buildings that were described as ruinous and dangerous. Ruinous or dangerous houses were categorised into three types. The first type included old houses that were in various stages of disrepair because of neglect. Such houses included those in all stages of decay, from such as having their ceilings partly fallen in, to those that were only represented by an odd wall or two. The second category comprised houses that had one or more rooms in various stages of decay as in the first type and consequently, ruinous in parts. The third type included houses or parts that were never completed and were in a state of decay because of neglect. Such buildings were considered insanitary because they were likely to become depositories for rubbish. And where ceilings leaked, pools were likely to form and become breeding spaces for mosquitoes. Again, such buildings were seen to unnecessarily add to the difficulties of inspection.⁵⁸

⁵⁵ see G C Cook, 'What Can the Third World Learn from the Health Improvements of Victorian Britain?', *Postgraduate Medical Journal* 81, no. 962 (1 December 2005): 763.

⁵⁶ GGC, 'Sanitary and Medical Reports, June 1887', 32.

⁵⁷ Ibid.

⁵⁸ GGC, 'Medical and Sanitary Report for the Year 1911', 195.

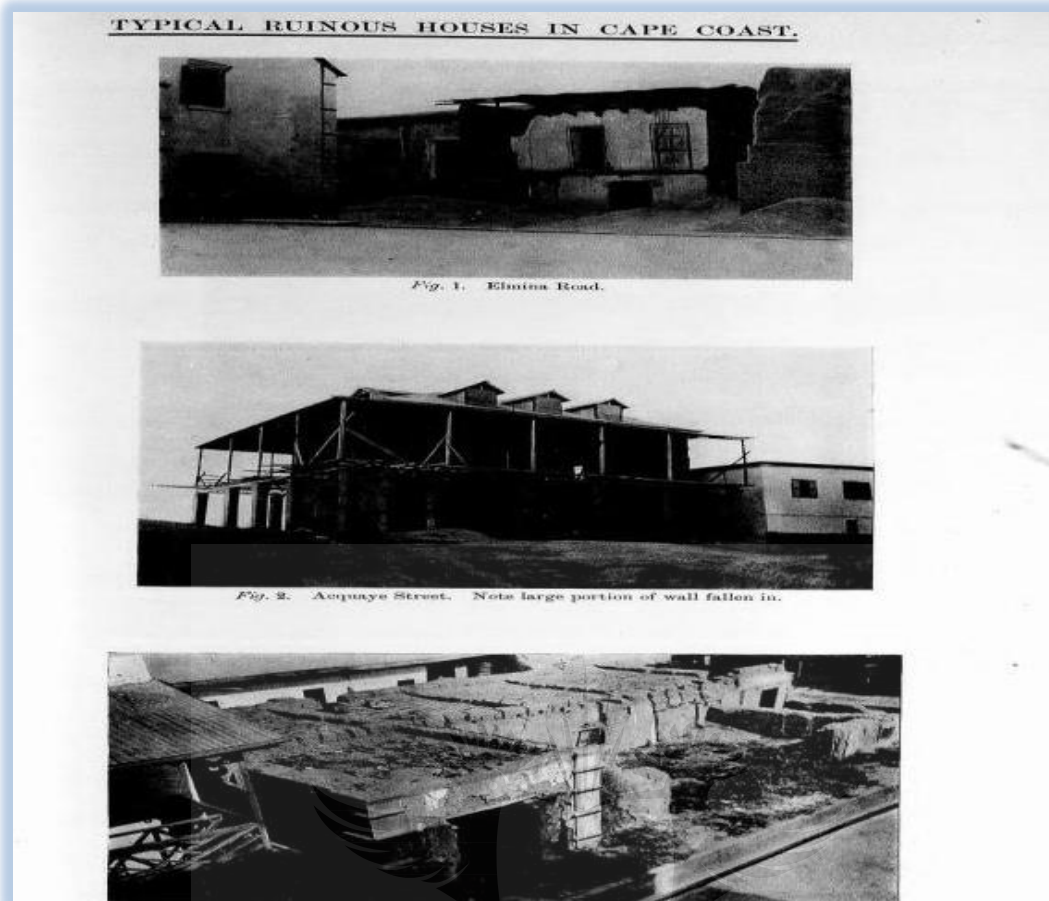


Figure 12: An example of a Ruinous Building as depicted by Colonial Officials. Source: GGC, Medical and Sanitary Report, 1911, Appendix.

Demolition of ruinous buildings in Accra commenced during the late 19th century and by 1902, it was reported that the removal of ruinous houses in Ussher Town was complete. However, in James Town, the exercise was still ongoing.⁵⁹ Apart from the demolishing of individual ruinous houses, in some instances, whole villages were moved from their original locations and rebuilt elsewhere. An example was the African township of Tarkwa in the Western Province which was demolished in the early 1900s and the inhabitants relocated to a new place. The new town that was built for the African population was giving glowing sanitary attributes, yet the relocation was self-serving and was not meant to serve the interest of the African population in the first instance. Rather, it was done to secure, primarily, the health of the European population.

⁵⁹ GGC, 'Medical and Sanitary Report for the Year 1902', 12.

As Branwen Gruffydd Jones has noted, in Africa, colonial administrators often deployed scientific theories of health, hygiene and disease in ways that allowed for the deliberate construction of distance between European and African settlements. To that extent, places of African residences were demolished periodically, if doing so, was perceived to secure a healthy, malaria-free environment for European administrators and settlers.⁶⁰ The report on the demolishing and relocation of the original village of Tarkwa is revealing:

Since the removal of the Native town from the vicinity of the European, the sanitary state has been very much improved. The new native town which is situated about a mile from the European is a model in its way. The streets are properly laid out, it is kept very clean, and in every way, may be looked on as possibly the best native town on the Gold Coast.⁶¹

However, before the 20th century, the attempts at improving the conditions of towns and villages through demolition and the construction of houses along sanitary lines was slow in achieving results. Colonial officials pleaded the lack of funds, while at the same time, blaming the African population of being the main hindrance to sanitary reforms. Colonial Officials argued that African towns did “not admit of much being done towards improving the sanitation.” Yet, it was felt in official circles that “the only possible way to improve the health of the Native town” was “to clear away” in some instances, “half the houses and open it up with wide and well-ventilated streets.” But, “To do this means a large expenditure, and here again, want of money blocks the way.”⁶² Furthermore, the PMO wrote in 1902 that:

...The greatest obstacle in the way of sanitary reforms is the rooted objection of the majority of the Natives to any improvement in their conditions of life; so far as their persons are concerned they are remarkably cleanly; but in their mode of life, houses, and surroundings generally, they are indescribably filthy, and do not appear to desire anything better...⁶³

Indeed, the African population did not take kindly to demolishing exercises. For example, tensions erupted in February 1889 when several houses in the Asere quarters in Accra were demolished. The skirmishes that ensued resulted in the

⁶⁰ see Jones, ‘Civilising African Cities’, 27 More on the separation of European settlements from those of Africans in chapter 6 where I discuss sanitary segregation.

⁶¹ GGC, ‘Medical and Sanitary Report for the Year 1902’, 18.

⁶² GGC, ‘Departmental Reports 1900: Report of the Principal Medical Officer for the Year 1900’ (London: Waterlow & Sons Limited, Printers, London Wall, 1901), 17.

⁶³ GGC, ‘Medical and Sanitary Report for the Year 1902’, 17.

arrest of thirty people and few others were wounded.⁶⁴ In 1902, the MOH of Accra, G.J. Rutherford reported that “there has been some difficulty in making the natives of James Town understand that clearing away ruins, etc., is to their benefit.”⁶⁵ It must be noted resistance to the demolishing of houses was not peculiar to the Gold Coast. As Liora Bigon has argued, demolishing exercises in colonial enclaves were resented wherever it was introduced.⁶⁶ And resistance arose because of the rigidity with which demolishing exercises were implemented, and its insensitivity to indigenous modes of life.⁶⁷

Nonetheless, during the first decade of the 20th century, new regulatory regimes were introduced to improve the sanitation of towns. One of the earliest was the introduction of building permits in 1907 to regulate building activities. Even so, it was said that few people procured building plans that were sufficient to secure the sanitary conditions of proposed structures; others either had no plans or had plans that were almost useless.⁶⁸ Houses thus remained badly built as towns and villages remained without any proper layouts.

Thus, when in 1908 there was an outbreak of Bubonic Plague in the Gold Coast, chief causes were said to be defective architecture, overcrowding, the lack of proper layout and the general insanitary conditions in towns and villages arising from them. Simpson who was commissioned to investigate the outbreak of the epidemic noted, for example, that in Accra:

The houses in the native town are generally of the most primitive type, which, in itself need not be unhealthy if regulated. There are no type or standard plans of healthy huts to guide the builder, and beyond a few good streets constructed after a large fire outbreak some years ago and the alignment which these streets give to the huts and houses facing them, there is no orderly arrangement. In Jamestown and Usshertown, the irregularity of the huts and houses in the interior of blocks between the streets might be likened to that formed if a cartload of bricks were overturned so that each brick will be on the ground.⁶⁹

⁶⁴ Parker, ‘The Cultural Politics of Death’, 214.

⁶⁵ GGC, ‘Medical and Sanitary Report for the Year 1902’, 36.

⁶⁶ see Liora Bigon, ‘Bubonic Plague, Colonial Ideologies, and Urban Planning Policies: Dakar, Lagos, and Kumasi’, *Planning Perspectives* 31, no. 2 (2016): 205–26.

⁶⁷ Ibid.

⁶⁸ GGC, ‘Medical and Sanitary Report for the Year 1911’, 194.

⁶⁹ Simpson, ‘Report by Professor W.J. Simpson on Sanitary Matters’, 39.

Simpson observed further that some of the houses were too dilapidated to inhabit. Others were described as having defective ventilation because of their being closely huddled together. He noted that the internal arrangement of the rooms of the huts and houses rendered them dark and inhibited enough ventilation.⁷⁰



Figure 13: An Insanitary Area Showing Houses and Huts Crowded Together. Source: Simpson, Report by Professor W.J. Simpson on Sanitary Matters, 1908.

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⁷⁰ Ibid.

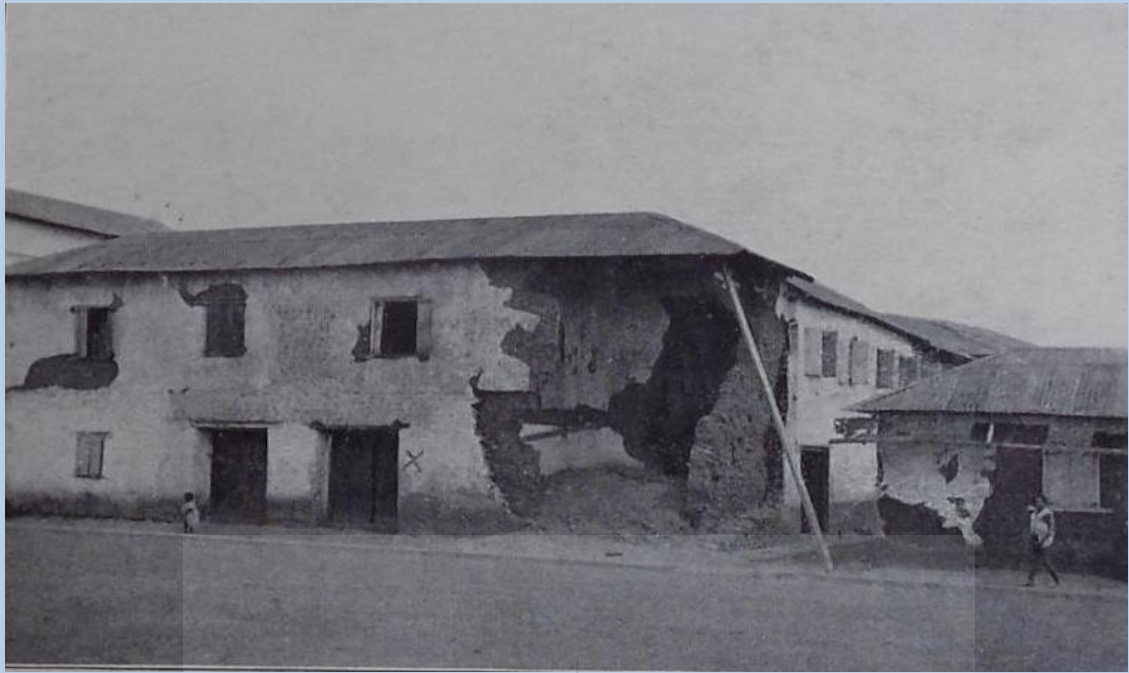


Figure 14: A Dilapidated Building in a Principal Street in Accra. Simpson, Report by Professor W.J. Simpson on Sanitary Matters, 1908.

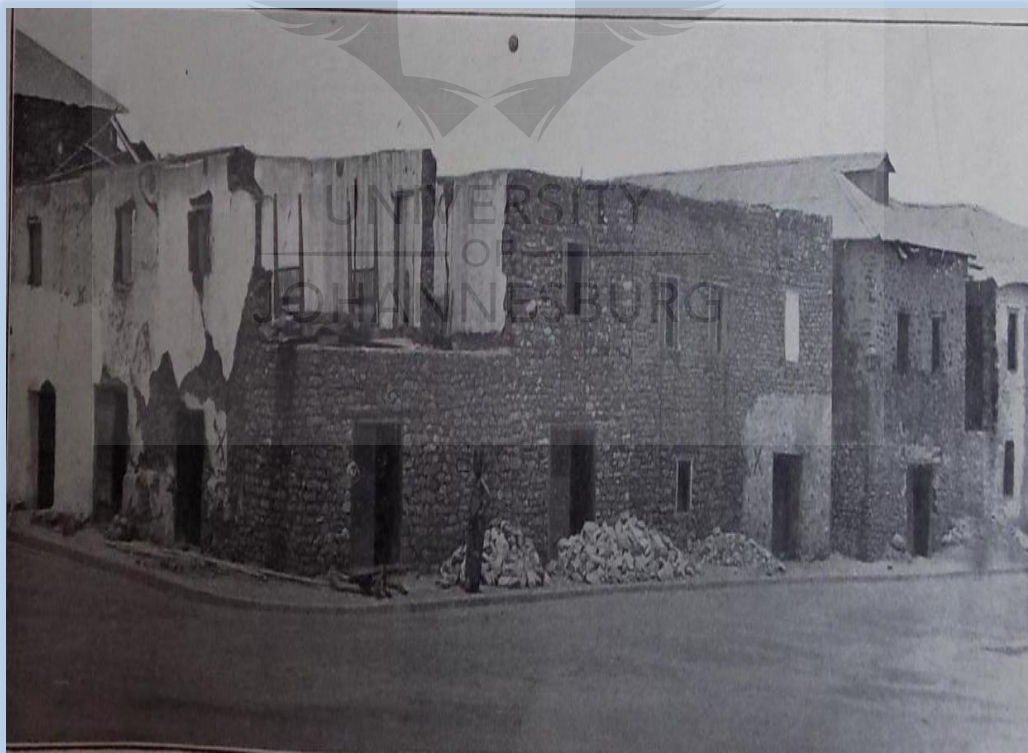


Figure 15: Dilapidated Houses in Accra. Simpson, Report by Professor W. J. Simpson on Sanitary Matters, 1908.

Nonetheless, for Simpson, the defective style, lighting, and ventilation of the African huts and houses were not because the people could not build good houses,

but because they were not directed and properly supervised. Feeling hopeless about the conditions of the African enclave of the town, he suggested that clearance of the huts and remodelling on healthy lines were the “only methods to improve the insanitary nature of the houses.”⁷¹

The colonial administration acted promptly on Simpson’s recommendation. Governor Roger took immediate steps and formed an executive committee comprising the Principal Medical Officer, the Director of Public Works (Chairman), the Director of Surveys, the Medical Officer of Health for Accra, the Secretary for Native Affairs, and other African Unofficial members. The Committee was tasked to come up with ways to improve the sanitary conditions in Accra to avert future disease outbreaks. The committee’s core mandate, among others, was to:

...Advise on the best means of remodelling those portions of the town which form insanitary areas owing to the crowding together of the huts and houses therein...To recommend, as far as possible, a plan for the future development of Accra on lines which will secure its improvement and growth in accordance with a definite and improved method, so as to prevent the creation of insanitary areas; and to suggest the procedure to carry the recommendations into effect.⁷²

The committee was further expected to formulate and present to the governor a report embodying a scheme which, having considered local conditions, allowed for the better division of the town into well-defined districts or zones, (business and residential), and the prevention of the erection of unsuitable buildings. The scheme was to make adequate provision for roadways, streets, back lanes, open spaces, recreation grounds and the reservation of sites for public and municipal requirements. Furthermore, it was to provide the means for effective control over all building blocks and plots and limit the number of huts or houses that could be built on an acre of plot according to the class of building and the quarter of the town.⁷³ It was to prescribe the class of building that could be erected in the different divisions of the town and the specific details of such buildings including, “...the height, width, and depth of the building, lighting and ventilation of rooms, the ventilation and airspace around the

⁷¹ Ibid., 40.

⁷² Simpson, ‘Report by Professor W.J. Simpson on Sanitary Matters’, 41.

⁷³ Ibid., 41–42.

building” and “the best means of rendering the building damp proof and the minimum cubic space per occupant.”⁷⁴

Rodger’s intervention might have been borne out of a genuine concern for addressing the health implications of what he considered as a crowded and a poorly planned town straggling in poorly constructed houses. It may have been conceived as a sanitary measure to secure the health and safety of the European population in the first instance and by extension, the health of the Africans. Yet his directives to the committee also reflected a familiar colonial agenda: the need to modernise and civilise what was perceived as a primitive African town.

The standards that were expected, were to conform to European spatial and building designs and implicitly had a “policing agenda” that sought not only to regulate the technical details of housing units but also access to spaces where such houses could be constructed. It is implicit in Roger’s directive that he sought to use the technical expertise of the committee to design a land use plan that could facilitate the regulation of the African population regarding their use of the built environment, the planning of their townships and the construction of their houses.⁷⁵ According to Njoh:

In colonial planning, the distinction between coercion and expertise was often blurred. This was more so in the case of physical control, of which zoning has always been an important part. As an instrument of land use control, zoning is empowered by the legal concept of police power. Police power connotes the right of whole communities to regulate the use of private property with a view to protecting the interests of the general public.⁷⁶

These interests were wide-ranging and included public health, safety, and public welfare.

Nonetheless, in subsequent years, whereas the sanitary conditions in other towns such as Kumase, Sekondi, Obuasi, Tarkwa, and Cape Coast, were said to be relatively better, a lot of improvements were required in other principal towns. Indeed, by 1911, the conditions of Cape Coast had deteriorated rather than improve. The Medical Officer of Cape Coast, Dr F. Beringer in his report of 1911, noted that:

⁷⁴ Ibid., 42.

⁷⁵ see Njoh, “Urban Planning as a Tool of Power” for details on how colonial authorities sought to use urban planning as a tool to control the social behaviour of Africans in urban spaces.

⁷⁶ Ibid., 311.

In the more densely congested areas, the hovels – the majority can be called little else – are placed without any relation whatever to one another; where there was a room a house was built. It might touch s neighbouring house, or it might not; it might stop the ventilation of neighbouring houses or it might not; it might block up a passage; it might intrude upon the yard of neighbouring houses or prevent the entrance of light; it might do anything. Only one question appeared to matter. Was there space for a room or two of any sort? If there was no space on the ground, it was put on the top of another house.⁷⁷

On the nature of their houses, he observed that:

The vast majority of houses in Cape Coast are badly planned; they are damp, dark, and ill-ventilated...ground rooms in which human beings live are unfit for the meanest domestic animals...and worst of all, and the crux of the whole matter, hovering every available piece of the building plot, which is very rarely rectangular – it very frequently forms a sort of Chinese puzzle in its intricate ramifications amongst neighbouring plots – with structures of one sort or another, necessitated by the increase in the family.⁷⁸

What the colonial officials described as the huddling together of houses within certain spaces should, however, be qualified. The practice must be understood within the context of the communal lifestyle of the African population. Most Africans were accustomed to communal ways of living and would rather live with their families in a common space than to emigrate to another location. The motivation to move was when they were struck by a natural disaster such as an epidemic outbreak, famine, or flooding. This communal lifestyle informing the spatial distribution of the African population was not unknown to colonial officials. However, they misconstrued the practice to mean congestion based on European standards. An observation by F. Beringer is revealing:

The idea underlying this congestion is that a certain community have lived for many years within a given area. There the community must remain, however, much its numbers increase. It cannot expand, as other communities surround it, and it will not emigrate...⁷⁹

The African population were unwilling to relocate from these spaces which colonial officials described as congested even when they were promised

⁷⁷ GGC, 'Medical and Sanitary Report for the Year 1911', 193.

⁷⁸ Ibid., 194.

⁷⁹ Ibid., 193.

compensation to induce them. An anecdote recorded by F. Berringer in 1911 is revealing:

One day the Acting Commissioner, a prominent Chief and I went to one of these congested areas. The question of compensation for breaking down houses in order to open up the area was discussed. The Chief was asked if an individual were given, say £10 for his house, whether he would go elsewhere to some less congested area, perhaps, ten minutes' walk away and build himself a new house. His reply was: No, he would rather live in one of the already overcrowded hovels with his own people.⁸⁰

The refusal to accept compensation to relocate was probably not because the people did not want to. But rather, because they were suspicious of the real intentions of the colonial administrators. Samantha Moyes has, for instance, argued that the African elites in the Gold Coast argued against the colonial government's claim that the destruction and relocation of African homes were to curb the spread of diseases. Rather, they represented demolition and relocation as an attempt by the colonial administration to appropriate spaces and exert control over African homes. They contended that rather than settle them in salubrious spaces, temporarily relocated huts were often placed along swamps where there were high risks of malarial infection. They also argued that relocation projects often disinvested Africans to rebuild their houses using African spatial designs and materials. And once demolitions were completed, people were denied permits to rebuild their houses in their previous settlements. The compensation packages were also said to be inadequate to reconstruct new houses in keeping with type designs that were preferred by the colonial administration.⁸¹

In the Gold Coast as elsewhere in British West Africa, a systematic attempt at town planning, however, started during the second decade of the 20th century. As Bigon has illustrated, "...town planning including the high social aims" it was intended to achieve only gathered momentum after the first international conference of town planning held in London in 1910.⁸² In this regard, a guideline was developed in 1912 to facilitate the laying out of new villages/towns and for the sanitation of the same in the Gold Coast. The document specified the technical details for laying-out streets and

⁸⁰ Ibid.

⁸¹ see Moyes, 'The Making of the Everyday', 35–37.

⁸² Bigon, 'Sanitation and Street Layout in Early Colonial Lagos', 250.

the pattern along which houses should be constructed. It clearly articulated the colonists vision of what ought to constitute modern towns and villages and reflected British town planning models. As R. K. Home points out, town planning was “part of the currency of progressive paternalist ideas” that was “circulating in the British empire during the early 20th century...”⁸³

The Guideline, stated *inter alia*, that:

1. Streets should be straight and intersect one another at right angles. The principal ones should be so constructed as to be in the direction of the prevailing breeze.
2. No street or road in a village should be of less width than 30 feet clear of verandas and no back lane of less than 15 feet, *i.e.*, in front of the house there should be a roadway of at least 30 feet, and behind the backyard of the house a lane of 15 feet.
3. Houses should be built in continuous lines with alignment, in their front and rear, to be prescribed by the local authority, and demarcated on the ground.
4. Between all detached houses abutting on the roadways of the village, there should be a space of at least 9 feet measuring from eaves to eaves or of 12 feet between houses. This space, together with the backyard, may be enclosed by respective owners by boundary walls not higher than 6 feet...
5. Not more than two-thirds of the house site should be covered with buildings.
6. Where a dwelling house abuts on a courtyard its height measured from the level of the courtyard or street should be less than its horizontal distance from the face of any opposite house.⁸⁴

The town planning model delineated above betray the Foucauldian notion of circulation in the context of town planning. Circulation is the idea that effective government is linked to spatial distribution.⁸⁵ Operating as a disciplinary technique, circulation treats multiplicities – that is population in spaces – “that is to say, the constitution of an empty closed space within which artificial multiplicities are organised” to conform to the “principle of hierarchy, precise communications of relations of power, and functional effects specific to this distribution,” for example, controlling housing.⁸⁶ It is, thus, as reflected in the above guideline, a case of structuring a space where discipline was deployed to the realm of construction.

⁸³ R K Home, ‘Town Planning and Garden Cities in the British Colonial Empire 1910-1940’, *Planning Perspectives* 5, no. 1 (1990): 27.

⁸⁴ see Appendix GGC, “Medical and Sanitary Report for the Year 1912.”

⁸⁵ Michel Foucault, *Security, Territory, Population - Lectures at the College de France, 1977-78*, ed. Michel Senellart, trans. Graham Burchel (New York: Palgrave Macmillan, 2009), 32.

⁸⁶ *Ibid.*

Discipline is deployed on either a space that was yet to be completely constructed or a built area that was to be properly planned to ensure the security of the population – in this case, the public health.

As Foucault notes, Circulation often takes place within a milieu – the space within which “series of uncertain elements unfold.”⁸⁷ The milieu acts as an element which produces a circular link between cause and effect – as in the tendency for overcrowding to cause more miasmas, and so, more disease. And more disease would mean more death, and more death means more corpses and so, more miasmas, etc. It is thus, this phenomenon of the circulation of cause and effect that is targeted and hence the need to intervene in the planning of towns to affect the population in ways that would stimulate how they organise their housing and townships.⁸⁸ Thus, towns/villages, as well as houses as envisaged by the colonial administration, were to be “well-ordered, sanitised and amenable to regulation.”⁸⁹

The efforts during the first three decades of the 20th century at regulating the building of houses and the planning of villages and towns on sanitary and hygienic principles, however, achieved mixed results. Newly demarcated villages (mostly model villages sited close to principal towns) were properly laid-out and considerable activity was recorded in the erection of new buildings. Yet, colonial officials complained about difficulty in getting most people to build in conformity with the layouts. For example, in 1913, it was reported that a new village laid-out for the fishing community in Sekondi at Ekuassie, westward of the main town had witnessed considerable improvement in existing conditions as concrete buildings were being erected. At the same time, it was recorded that in the main town, while remarkable activity was witnessed regarding the erection of new huts, mostly outside municipal areas, most of such huts were built without permits and subsequently did not conform to the sanitary standards.⁹⁰ The problem was attributed to the lack of Building Inspectors. It was said that “...without the service of a building inspector it is impossible to prevent such

⁸⁷ Ibid., 36.

⁸⁸ Ibid., 34–38.

⁸⁹ Abiodun Akeem Oladiti and Ajibade Samuel Idowu, ‘The Interplay of Town Planning and Colonialism: The Contributions of Albert Thompson to Urban Development in Lagos, 1920–1945’, *Social Evolution and History* 16, no. 2 (2017): 133.

⁹⁰ GGC, ‘Medical and Sanitary Report for the Year 1913’, 19.

buildings, or even check additions and alterations to buildings that are being erected on permits”.⁹¹

Nonetheless, new villages continued to be laid out along sanitary lines. For example, in 1914 new layouts were said to have been demarcated in Takoradi and many other villages. By 1919, new layouts were completed for Mumford, Swedru and in Imbraim, a Hausa quarter was laid-out. And layouts were accompanied by improvements in the issuance of building permits in urban areas. For example, in 1919 two-hundred and twenty-four building permits were issued in Accra alone.⁹²

Fire-outbreaks in towns or villages provided the most opportune condition for preparing new layouts. For example, when fire gutted the village of Bereku in 1915, the colonial administration described it as a blessing in disguise – the village was surveyed, and a town planning scheme was drawn up for its rebuilding. As Liora Bigon has argued while fire outbreaks caused aggravation of sanitary problems, colonial administrators always saw that as an opportunity to pass preventive legislations regarding the laying of streets, building materials to be used for rebuilding, and the kind of buildings to be erected. Such practices were very common throughout colonial Africa.⁹³

Despite persistent challenges with an insufficient number of building inspectors to enforce conformity to building regulations, the health department often reported significant progress in town planning activities. For example, in 1914 it was reckoned that:

“...Efforts to ensure that native houses should be erected only in conformity with sanitary and hygienic principles have been maintained as far as possible during the year, and some of the model townships connected with the larger centres have been developing on sound lines under the supervision of the sanitary engineering staff...”⁹⁴

A similar picture was painted in 1915. It was observed that a great number of authorised buildings were started and completed by Africans both in seaport towns and in the cocoa growing areas. Town Councils issued building permits in towns where

⁹¹ Ibid.

⁹² GGC, ‘Reports on the Medical and Sanitary Department for the Year 1919’, 18.

⁹³ Bigon, ‘Sanitation and Street Layout in Early Colonial Lagos’.

⁹⁴ GGC, ‘Medical and Sanitary Report for the Year 1914’, 47.

such bodies existed and in other places, by Sanitary Committees. Some Africans, however, continued to build without recourse to either town planning procedures or sanitary and hygienic principles.⁹⁵

Yet, congested areas and insanitary dwellings continued to be present in some principal towns. For example, the persistence of overcrowding and insanitary dwellings in Cape Coast compelled the colonial administration to send Mr L.C.S. Wellacott to the town in 1914 to consider how a scheme that was drawn up in 1913 by Dr F. Berringer to relieve the town of congestion could be implemented. Wellacott prepared a schedule in which he detailed, among others, the houses to be demolished, names of their owners, and amount of compensation required to enable occupants to erect new buildings in conformity to sanitary regulations. He also surveyed and proposed a new layout for the reception of dispossessed inhabitants. Under his schedule the Wangara settlement in Cape Coast was demolished in 1914 at a cost of £65 5/- in compensation. The remaining part of the exercise, however, stalled because of financial challenges arising from World War I.⁹⁶

Indeed, the laying-out of new towns, decongestion exercises and demolition of ruinous buildings was halted during World War I. Building inspections became sporadic, and the making of new layouts received limited attention. The situation was attributed to the depletion of the staff strength of the Sanitary Branch, and financial constraints. The impact of this neglect on the sanitary conditions in towns and villages became evident in subsequent years. For example, the Senior Sanitary Officer, J. M. Dalziel lamented in 1919 that, "Laxity resulting from a shortage of European Staff during the war has become evident, buildings being erected without or contrary to permit."⁹⁷ He observed that appointing European Building Inspectors was more pressing than ever before because of the need for more town planning and improvement schemes as well as supervision and compliance with site and building permits. This urgency was underscored by the emergence of new settlements in prosperous cocoa growing districts and along newly completed railway lines.⁹⁸

⁹⁵ GGC, 'Medical and Sanitary Report for the Year 1915', 18.

⁹⁶ 'Gold Coast Legislative Council Debates: Session 1927-1928' (Government Printer, 3 March 1927), 126.

⁹⁷ GGC, 'Reports on the Medical and Sanitary Department for the Year 1919', 18.

⁹⁸ see *ibid.*

After the war, however, more work was done in laying-out new villages, remodelling existing ones, and enforcing strict compliance with building regulations. Decongesting crowded and insanitary areas in principal towns were also resumed. New housing and building schemes were also introduced. For instance, in 1919, fourteen dwellings considered insanitary were demolished in Accra, and fourteen more, for having been erected without a permit. By 1922, congested areas in several towns in the Colony Proper and Asante were either cleared or were being dealt with. In Kumase, a comprehensive scheme was developed to relay-out a large part of the town. The whole area of Old Asafu, a suburb in Kumase, which was described as “unsightly and insanitary with dwellings” was demolished.⁹⁹

By the beginning of 1924 several congested areas in Kumase, Accra, and Koforidua were cleared by the health department.¹⁰⁰ In Cape Coast, the stalled demolition exercise which began in 1914/15 was completed in 1924. The site was graded, and a new layout was prepared. Affected Owners were assigned new plots and compensated to rebuild their houses. A new township, New Amanful, was planned to accommodate excess owners who could not be assigned plots in the decongested area. The new buildings were to conform to type-plans approved by the Cape Coast Municipal Council. However, the people were reluctant to build, both in the decongested area and in the newly planned township.¹⁰¹

These efforts notwithstanding, colonial officials continued to complain about the presence of insanitary spaces and overcrowding in some principal towns. For example, in 1924 when a second bubonic plague outbreak started in Sekondi it was attributed partly to insanitary conditions arising from overcrowding and congestion. The spread of the plague to Kumase was, similarly, attributed to the existence of insanitary conditions, particularly, in the Zongo area. Simpson, who was once again commissioned to investigate the outbreak observed that Kumase, generally, was, “... in an insanitary condition, which” was “aggravated in certain localities by overcrowding

⁹⁹ see GGC, “Report on the Medical Department for the Period January 1922 - March 1923.”

¹⁰⁰ GGC, ‘Report on the Medical Department for the Period April 1923 - March 1924’; GGC, ‘Report on the Medical and Sanitary Department for the Period April 1924 - March 1925’. The Kumasi Zongo consisted of Twenty-six compounds each containing twelve rooms. It was mostly rented out and in 1926/27 yielded over £1,380 in rent.

¹⁰¹ GGC, ‘Report on the Medical and Sanitary Department for the Period April 1924 - March 1925’; ‘Gold Coast Legislative Council Debates: Session 1927-1928’ (Government Printer, 3 March 1927).

of the inhabitants into areas which are covered with huts and houses badly planned and too close together.”¹⁰²

Simpson, however, acknowledged that significant advance had been made towards the housing problems for African communities in various parts of the Gold Coast since his last visit in 1908. However, he also observed that much work was still required if insanitary dwellings and congestion in towns were to be completely abated. He noted that in Sekondi, congested areas and slums existed which should never have been allowed to arise if due diligence was done. Simpson blamed the persistence of insanitary conditions and overcrowding on the colonial administration, noting that, “it is no great advantage to cut roads through congested areas in a town at enormous expense if new congested areas are allowed to spring up in other parts of the town.”¹⁰³ Thus, following the outbreak of the plague, extensive demolition was carried out both in Kumase and Sekondi. And in Kumase, a new Zongo was built in 1924 for the accommodation of dispossessed people affected by the demolition exercise.¹⁰⁴



¹⁰² William Simpson, 'Report on the Outbreak of Plague in the Gold Coast, 1924', 31 December 1924, 10, GH/PRAAD/ADM5/3/23.

¹⁰³ Ibid., 6.

¹⁰⁴ see GGC, "Report on the Medical and Sanitary Department for the Period April 1924 - March 1925."

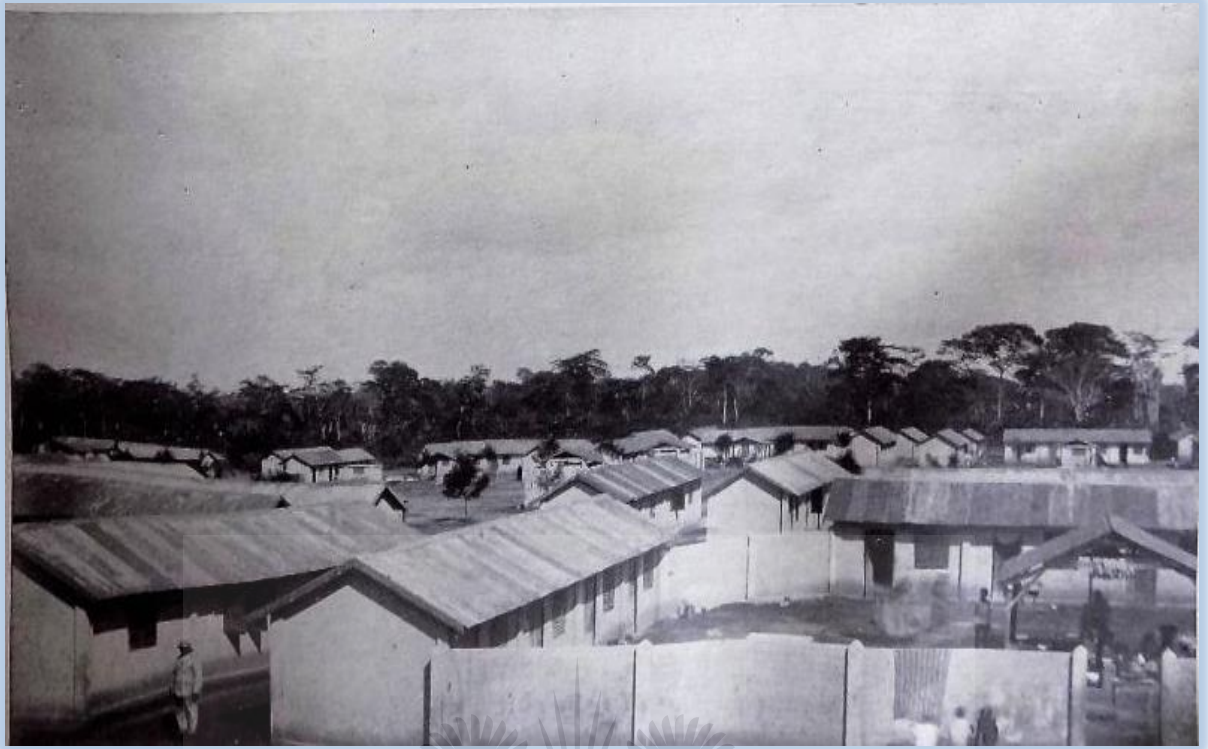


Figure 16: Part of the New Zongo in Kumasi Built in 1924. Source: Simpson, "Report on the Outbreak of Plague in the Gold Coast", 1924

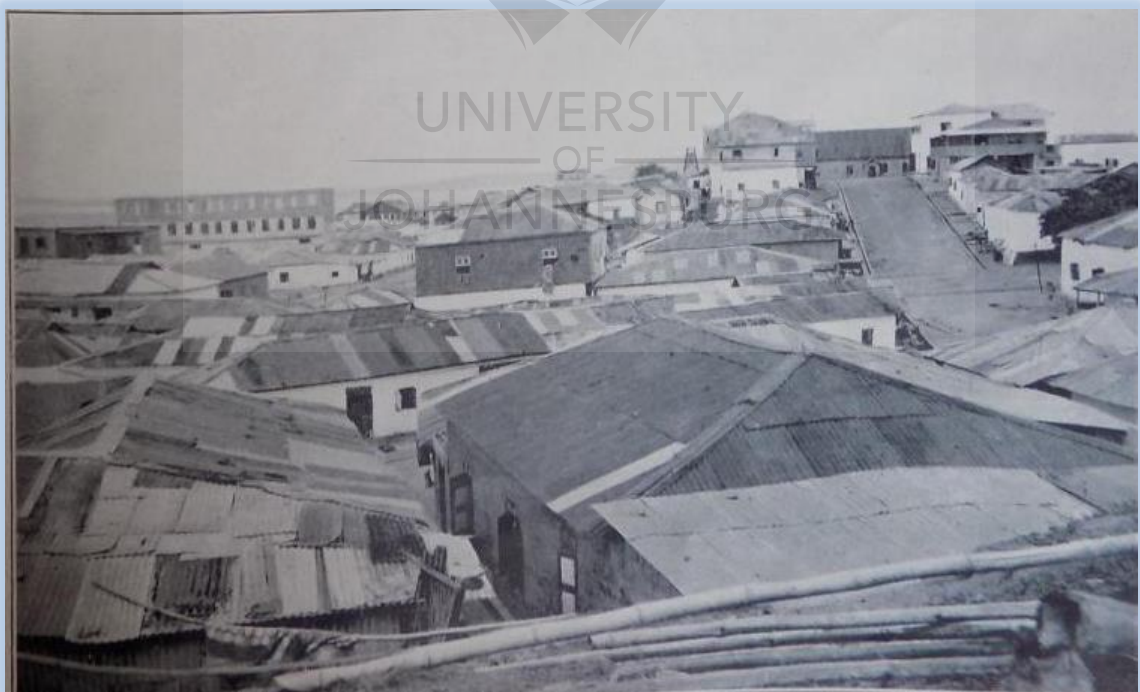


Figure 17: Accra Town in Sekondi Showing Part of a Congested Area. Source: Simpson, Report on the outbreak of Plague in the Gold Coast, 1924.

In 1925, a Town Planning Ordinance (No. 20) was passed to streamline the control of buildings and the laying-out of streets. During the same year, “new building regulations...with minor modifications to conform with local conditions” and secure uniformity in its application in important stations in the Colony Proper and Asante was being considered.¹⁰⁵ It was anticipated that these new regulations would be ready for implementation in 1927/1928. The colonial administration intensified efforts to ensure that buildings did not just conform to type plans, but they also discouraged the use of local materials for construction. Bricks, concrete blocks, or reinforced concrete were the preferred materials for building. Where supervision was available, well-ventilated swish houses with concrete floors and internal and external walls faced with cement was allowed.¹⁰⁶ But, generally, local materials were perceived to be inferior and easily prone to insanitary conditions and therefore, their use was generally proscribed. In his 1926/27 report, the Acting DDSS Selwyn-Clarke noted that:

...Would-be builders were dissuaded as far as possible from building in swish and wattle since such houses became ruinous in a short time, the wattle rotting or becoming ant-eaten and the hollows so formed in the walls serving as nests for rats and mice and a variety of insects.¹⁰⁷

Despite the public health logic which the colonial administration employed to justify the banning of local building materials and the regulation of the spatial distribution of houses, it does appear that a latent motive was to subtly seduce the local population to develop a taste for European building standards, materials, and spatial designs. As Njoh has argued, “to achieve the imperial and capitalist goal of expanding markets for European goods” especially, building materials, colonial authorities developed varying strategies including the use of propaganda which was intended to persuade the African population to accept European standards of environmental design, and perhaps to add, consumption pattern regarding housing.¹⁰⁸ In doing so, colonial officials passed disparaging commentaries, such as expressed in the above quote on African building materials and construction practices while at the same time, extolling European equivalents. According to Njoh, such strategies

¹⁰⁵ see GGC, “Report on the Medical and Sanitary Department for the Period April 1925 - March 1926.”

¹⁰⁶ GGC, “Report on the Medical and Sanitary Department for the Period April 1926 - March 1927” (Gold Coast, Accra: Government Printer, 1927), 31–32, BOA, <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.

¹⁰⁷ *Ibid.*, 31.

¹⁰⁸ Njoh, ‘Urban Planning as a Tool of Power’, 303.

succeeded to a large extent in “irreversibly changing the housing consumption taste and habits of Africans.”¹⁰⁹

It does appear that by the latter part of the second decade of the 20th century the influence of European modes of building and spatial design was beginning to make an impact. Some sections of the local population had become receptive to town planning and colonial building standards, and many villages and townships were being laid-out. Some local Chiefs, particularly in Asante showed enthusiasm by applying to the Sanitary Branch to have their villages and townships laid-out. In 1926 Selwyn-Clarke noted that:

... Good work is being done as regards villages and small townships more especially in Ashanti where considerable progress was made during the year in the laying out of small centres of population. The applications to the Health Authorities through the Local Commissioners of Districts from chiefs for assistance in laying out new towns and villages were more numerous than existing staff could cope with.¹¹⁰

Other towns also demonstrated similar enthusiasm. Indeed, the colonial administration reckoned that:

The African in the more advanced towns has shown a preference for the developed areas and a readiness to conform with the layouts which have been prepared. There are, of course, exceptions to this pleasing rule, but in the main, it is true to say that the people of the Gold Coast are now fully sensible of the advantages of living in a well laid-out area under sanitary conditions.¹¹¹

Encouraged by the receptiveness of the African population to the colonial planning scheme, the administration remained relentless in laying-out new towns and villages and constructing model villages and houses. It was anticipated that model villages and dwelling houses would serve as useful examples for the African population to imitate. A statement made by Selwyn Clarke in 1926 is revealing:

model layouts complete with latrines for both sexes, swish incinerators, markets, shade trees, measured house plots, regular streets and lanes and

¹⁰⁹ Ibid., 303.

¹¹⁰ GGC, 'Report on the Medical and Sanitary Department for the Period April 1926 - March 1927', 32.

¹¹¹ GGC, 'Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1936-1937' (London: His Majesty's Stationary Office, 1937), 16.

hygiene types of dwellings were constructed...in various districts and served as examples to be followed by other villages and townships.¹¹²

Despite the seeming progress in implementing planning models and the construction of sanitary dwelling spaces, teeming challenges remained. For example, despite, the enthusiasm that was reportedly shown in Asante little could be achieved. Three challenges accounted for this. Firstly, changes in staff and the rejection by the colonial government of a proposed layout of Kumase submitted by the KPHB in 1925. Secondly, the delay by the government in completing the new building regulation which was under consideration. And, thirdly, the inadequacy in the number of European Building Inspectors.¹¹³ The annual report of the KPHB for 1927 stressed that:

Not only were persons willing and anxious to build sanitary dwelling houses in many cases prevented from doing so by an absence of building lines, but many who obtained permits to build received entirely inadequate supervision so that cases occurred where the final structures differed considerably in essential details from the approved plans.¹¹⁴

Other principal towns like Sekondi and Accra were also confronted with significant challenges. Firstly, both towns were confronted with overcrowding arising from the limited availability of houses and, secondly, the question of dealing with the complexities of clearing congested areas. In 1927, the President of the Sekondi Town Council, H. W. Thomas, lamented that housing in the town was in an “extremely unsatisfactory state”.¹¹⁵ He asserted that there was “marked scarcity of accommodation and congested areas with extreme overcrowding in highly insanitary hovels is prevalent.”¹¹⁶ He remarked that the town planning scheme for Sekondi “exist on paper but very little new building is going on; no funds for compensation exist and the slums are not likely to be cleared before an outbreak of infectious disease gives the Medical Officer of Health power to deal with them.”¹¹⁷ The problem in Sekondi,

¹¹² GGC, ‘Report on the Medical and Sanitary Department for the Period April 1926 - March 1927’, 34.

¹¹³ GGC, ‘Report on the Kumasi Public Health Board for the Year Ended 31st March 1927’, Annual Departmental Report (Accra: Government Printer, 1927), 5; 33–35, GH/PRAAD/ADM5/1/84.

¹¹⁴ Ibid., 33.

¹¹⁵ GGC, ‘Sekondi Municipal Annual Report for the Year 1926-1927’, Departmental Report (Accra: Government Printer, 20 May 1927), 19, GH/PRAAD/ADM5/1/84.

¹¹⁶ Ibid.

¹¹⁷ Ibid.

related partly to the rising number of immigrant labour, mostly, labourers employed in the construction of the neighbouring Takoradi Harbour.¹¹⁸

Confronted with a similar challenge, J.P. Ross, the President of the Accra Town Council noted that:

The relief of congested areas cannot be dealt with adequately without the provision of suitable houses for the dispossessed population. It is obvious that the same number of people living in one of these congested areas cannot be accommodated in it after it has been properly planned. There must be surplus for whom accommodation has to be provided elsewhere. The land question is always difficult to deal with and the only satisfactory solution is for the government to acquire the land and subsequently recover to those who wish to purchase at a price equal to the cost of acquisition plus the cost of development.¹¹⁹

The foregoing account suggests a classic case of pursuing sanitation on a 'shoe-string.' Whereas the government was relentless in persuading the African population to adhere to sanitary and hygienic, albeit, Eurocentric principles regarding the building of dwelling houses, it failed to provide the required resources to make this possible. In a similar vein, while the government was quick to declare congested areas as insanitary and called for their clearance, it did not address itself to deal with the complexities involved. Thus, the colonial administration appeared to oscillate between two poles. On the one hand, it was dissatisfied with the persistent insanitary conditions in towns, and it was concerned that something needed to be done about it. On the other hand, it did not seem to be fully committed to dealing decisively with the challenge. The key problem was funding and human resource constraints. As Njoh argues, it was primarily the problem of limited funding that thwarted the full implementation of town plans that embodied or reflected Euro-centric ideals.¹²⁰

Rather than address these core challenges affecting town planning and housing, the colonial administration was rather concerned to amend the existing town planning legislation. By 1928/29, the existing Town Planning Ordinance was regarded as obsolete and new regulations were being considered. Colonial officials argued that

¹¹⁸ see GGC, 'Sekondi Municipal Annual Report for the Year 1926-1927'.

¹¹⁹ GGC, 'Accra Municipal Annual Report for the Financial Year Ended 31st March 1927.', Annual Departmental Report (Accra: Government Printing Department, 1927), 9–10, PRAAD/ADM5/1/84, Accra.

¹²⁰ Ambe J Njoh, *Planning Power: Town Planning and Social Control in Colonial Africa* (London; New York: UCL, 2007), 39.

the existing ordinance was complex and insensitive to local conditions. The Sanitary Branch, therefore, advocated for "...a simple form of legislation to meet local conditions" which would be "dissimilar from those in England."¹²¹ Delay in getting the new regulations formulated, however, impinged on town planning and housing schemes, particularly, between 1928 and 1930. The DDSS lamented in his 1928/29 report that:

...Little work has been carried out under the provisions of the Town Planning Ordinance of 1925, and the opinion is generally shared that this enactment is not well adapted to overcome difficulties arising from the customs relating land tenure in this colony.¹²²

Even so, there seemed to have been some significant progress. In 1929 one hundred and twenty-four village layouts were approved by the CBH and were in the process of being implemented. In Kumase an approved town planning scheme was said to have proceeded steadily and satisfactorily. And the colonial administration was optimistic that the town could potentially become "the finest and best laid out town in the whole of British West Africa."¹²³ Outlying Districts in Asante such as Mampong also experienced remarkable progress in town planning activities. Indeed, between 1928 and 1929 seventeen towns were laid out while other villages had sites ready for new layouts. Town planning surveys of Mampong, Suyani, and Goaso, all important towns in Asante were also completed, as the towns of Manso-Nkwanta, Wenchi and Kumawu were being surveyed.¹²⁴ In Sekondi, the MOH reported that housing congestion was improved and buildings that were erected without regard to hygienic considerations were demolished, such structures numbering seventeen.¹²⁵

In 1930/31, town planning in Accra's outlying districts was reckoned to be satisfactory and so were the conditions of dwelling houses. At Takoradi, dwelling houses in the African township were reported to be of "excellent quality, all being of stone, brick or concrete." In Winneba, a new layout was provided, and people were made to move to this new site – as houses in the congested area became more "insanitary and dangerous". In the Northern Territories, progress was recorded at

¹²¹ GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929', 34.

¹²² Ibid.

¹²³ Ibid.

¹²⁴ GGC, 'Report on Ashanti for the Year 1928-1929', Annual Departmental Report (Accra: Government Printing Department, 1929), 12, PRAAD/ADM5/1/86, Accra.

¹²⁵ GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929', 34.

Tamale, “where the Ashanti type of compound” was being built.¹²⁶ The MOH noted that:

During the year the area which lies between the regimental lines and Zongo road on the South-East of the town was surveyed and demarcated into building plots. Of these 98 plots have been allocated and building has commenced on 33. On the Moshi Zongo 28 plots have been taken up and in Tishigu lay-out, 116.¹²⁷



Figure 18: Kumasi Old Town Rebuilt. Source: GGC, “Report on the Medical and Sanitary Department, 1928-1929”, 26. PRAAD/ADM5/1/86).

¹²⁶ GGC, ‘Report on the Medical Department for the Year 1930-31’, 38.

¹²⁷ Ibid.

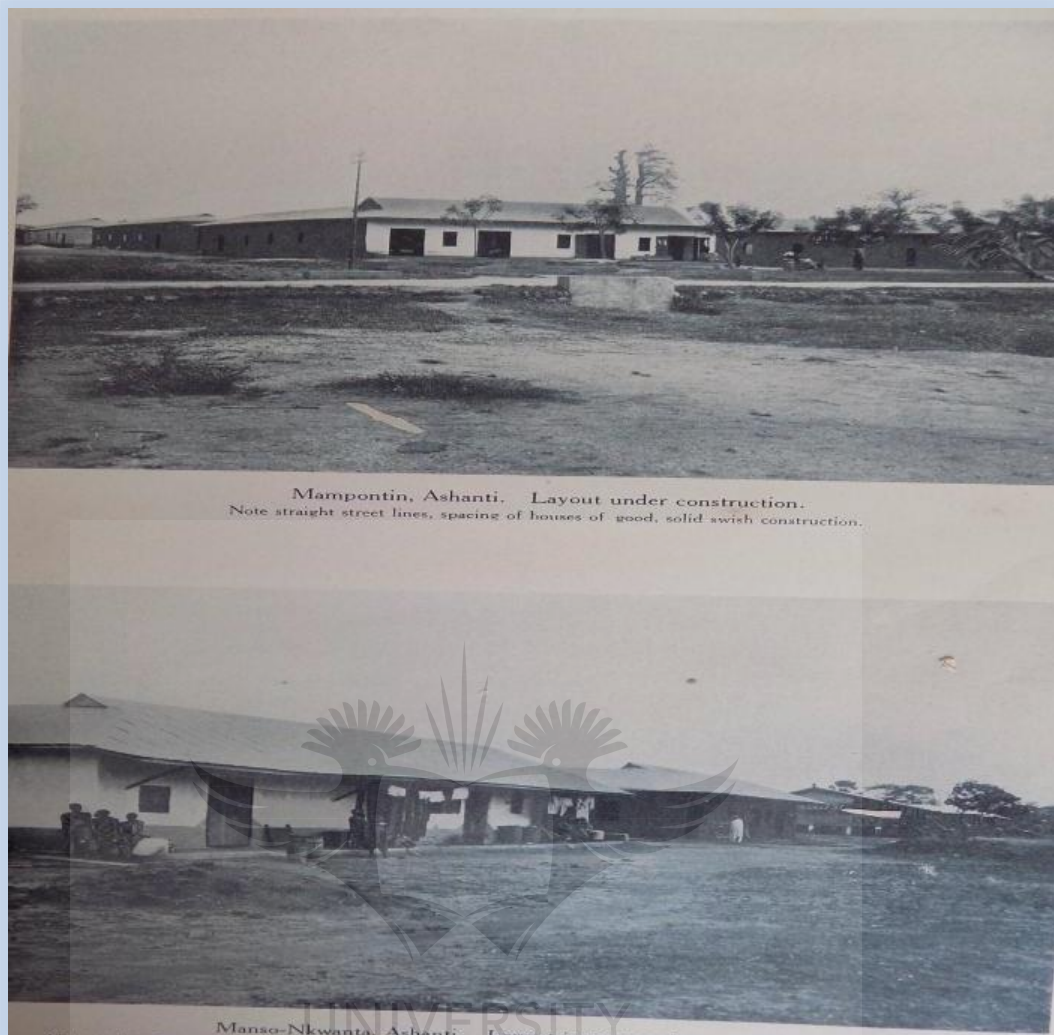


Figure 19: New Layouts in Some Asante Towns under Construction. Source: GGC, "Report on the Medical and Sanitary Department, 1928-1929", 26. PRAAD/ADM5/1/86).

Despite this somewhat significant progress, the economic constraints of the 1930s presented formidable challenges. In most of the larger towns, except Kumase, congested areas could be found in the middle of towns. Such areas were described as insanitary and in need of prompt action. In Cape Coast, for example, the Hausa Zongo, Rocky Lane, and Low Town districts were regarded as plague spots because of their insanitary and crowded conditions. Generally, the housing conditions in Cape Coast was inadequate. The Housing scheme at Amanful was still hanging and a new one which was under consideration did not seem promising. For which reason, the MOH lamented that "At present rate of building, it will be thirty years before Cape

Coast becomes a well-built town."¹²⁸ It is likely that increasing population without a corresponding increase in housing accounted for such overcrowding and slum situations.

Asante which experienced remarkable improvements in layout and dwelling houses were noted to be suffering setbacks during the early 1930s. The economic depression resulted in a lot of uncompleted compounds. An observation by the Senior Health Officer, Asante, and Northern Territories is instructive:

This list has an encouraging aspect, but by now one has learned to wait and see what will ensue on the completion of the swish-walls, when the building is ready for roofs of corrugated iron, window-frames, shutters, and doors, a pause follows, and it has to be admitted that throughout Ashanti, meeting on every side the melancholy spectacle of well laid-out roofless and unoccupied towns, the impression one receives is that of a country ravaged by war or desolated by pestilence; mute monuments to the unattainable ambitions of a penurious people as one Superintending Sanitary Inspector puts it. The entire village rebuilding scheme is, without question, an admirable inspiration, and in the prosperous days of its inception deserved energetic support and was entitled to count on successful contribution. But now that prosperity has faded to an extent which nobody could have foreseen, none can say when if ever, it will return. The position is distressing to the Health Officer, and a subject of constant and anxious reflection in the search for such modifications of dimensions and materials as would better suit people's altered means without, however, mutilating the original plan. Corrugated iron and carpenter-made doors and windows are expensive, especially far away from Kumasi; for most Zongo inhabitants the cost is prohibitive. What cheaper materials may be sanctioned? Discussing these questions with Superintending Sanitary Inspectors, Village Overseers, and the people themselves, I came to the conclusion that the choice now lies between standing fast for the unmodified type, i.e. acquiescing in the present depressing wilderness for years during which the unprotected walls will collapse, and accepting certain modifications.¹²⁹

This observation, was, however, more pronounced in small towns and villages. It was reported in 1932/33 that:

...Several layouts, on which good work had been done previously, have had to be abandoned and have largely reverted to bush...the set back that house construction has received on well-laid-out schemes in the smaller townships and villages is much to be regretted.¹³⁰

The colonial administration was, however, optimistic that the African population had sufficiently assimilated European building models. To that extent the

¹²⁸ GGC, 'Report on the Medical Department for the Year 1930-31', 38.

¹²⁹ *Ibid.*, 38-39.

¹³⁰ GGC, 'Report on the Medical Department for the Year 1932-33', 1933, 33.

administration was convinced that "...the people really wish for better [housing] conditions, and are not likely to go back to "wattle and daub" hovels of the past without a struggle."¹³¹ Yet, whereas it may be true that some Africans may have been reluctant to revert to building with "wattle and daub", it is also true that it was the coercion of the colonial administration that prevented a lot more from doing so. For instance, in 1933, the people of Twifu in the Central Province requested the Provincial Commissioner to allow them to build in "wattle and daub" and use grass as roofing. The Commissioner responded that "The...request is impossible."¹³² With such kind of response, the African had no choice, but to build in conformity to laid-down regulations.

Nonetheless, the big towns and principal stations continued to witness improved housing both in quantity and quality, in spite of the economic depression. For instance, the Senior Health Officer, W. M. Howells, remarked in 1933 that "one might conjecture that the prevailing depression would be reflected in a diminution in the number of houses commenced and completed in the larger centres, but is not very marked."¹³³ He noted that despite the depression most Africans constructed improved type of houses in the big towns. By improved houses, he meant that people built in cement blocks and roofed with corrugated iron sheets and adhered to sanitary and hygienic principles. Indeed, in Koforidua, forty-four houses were completed in 1932/33 as against thirty in 1931/32 and Sekondi, seventeen as against thirteen in the previous year. In Accra, twenty-one houses were completed as compared with seventeen in 1931/32. Cape Coast, however, recorded a decline – as seventeen houses were erected in 1932/33 as against eighteen during the previous year. In Kumase, while the exact number of houses was not recorded, building permits to a total estimated value of £200000 were issued during 1932/33 compared to £40000 in 1931/1932.¹³⁴ In 1934, Selwyn-Clarke noted that:

In spite of the shortage in capital, it is significant to note that the construction of a good type of concrete or cement block house continues to take place in the more important towns. Every pride in substantial and well-built houses

¹³¹ Ibid.

¹³² 'Memo from the Provincial Commissioner's Office (Central Province) to the District Commissioner, Cape Coast', 22 May 1933, PRAAD/ADM23/1/595, Central Regional Archives, Cape Coast.

¹³³ GGC, 'Report on the Medical Department for the Year 1932-33', 1933, 32.

¹³⁴ Ibid.

becomes more and more noticeable, especially amongst the educated classes.¹³⁵

When the economic depression abated in the mid-1930s, the housing conditions improved markedly. For example, in Accra, ninety-two houses valued at £48000 were constructed in 1935 as against twenty-six in 1934, and building permits totalling 263 with an estimated value of £172, 900 were issued. In other parts of the colony, several layouts were drawn up for various townships, and extensions were made for existing townships, particularly, rapidly growing towns.¹³⁶ In 1936, seventy-one permits were passed in Kumase and demolition of insanitary areas, particularly, on the Zongo road proceeded steadily.¹³⁷ In 1937, one hundred and fifty-three permits of a total building value of £122,305 were granted. In Accra, one hundred and eighteen permits were issued. In Cape Coast, forty-two permits were granted. In Sekondi, twenty houses were completed while fifty-five were under construction.¹³⁸

In 1938, Accra recorded one hundred and seventy new buildings and building permits totalling three hundred and sixty-nine were issued. In Cape Coast, thirty-two building permits were granted and sixty-two buildings were either repaired or demolished on account of their insanitary status. In Sekondi sixty-six new buildings were being constructed in 1938 while twenty-three were completed. The Sekondi Town Council also considered a comprehensive preliminary survey of the area westward of the town where future expansion was envisaged. In Kumase, the KPBH formed a Town Planning Committee to regulate buildings. Under this committee, ninety-one building permits valued at £62,543 were granted.¹³⁹

The remarkable progress in the erection of good class private dwellings, in all the large centres, however, did little to abate overcrowding and insanitary conditions. It was reckoned that while the construction of good class private dwellings in the suburban areas was not lacking, it did "little to relieve the older congested slums to be found in most of the larger centres in the Gold Coast." Such slums, it was suggested, required government assisted municipal schemes before they could be eradicated,

¹³⁵ GGC, 'Report on the Medical Department for the Year 1934', 22.

¹³⁶ GGC, 'Report on the Medical Department for the Year 1935', 26.

¹³⁷ GGC, 'Report on the Medical Department for the Year 1936', 30.

¹³⁸ GGC, 'Report on the Medical Department for the Year 1937', 29.

¹³⁹ GGC, 'Report on the Medical Department for the Year 1938', 35.

and the site on which they stood could “be laid-out on modern sanitary lines.”¹⁴⁰ The persistence of slum spaces related partly to the laxity in the enforcement of building regulations. For instance, in 1938, it was observed that whereas suburbs such as Christiansborg and Adabraka in Accra witnessed increasing building activity¹⁴¹, “building control in the town and the guardianship of the best future of the town” was “lacking.” It was felt in official circles that “...the growing disregard for the building regulations” created a situation of “increasing uneasiness” that could “eventually only lead to the bequeathment to a future generation of an insanitary legacy.”¹⁴²

Indeed, in 1935, about ten per cent of the population in Accra lived in what was described as congested slums.¹⁴³ It is uncertain, however, how the colonial administration measured what constituted slums. As it were, even in metropolitan Britain during the 20th century, controversy existed regarding what constituted “slums.” As Allan Mayne argued, in 20th century Britain slum was a bourgeois construct which condemned varying urban forms and social conditions as abominable. To that extent, slums were social conditions that were considered unacceptable and therefore needed to be abated.¹⁴⁴ It would not have been unusual for colonial officials trained in Victorian Britain to have inferred such meanings when referring to “slums” in the colonial context. Whatever way it was understood to mean the presence of conditions described as congested slums prompted the Accra Branch of the Red Cross Society to undertake a social survey in 1935 to ascertain the scope of the challenge.

Following the survey, the Red Cross Society proposed to the government a rehousing scheme, estimated to cost £70000. The scheme focused on the clearance and rebuilding of the Asere area, which was considered the worst slum location in Accra. However, by 1937 the scheme was still hanging and the delay was attributed

¹⁴⁰ GGC, ‘Report on the Medical Department for the Year 1938’, 35.

¹⁴¹ Christiansborg was a predominantly administrative area that was settled by Europeans and African elites. And Adabraka was started in response to the outbreak of the bubonic plague in 1908 but was not properly developed until the decades following the outbreak of the yellow fever epidemic in 1911. It was envisaged to relieve the central congested area of Accra, but in the end, it attracted the African elite who moved there to develop what would become the first African middle-class neighborhood. See Quayson, *Oxford Street, Accra*, 69.

¹⁴² GGC, ‘Report on the Medical Department for the Year 1938’, 35.

¹⁴³ GGC, ‘Report on the Medical Department for the Year 1936’, 30.

¹⁴⁴ cited in Liora Bigon, ‘Between Local and Colonial Perceptions: The History of Slum Clearances in Lagos (Nigeria), 1924-1960.’, *African & Asian Studies* 7, no. 1 (February 2008): 56.

to what was described as “various conflicting considerations.”¹⁴⁵ The problem was, nonetheless, revisited in 1938 and a committee under the chairmanship of the Director of Public Works was constituted to review the situation. The Committee was to consider previous reports and existing conditions and advise the government on the best way to deal with the problem. In a similar vein, the question of the central congested area of Sekondi was also reviewed in 1938. After which the Sekondi Town Council revised the existing building regulations with the aim to obtain additional powers to deal with the problem.¹⁴⁶

For the situation in Accra, it took the occurrence of an earthquake in June 1939 for the colonial administration to consider the implementation of the rehousing scheme seriously.¹⁴⁷ Houses of a temporary nature were hastily constructed to accommodate dispossessed victims of the earthquake. Efforts were also made to construct new estates to accommodate persons who were to be removed from slum areas in the centre of the town. However, in doing so, the colonial administration sought to fashion out these spaces in accordance with their imperial spatial designs of what constituted a sanitary town and to appropriate the affected spaces for commercial purposes. Ato Quayson has argued citing Richard Brand that the spatial constellation of Accra was designed to privilege European commercial interests.¹⁴⁸

The new spatial designs were not limited only to the physical patterning of the space, but also, the ordering of the affected population into designated enclaves which could result in the evolution of new forms of social relations. As Clarke and Dutton have demonstrated, space and its design can be used to forge “sets of social relations [that] introduce and legitimise ways and forms of life. In such circumstances, space and programme either maintain the status quo or they can be formulated to express alternative social relationships.”¹⁴⁹ In this instance, the design of the spaces where the affected victims of both the earthquake and slum decongestion were to be reassigned

¹⁴⁵ GGC, ‘Report on the Medical Department for the Year 1937’, 29.

¹⁴⁶ see GGC, ‘Report on the Medical Department for the Year 1938’.

¹⁴⁷ 537 houses were demolished, and 1275 two-roomed structures were built to accommodate approximately 7000 people.

¹⁴⁸ Quayson, *Oxford Street, Accra*, 72.

¹⁴⁹ As cited in Pellow, ‘The Power of Space’, 415.

could potentially have resulted in the evolution of a new set of social relations. A statement in the 1939 Medical and Sanitary Report is revealing:

As the new housing estates are in the suburbs it is intended to open up the centre of the town by removal of slum areas and provision of open spaces and, as far as may be possible, reserve the area for business and commercial purposes. Three grade of dwelling houses are to be built on the new housing estates and these will be in zones within the estates. The fishermen are housed in an estate to the west of the town and will have a special type of 12-roomed compound suitable for housing the crew of a canoe and their families. A “Zongo” will also be built to house the labouring classes. Ample provision has been made in the new layouts for open spaces, schools, markets, and general amenities.¹⁵⁰

Beyond re-ordering the spaces of the affected population, the scheme could potentially afford the colonial administration an opportunity to confine the African population to an environment in which they could be easily brought under the gaze of the colonial surveillance apparatus.¹⁵¹

Nonetheless, town planning and Housing activities slowed down considerably during the 1940s because of difficulties in obtaining imported European building materials during World War II.¹⁵² As a result, the question of insanitary housing and overcrowding became once again, the bane of the Health Department, and the situation was reckoned to be obstructive of improvements in health and social progress. It was noted in 1943 that, “Bad housing and overcrowding, particularly, in the large centres of population, constitutes one of the major problems of health and social welfare.”¹⁵³ It was observed that “overcrowding and congestion” was “the rule rather than the exception in the large centres.”¹⁵⁴ Town planning activities that were being undertaken in Accra, Takoradi, Sekondi, Kumase, and Tarkwa were put in abeyance pending the availability of building materials.¹⁵⁵ This lag and its concomitant health challenges related to two factors: financial constraints and lack of staff to carry

¹⁵⁰ GGC, ‘Report on the Medical Department for the Year 1939’, 5.

¹⁵¹ see Njoh, *Planning Power*.

¹⁵² see GGC, ‘Report on the Medical Department for the Year 1940’; GGC, ‘Report on the Medical Department for the Year 1941’.

¹⁵³ GGC, ‘Report on the Medical Department for the Year 1943’ (Gold Coast, Accra: Government Printing Department, 1944), 6, BOA, <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.

¹⁵⁴ GGC, ‘Report on the Medical Department for the Year 1944’, 6.

¹⁵⁵ Ibid. The one exception though, during this period, was in the Sekond-Takoradi area where some 700 quarters were constructed on an estate and provided with proper drainage, conservancy, and related public health facilities for use by labourers.

out sanitary work during the period. The government also blamed African house owners for complicating the overcrowding situation. Colonial officials argued that "...the average house-owner" was "altogether too prone to let every available corner of his house, out-buildings and verandah to those seeking shelter and able to pay for it..."¹⁵⁶ In doing so the sanitation of such dwelling spaces was compromised.

To mitigate overcrowding and the presence of insanitary buildings arising from the housing deficits during this period, the Health Branch proposed the extension of existing planning and building schemes, the institution of new communal building programmes and housing estates, and the establishment of regional planning committees. At the end of the war, when building materials became readily available, the colonial administration committed to implementing housing schemes that were aimed primarily at easing overcrowding in congested areas in the principal towns. By the end of 1945, a new village, Adiembra, near Sekondi, laid-out and constructed on sanitary and hygienic principles was completed. Another Housing Estate, Takoradi No. 2 housing estate was under construction by the end of the year.¹⁵⁷

In 1946, a new Department of Social Welfare took over the activities of the Accra Rehousing Scheme to oversee government housing estates and housing policy. The Department, as a matter of priority, oversaw the provision of sanitary housing in Sabon Zongo, comprising twenty-nine improved two-roomed burnt brick houses with separate sanitary quarters. In the following year, the scheme was extended to other areas within the municipality and any such scheme bore the name of the suburb where it was located. Six of such schemes that were either completed or near completion by 1947 were the North Christiansborg, Lababdi, Kaneshie, Abbosse Okai, North-West Korle Gonno and Chorkor housing estates. Similar housing schemes, the Asawasi Housing Estate and Siwdu Housing Estate were started in Kumasi and Cape Coast respectively and they were anticipated to be completed by March 1948. All the estates comprised two and three bedroom semi-detached units and single rooms of various types and were reserved exclusively for the African population. However, they were

¹⁵⁶ see GGC, 'Report on the Medical Department for the Year 1945', 12.

¹⁵⁷ see GGC, 'Annual Report on the Gold Coast for the Year 1946', 54.

offered in some instances, for sale to persons who could afford them and in other instances, for rent to the labouring class.¹⁵⁸

In the meantime, in April 1945, the government passed the Town and Country Planning Ordinance, (No. 13). The Ordinance provided for the creation of a Town and Country Planning Board that comprised not less than six members including the Director of Medical Services, the Director of Public Works and the Lands Commissioner or their representatives. The Board took over the functions of the CBH regarding the control of building in planning areas. Town Planning Committees were formed and by 1948, such committees existed in Accra, Sekondi-Takoradi, Kumasi and Cape Coast. A special ordinance was enacted to give the government the power to acquire land for housing schemes anywhere within the Gold Coast.¹⁵⁹

Despite these initiatives, by 1950 formidable challenges persisted. In spite of the increasing number of new buildings, there was still housing deficits in most large towns. This was partly the direct result of increasing population and intensified urbanisation. The result was the emergence of slums in most large towns that urgently needed to be cleared. There was also difficulty in getting potential house owners to build to regulation. Some house owners and even tenants in the principal towns converted bathrooms and latrines to living rooms to accommodate more people. Such practices resulted in overcrowding, thereby complicating the sanitary conditions of dwelling spaces.

Thus, the results of the efforts of the colonial state to ensure that the African population built their dwelling places and patterned their communities along sanitary lines remained tenuous for most of the period. The extent to which town planning and the transformations in African building styles improved sanitation and consequently, the public health is also difficult to gauge. But certainly, the local population's holistic approach to the spatial design of their villages and towns and their use of the built environment was altered, and for good.

¹⁵⁸ see *ibid.*, 54; GGC, 'Annual Report on the Gold Coast for the Year 1947' (London: His Majesty's Stationary Office, 1948), 62–63.

¹⁵⁹ Town and Country Planning in the Gold Coast, Bulletin no. 2, 30th September 1949. GH/PRAAD/ADM5/4/80, National Archives Accra.

Sanitation of Market Spaces, Slaughter Houses, Restaurants, and Bakeries

The Public Health Ordinance of 1878 enjoined the government to provide and regulate market sheds/structures and slaughterhouses to ensure the sale of wholesome food to the public. And while control of bakeries and restaurants were not mentioned in the ordinance, by the late 1920s, the Health Branch was exercising oversight responsibility for such spaces to ensure that they conformed to hygienic and sanitary standards. However, I argue that by presenting the control of market spaces, slaughterhouses, restaurants, and bakeries as necessary to the maintenance of the public health, the colonial administration could demonstrate and reinforce its power over the African population.

Neither the provision of market structures nor the construction of slaughterhouses received urgent attention as one would expect during the late 19th century. By 1888 only Accra had a market shed which was said to be small for the wants of the people. Market sheds were yet to be erected in any of the other principal towns such as Cape Coast and Elmina.¹⁶⁰ And there is no mention of the erection of a market shed in any part of the Gold Coast until 1903 when the annual report indicated the completion of a new market shed at Christiansborg. However, by 1913, there were sixteen government markets in the Colony Proper, four in Asante and eight in the Northern Territories. In 1914, eight more market sheds were constructed.¹⁶¹ By the 1920s, relatively larger markets were being constructed in the principal towns. In rural areas, where the government could not construct market sheds, chiefs were persuaded to encourage their people to erect market sheds. In 1926/27, it was reported that:

...The provision of new and the improvement of existing markets was carried out throughout the Gold Coast, and where Government funds were not available, the Chief or Headman of the town or village was persuaded in many cases to induce his people to pool resources to erect market stalls.¹⁶²

The colonial administration was generally receptive to the construction of any kind of market shed if it provided for the sale of food under hygienic and sanitary

¹⁶⁰ GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 34.

¹⁶¹ GGC, 'Medical and Sanitary Report for the Year 1914', 48.

¹⁶² GGC, 'Sekondi Municipal Annual Report for the Year 1926-1927', 34.

conditions or a convenient means of regulating what could be sold to the public. The government explained that:

In the interests of the general public, the construction of markets – whether in concrete, as in larger townships, or with bush-stick and thatch or corrugated iron in villages – receives the warm encouragement of the health authorities as affording a ready means not only of ensuring that food is sold under the best possible conditions but of facilitating inspection and thereby ensuring good quality.¹⁶³

By 1928, extensions were already being made to markets in Accra and Kumase as steps were being taken to provide what was described as a “much needed new market” at Winneba¹⁶⁴. During the same period, the erection of a new market for Cape Coast was approved.¹⁶⁵ By 1930 “...many new markets” had “been constructed throughout the Colony Proper, Asante, and the Northern Territories.”¹⁶⁶ The African population was generally receptive to the idea of erecting and selling under such market sheds. As Selwyn-Clarke observed:

the importance was fully appreciated of making provision for the sale of food under hygienic conditions rather than under bad conditions where the liability of contamination by food and flies existed.¹⁶⁷

All users of market spaces were individually and collectively required to ensure that they were kept clean and under hygienic conditions all the time. For instance, rule 11 of Salt Pond market regulations stated *inter alia* that:

Every occupier of any stall, table, or space in the market whether paying shall every day on which he shall use such stall, table or space keep the same in a perfectly clean state and shall at the close of each day's business and before leaving the market, brush, sweep, and clean away all dirt and rubbish from the stall, table or space occupied, and thoroughly wash, cleanse and wipe, dry the same, so that no blood, water, dirt or rubbish shall be left therein or thereon, and shall also sweep and clean away all dirt and rubbish from the unoccupied space adjoining the stall, table or space, or such portion as may be fixed by the

¹⁶³ GGC, 'Report on the Medical and Sanitary Department for the Period April 1927 to March 1928', 31.

¹⁶⁴ A new market scheme to cost £10000 was approved for Winneba in 1927.

¹⁶⁵ The Cape Coast Market was completed and opened in October 1931. This was named the Kotokuraba market, after the vicinity where it was sited. Until today, the kotokuraba market remains the most important in Cape Coast.

¹⁶⁶ GGC, 'Report on the Medical Department for the Year 1930-31', 41.

¹⁶⁷ GGC, "Report on the Medical and Sanitary Department for the Period April 1926 - March 1927," 34.

Officer having power to as his fair portion to be kept clean of the unoccupied space common to all in the said sheds...¹⁶⁸

Live animals were not allowed to stray in any part of the market shed or any part of the market where food items were exposed for sale. And Mothers and caretakers were to ensure that such children did not commit any nuisance in the market.¹⁶⁹

Yet, markets were not constructed just for the sake of sanitation and public health. Rather, it was the considered view of the colonial administration that "...the primary aim of the market was to ensure a plentiful, cheap supply of local foodstuffs."¹⁷⁰ But also, it provided a convenient avenue through which the colonial administration could extract revenue. Indeed, substantial revenue was generated through the letting of market stalls. For example, in 1926, the amount realised in market fees in Accra was £2,162. This increased to £2,327 in 1927.¹⁷¹ In 1935, £4,120 was generated from the Kumase market and in the following year, the figure increased to £4,161.¹⁷²

Market spaces also provided an avenue for the colonial administration to determine what food was wholesome to consume, and to control conditions under which food items could be exposed for sale to the public. Markets were subjected to the full-time supervision of sanitary inspectors. In all large towns, bye-laws were enacted to regulate not only the sale of foodstuffs but also the general sanitation of the market.¹⁷³ All foodstuffs exposed for sale in public markets were inspected regularly by either a Superintending Sanitary Inspector or any Health Officer. Any food item that was found to be unwholesome for consumption was condemned and destroyed.¹⁷⁴ In some cases, persons who exposed unwholesome food items for sale were prosecuted and fined. For example, a total of ninety-nine persons were prosecuted in 1927/28 for the sale of unwholesome food and £98 5/- was collected in fines.¹⁷⁵ In 1928/29, fifty

¹⁶⁸ F. G. Guggisberg(Governor), 'Gold Coast Colony: Rule No. 2 of 1924 under the Towns Ordinance', 29 January 1924, ADM23/1/503, Central Regional Archives, Cape Coast. Similar regulations were applied in all other towns where public markets could be found.

¹⁶⁹ Ibid.

¹⁷⁰ see GGC, 'Report on the Medical Department for the Year 1937', 32.

¹⁷¹ GGC, 'Accra Municipal Annual Report for the Financial Year Ended 31st March 1927.', Annual Departmental Report (Accra: Government Printing Department, 1928), 8, ADM5/1/84, PRAAD, Accra.

¹⁷² GGC, 'Report on the Medical Department for the Year 1936', 32.

¹⁷³ see GGC, 'Report on the Medical Department for the Year 1930-31', 40-41.

¹⁷⁴ see GGC, 'Report on the Medical and Sanitary Department for the Period April 1925 - March 1926', 17.

¹⁷⁵ GGC, 'Report on the Medical and Sanitary Department for the Period April 1927 to March 1928', 31.

persons were prosecuted – resulting in £55 4/- in fines.¹⁷⁶ Every effort was made to prevent the hawking of food items outside market spaces. Legislations were subsequently enacted to regulate hawking and hawkers were accordingly issued with licenses to operate.

Like market accommodation, no slaughterhouse existed in the Gold Coast before the 20th century. In 1888 Dr Waldron suggested to the government, to as a matter of urgency, erect a meat market and a slaughterhouse at Accra. He complained that the indiscriminate slaughtering of animals in private homes for sale to the public made it impossible to determine the wholesomeness of the animal slaughtered. He argued that the health of the public was exposed to great danger if they were made to consume animals whose conditions could not be confirmed before being slaughtered. He emphasised the necessity to slaughter all animals under official supervision if they were to be exposed for sale to the public.¹⁷⁷ Other MOHs continued to make persistent recommendations throughout the late 19th century for the erection of slaughterhouses to facilitate slaughtering of animals under sanitary and hygienic conditions. Their calls only yielded results during the first decade of the 20th century when the facility was made available in some large towns and few rural communities.

By 1910, there were nine slaughterhouses in the entire Gold Coast. The number increased to ten in 1911 and by 1913, there were twelve slaughterhouses in the colony and nine in Asante and the Northern Territories.¹⁷⁸ In 1914, there was a total of twenty-six slaughterhouses.¹⁷⁹ By the beginning of the 1930s, most of the larger towns maintained satisfactory slaughterhouses which had hanging accommodation and related sanitary facilities for the disposal of offal and excrements. Some slaughterhouses, such as the one built in Kumase in 1925 had a dressing room, cooling facilities, and offices. Some smaller towns also had slaughterhouses of very simple types or slaughtering slabs.¹⁸⁰ Just like markets, apart from its public health

¹⁷⁶ GGC, 'Report on the Medical and Sanitary Department for the Period 1928-1929', 35.

¹⁷⁷ GGC, 'Gold Coast Sanitary and Medical Report for 1887 and 1888', 6.

¹⁷⁸ see GGC, 'Medical and Sanitary Report for the Year 1910'; GGC, 'Medical and Sanitary Report for the Year 1911'; GGC, 'Medical and Sanitary Report for the Year 1913'.

¹⁷⁹ GGC, 'Medical and Sanitary Report for the Year 1914', 47.

¹⁸⁰ see GGC, "Annual General Report for the Period 1st April, 1925 to 31st March, 1926" (Accra: Government Printing Department, 1926), GH/PRAAD/ADM5/1/84; GGC, "Report on the Medical Department for the Year 1932-33" (Accra: Government Printer, 1933), GH/PRAAD/ADM5/1/128; GGC, "Report on the Medical Department for the Year 1932-33," 1933.

benefits, the slaughterhouses also created avenues for the extraction of revenue as users were charged daily fees.

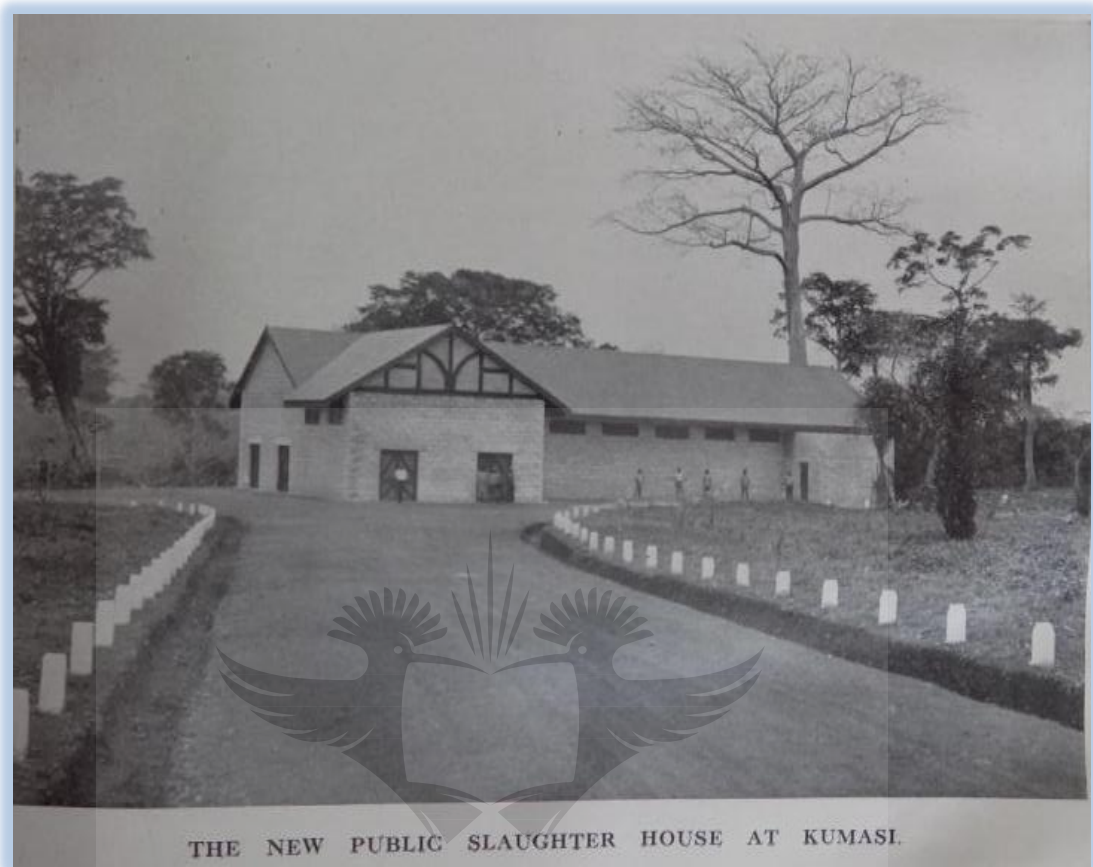


Figure 20: A Public Slaughter House at Kumasi. GGC, Report on the KPHB 1927, 13.

Guidelines determined by the CBH guided the siting of slaughterhouses. These guidelines reinforced sanitary precautions advocated by the colonial administration and were so made to keep the facility not only from being exposed to insanitary practices of the host communities but also to safeguard the community from potential nuisances that could derive from its usage. In general, slaughterhouses were built outside town boundaries, at least 300 yards from the nearest house. Under no circumstance could a slaughterhouse be sited in the centre of an already settled area. They were constructed in well-drained places but close enough to water or river sources, yet they were positioned in a manner that could not result in the pollution of the water source. Beyond that, they were to be sited at places that could ensure that

cattle approaching the facility would not be driven through the town and thereby cause nuisances for the inhabitants.¹⁸¹

Like market spaces, slaughterhouses were subjected to strict control. Elaborate regulations were enacted to ensure that they were kept in sanitary and hygienic conditions always. For instance, users were expected to “remove all blood, offal, filth, and rubbish” and deposit them at designated spaces for such purposes. All articles including knives, slaughter boards, tubs, and buckets were to be kept “clean and sanitary” after use. Additionally, users were required to adhere to any other instruction of the MOH or his assign. Beyond that, no person suffering from any contagious disease such as leprosy or infectious disease of any form or ulcer of any kind was permitted entry into a slaughterhouse. Others “whose body or clothing” was “dirty or insanitary” were also prevented from entering slaughterhouses.¹⁸²

All slaughterhouses were subjected to sanitary policing and periodic inspections were conducted to ensure that they were kept under hygienic and sanitary conditions. Every animal slaughtered in the facility was inspected either by an officer of the Animal Health Department or the sanitary branch. Carcasses were subjected to closer scrutiny and when the various parts were passed as wholesome, they were “stamped” before being dispatched to the meat-market. All carcasses found to be exhibiting signs of disease were condemned wholly or partially – depending on the nature and extent of the disease. In large centres, fly-proofed market sheds were provided for the sale of meat and in smaller towns, either fly-proofed stalls or wire-gauge cages were provided to keep under hygienic conditions meat meant for sale to the public.¹⁸³

Apart from the construction and regulation of market sheds and slaughterhouses, the colonial administration also concerned itself with the sanitation and hygienic preparation of food exposed for sale to the public. By the late 1920s, there was a considerable increase in the number of bakeries, public eateries, and

¹⁸¹ “Extract from the Minutes of the 109th Meeting of the Central Board of Health, Held on 18th December 1928.,” December 18, 1928, GH/ADM23/1/2354, Cape Coast Regional Archive.

¹⁸² ‘Regulations Made by the Governor in Council under Sub-Section (1) of Section Twenty-Seven of the Towns Ordinance’, June 1930, GH/PRAAD/CSO5/1/15. This regulation was made for Takoradi, but all other kinds of regulations governing the use of slaughter houses in the colony followed the same pattern.

¹⁸³ see GGC, “Annual General Report for the Period 1st April 1925 to 31st March 1926”; GGC, “Report on the Medical Department for the Year 1932-33,” 1933.

restaurants in the principal towns. This caught the attention of the colonial administration which moved quickly to subject their activities to sanitary surveillance in the interest of the public health. The KPHB was the first to regulate the activities of bakeries. In 1927, the Board published a bye-law that sought to license bakeries in Kumase. And a fee of 1/- was fixed for licensing certificate. A hawkers' fee of £2/6d per month was also fixed for bread hawkers. This was, however, protested by the bread bakers and subsequently, in 1929, the licensing fee was abolished, while the hawkers' fee was reduced to 1 shilling per month.¹⁸⁴

However, it appeared that what the KPBH was unable to achieve as officially sanctioned fees was compensated for by the constant arrest and fines inflicted upon bread hawkers. A development that prompted a group of bakers to petition the Chief Commissioner, Asante. The petitioners noted that:

...It now appears that, for a considerable length of time past, the very lives of your humble petitioners, hawkers have been pestered by the Sanitary Boys who frequently arrest and have them arraigned before the District Commissioner's court where they are always fined ten shillings (10/-) each, without any exemption...¹⁸⁵

They argued, further that "the Hawkers' license was introduced with a view to ensnaring bread Bakers, or to be used as a bait with which to angle the scanty earnings realised from our poor bakeries."¹⁸⁶ The petitioners were convinced that the treatment meted to the hawkers by the Sanitary Boys was "undoubtedly...due to instructions, or orders given, by the Sanitary Authorities."¹⁸⁷ However, while, the sanitary authorities admitted that the activities of the Sanitary Boys were undertaken under their instructions, they denied that any maltreatment had taken place. Rather, they argued that hawkers constituted a "great nuisance in Kumasi" and that "rigorous measures were called for and have been instituted on account of the complaints received from the merchants".¹⁸⁸

¹⁸⁴ 'Extract from the Minutes of the Monthly Meeting of the Kumasi Public Health Board Held on 9th October 1928', 9 October 1928, ARG1/14/3/13, Ashanti Regional Archives, Kumasi.

¹⁸⁵ 'Bread Bakers to the Chief Commissioner, Ashanti', 27 April 1931, ARG1/14/3/13, Ashanti Regional Archives, Kumasi.

¹⁸⁶ Ibid.

¹⁸⁷ Ibid.

¹⁸⁸ 'Provincial Commissioner, Eastern Province to Chief Commissioner, Ashanti', 11 May 1931, 2, ARG1/14/3/13, Ashanti Regional Archives, Kumasi.

By 1931, the government was considering licensing all bakeries in large towns and subject them to regular inspection. Prospective licensees were to keep a clean, well-constructed and well-ventilated mixing rooms and a clean fly-proof storage room for bread.¹⁸⁹ In 1933 regulations under the Towns Ordinance for licensing bakeries was passed in Sekondi. In 1934 licensing of bakeries in Kumase was reintroduced and a similar ordinance was operational in Accra. Licenses were used as a lever “to insist on the institution of proper methods of storing and baking.” It was reckoned that “...Without some of such safeguards, an insanitary bedroom” was “usually the scene of the processes of breadmaking” except firing.¹⁹⁰ By 1937, bakeries were found in almost all big towns, in most cases, numbering about a hundred. In Accra, Kumase, and Sekondi and in all other towns where the staff of the sanitary department were stationed, bakeries were subjected to periodic inspection and rules were enacted to among other things, compel bakers to cover with fly-proof materials loaves that were exposed for sale.¹⁹¹

Restaurants and other eateries were also subjected to regular inspection to ensure the “preservation of hygienic conditions, especially, as regards good ventilation, general cleanliness, protection of food and drink from dust and flies, disposal of water and the provision of adequate water supply for washing up eating utensils.”¹⁹² Cleanliness regarding food storage, cooking, and eating utensils were also insisted upon. By 1934 restaurants in Kumasi, Accra and elsewhere were licensed. And licenses were issued only to applicants whose premises and other facilities were in “good condition and thoroughly sanitary.”¹⁹³

Conclusion

I have examined sanitary and public health measures that targeted burials, housing and town planning, markets, slaughterhouses, bakeries and restaurants. I have demonstrated that despite the manifest motive of ensuring the sanitation and public health, measures directed at achieving these ends, also sought to achieve wider social

¹⁸⁹ see GGC, ‘Report on the Medical Department for the Year 1930-31’, 41.

¹⁹⁰ GGC, ‘Report on the Medical Department for the Year 1933-34’, 38.

¹⁹¹ see GGC, ‘Report on the Medical Department for the Year 1933-1934’; GGC, ‘Report on the Medical Department for the Year 1936’; GGC, ‘Report on the Medical Department for the Year 1937’.

¹⁹² GGC, ‘Report on the Medical Department for the Year 1931-32’, 32.

¹⁹³ see GGC, ‘Report on the Medical Department for the Year 1933-1934’, 37.

control. Town planning which sought to reorder rural and urban spaces and rid townships of insanitary buildings, for instance, implicitly created an avenue for policing such spaces and the ordering of the activities of the African population regarding how to build. It also provided an avenue for the colonial administration to appropriate rural and urban spaces and imposed a Eurocentric vision of how towns should be patterned and how houses should be built. In a similar vein, the creation of cemeteries to achieve sanitary burials did not only result in the control of such spaces but also did to some extent, reorient the people's mortuary practices. Taking together, these measures resulted inevitably in altering the African population's understanding of health, identity and the spatial demarcation of their communities as well as their use of the built environment to achieve their health and spiritual needs, which were hitherto intertwined.

Furthermore, the provisioning and policing of market spaces, slaughterhouses, bakeries and restaurants, aimed at achieving the sale of food items under sanitary and hygienic conditions, also provided an avenue for the colonial administration to flex its power and engineer some form of social control. The extent to which these measures inured to the benefit of the public health, is, however, difficult to gauge. Arguably, though, these measures, to a large extent, had some transformative effect on the culture of the African population.

Chapter Eight

Conclusion

In this dissertation, I set out to examine the management of sanitation and public hygiene in the Gold Coast within the broader context of power and control and to explicate its implications for public health in the Gold Coast. I focused on the late 19th century until 1950. The key question that has guided the research is: how did the management of sanitation and public hygiene and the discourses it engendered help the colonial administration to achieve its public health objectives? To be able to do this, I have examined the various measures and interventions which the colonial state deployed in managing sanitation and public hygiene.

To explain why sanitation and hygiene became important issues to the colonial administration, I started by examining the health status of the Gold Coast before formal colonisation. In Chapter two, I demonstrated that European accounts from about the 17th century onward presented the climate and physical environment of the Gold Coast littoral as insalubrious and unhealthy. The inhabitants were described as unhygienic and their social practices were represented as contributing to the dire sanitary conditions and insalubrity of the environment. These conditions were held accountable for the high European morbidity and mortality rate on the Gold Coast littoral. However, I indicated the flaw in such narrative to argue that European morbidity and mortality was caused not by climatic factors but by real diseases that were endemic to the region and new ones that were introduced by European sojourners, merchants, etc. I demonstrate, further, that the inhabitants of the interior had practical sanitary arrangements and adhered to strict regimes of sanitation. I, therefore, implicate the European presence in the coastal settlements as a factor that contributed to the depressing sanitary conditions. I do this at two levels. Firstly, I show how their commercial activities on the Gold Coast littoral stimulated trade and a concomitant nascent urbanism that contributed to the depressing insanitary conditions. Secondly, I argue that the attempts by the Europeans, especially, the British to exercise power on the Gold Coast, especially, from the 18th century onwards, crippled the powers of the chiefs who were responsible for managing the sanitation of their towns and villages. And because the British did not have the clout during that period to compel the local population to keep their towns and villages clean, the insanitation of the

coastal settlements worsened compared to the interior where chiefly rule remained intact.

Yet, when the British formally colonised the Gold Coast in 1874, one of the key health challenges that confronted them was the dire insanitary conditions, especially in the towns along the littoral zone. I have illustrated in chapter three that to mitigate the sanitation and health challenges, the colonial state took the first important step by formulating a public health ordinance in 1878. This was followed by the establishment of a medical department in 1884 to manage health conditions including sanitation and public hygiene. In 1909, a sanitary branch of the medical department was established to deal principally with the management of sanitation and hygiene. This was in response to the outbreak of a bubonic plague epidemic in 1908, which was attributed to the pervasiveness of the insanitary conditions of the Gold Coast. In subsequent years, sanitary committees, health boards, native authority administration and municipal/town councils were constituted and empowered to complement the sanitary branch in managing sanitation and public hygiene. Sanitary Inspectors and Overseers were recruited and trained to carry out the mundane activities of the sanitary branch. Thus, by the end of the second decade of the 20th century, an administrative apparatus charged with managing sanitation and public hygiene was firmly established.

From the 1880s and intensifying during the first decade of the 20th century and beyond, the colonial state, first through the medical department and later, through the sanitary branch and its allied agencies and agents deployed several measures to address the sanitary challenges in the Gold Coast. In chapter four, I demonstrated how the colonial state sought to address filthy conditions in towns and villages through the supply of public dustbins, incinerators, and conservancy lorries (in urban areas), to prevent indiscriminate littering and encourage the proper disposal of refuse. To prevent open defecation, the colonial state initiated the provision of public latrines, experimented with several latrine types, and adopted varying techniques of disposing of night soil. Chapter five focused on the efforts at solving the challenge with access to potable water through the construction of reservoirs, wells and the provisioning of pipe-borne water. Chapter six examined anti-mosquito sanitation measures and educational prophylaxis. The fight to eliminate mosquitoes led to the implementation of measures comprising sanitary segregation, swamp and lagoon reclamation,

sanitary inspection, weed control, construction of drains and the application of larvacides. The colonial state also employed the teaching of hygiene to school children and the adult population through public lectures to provide instruction regarding how to maintain clean homes and environmental sanitation as well as how to prevent the breeding of mosquitoes.

Sanitation measures that targeted the creation of spacious neighbourhoods, the selling of food items and meat under sanitary conditions as well as the sanitary burial of the dead in are examined in chapter seven. I demonstrated how the colonial government sought to use the mechanism of the demolition of houses, the laying-out of towns/villages, and the banning of local building materials to force the remodelling of villages and towns along sanitary lines. Similarly, I examined the institution of a regime of sanitary regulation of market spaces and slaughterhouses, bakeries and public eateries which was intended to ensure that food and meat sold to the public were done under hygienic conditions. Furthermore, I investigated the banning of home burials and institution of cemetery burials to ensure that the interment of corpses conformed to sanitary standards as defined by the colonial administration.

The theoretical underpinning driving this dissertation rests on the Foucauldian concept of biopower. As explained in chapter one, Foucault posits that biopower was concerned with two extremes: firstly, it focused on the individual body through disciplinary techniques. Secondly, it targeted the social body (nation/state) through governmental regulations. But also, underpinning biopower is the belief that scientific and medical discourses could legitimate state control of subject populations and that both the individual body and the social body could be made to internalise medical discourses of social control. Foucault believed that, when combined, the two extremes, could allow dominant powers to regulate both the private and public spaces of their subject populations. For Foucault, therefore, the 18th century Western European nation's preoccupation with redefining populations, constructing social hierarchies, and regulating the conduct of populations were all important markers of biopower. These techniques of power reflected in measures that were deployed to manage sanitation and public hygiene in the Gold Coast.

The colonial administration relied on biomedical discourses on sanitation and hygiene to intervene in both the private and public spaces of the African population

and to regulate their conduct through several disciplinary techniques and measures. In the first place, the colonial state instituted a regulatory regime through the enactment of ordinances and sanitary norms, and the institution of a surveillance apparatus through inspections, the import of which was to regulate the conduct of the local population regarding sanitation and public hygiene. This could be achieved through the deployment of Sanitary Inspectors, Medical Officers of Health and other health personnel whose activities served to focus the inspectorial gaze of the colonial state in African homes and neighbourhoods and thus, enabled the regulation and control of domestic practices, manners and habits in African households. Similarly, the preoccupation with managing dirt in its various forms (faeces, rubbish and related waste substances) manifested an attempt to impose some form of order and control on both the individual and the social body – and on the social and physical environment. Essentially, these measures also reflected the colonial discourses on modernising the habits and conducts of a supposedly primitive African population.

The teaching and learning of hygiene and sanitation in schools, and later, to the public through public lectures and related activities was one way through which the colonial administration sought to normalise African habits. In this endeavour, the colonial administration elicited the support of teachers whose perceived influence over their pupils was obvious. African Sanitary Inspectors and Overseers apart from their use of coercion could also, after their training, act as agents in the campaign to shape the habits and practices of the African by educating the public on hygiene and sanitation. Thus, through carefully crafted lectures, standardised curriculum, meticulously designed activities such as health weeks and health months, designated colonial officials, exercising power in the Foucauldian sense could translate and inculcate in school children, trainee-inspectors as well as the adult public, European conceptions of sanitation and hygiene. The belief was that the knowledge and experiences gained could potentially shape and condition habits and practices of the subject population and in the long-term result in the internalisation of practices that could improve sanitation, hygiene and general health. In another sense, one could argue that through these techniques, the colonial state also sought to recast the habits and practices of the people with the intention of reconfiguring their social and cultural practices in ways that reflected the broader discourses of the colonial 'civilising mission.'

The measures that targeted the regulation of housing and town planning, market and slaughterhouses, restaurants, and cemeteries, essentially, conceived of the town as a medicalisable object in the Foucauldian sense. Gold Coast towns/villages were conceptualised as pathogenic and this informed sanitation and hygiene discourses that sought to place under surveillance a range of urban and rural developments including the construction of dwelling spaces, the siting of slaughterhouses, the control of market spaces, public eateries and bakeries, as well as the creation of public cemeteries. Town planning allowed the colonial state to police urban and rural spaces through their building inspectors and other officers of the health department and to reorder such spaces, manifestly to prevent the outbreak of epidemics, but latently, to achieve some form of broader social control.

Through the sanitary regulation of the construction of dwelling spaces, the colonial administration could also express and impose some form of European cultural hegemony, and could, therefore, manipulate African style, taste and desire in respect of building. Similarly, the banning of home burials and the imposition of cemetery interment did not only result in government control of burial spaces, but also, reoriented the peoples' mortuary practices, and their understanding of the spatial demarcation of burial spaces and its relations with health, well-being and social identity. In doing so, a Eurocentric vision of what constituted sanitary burial was upheld and everything else that the local population associated home burials with was reconfigured. It can, thus, be surmised that despite the manifest motive to maintain the public health, measures targeting the management of sanitation and public hygiene became avenues through which the colonial administration sought to reorder, reorganise and reorient the habits, social practices and the predispositions of the indigenous population of the Gold Coast regarding health.

However, the desire by the colonial administration to settle Europeans away from African settlements in urban areas, based on dubious assumptions about Africans' unhealthfulness, initially presented a conundrum. This was because even among the European population not everyone supported the creation of settlements patterned on race. On the one hand, some colonial administrators were initially adamant to implement segregation because of political expediency and their liberal political predispositions. On the other hand, some European merchants were reluctant

to comply with directives to move to segregated settlements because of their business interests. However, these objections (contra Epprecht) did not impact in any significant way on the creation of segregated settlements. Thus, in the end, race segregation was enforced in the principal towns, albeit to a limited extent compared to other colonial enclaves – and the justification was the need to protect Europeans from conditions conducive to malarial infection. This contributed to the construction of the Gold Coast African as dirty, unhealthy and dangerous. As a result, I argue in agreement with Swanson, Ngalamulume and Murunga, whose studies of sanitation in different African contexts, concur that the colonial state did in some sense succeed in creating a paradigm of difference in which the African was represented as the “diseased and dirty other” and on that basis justified the need to create segregated neighbourhoods. By settling Europeans away from Africans, the colonial state was partially successful in imposing a hierarchy based on racial residential patterns in urban areas through which the colonial administration could express European superiority and cultural hegemony.

Yet, colonial biopower was limited in its application and therefore, in its impact. The measures that were adopted to maintain sanitation and public hygiene were not always benign in the Foucauldian sense. Biopower, as conceived by Foucault, operates through the production of knowledge and the manipulation of desire to conform to the norms established by the knowledge regime. However, colonial biopower in the Gold Coast was often tangled with coercion. Sanitary inspection was, for example, very coercive as it involved prosecution, fines, imprisonment and forceful entry into peoples’ private spaces. Similarly, the demolition of supposed insanitary buildings, slum clearance and relocations often involved coercion. Such use of force elicited resistance from the local population either through confrontation, demonstrations or the writing of petitions. Coercion, thus, produced a disinterest in sanitary matters among the African population as resistance impinged on the extent to which the colonial administration could co-opt the local population into their sanitary campaigns. Thus, even though the colonial administration asserted European sanitary ideas and practices, it failed to achieve hegemony in the strictest Foucauldian sense. This also partly related to the half-hearted attitude of the colonial administration towards the implementation of sanitary reforms. Thus, there seemed to have been an inherent contradiction in the implementation of the colonial hegemonic project as the

colonial administrators' politico-economic interests often had conflicting implications for their strategies of control.

Thus, colonial measures targeting sanitation and hygiene and their intended outcomes were not unmitigated successes. For most of the colonial period, the government's approach to sanitary reforms was piecemeal and lackadaisical. Political officials were sometimes apathetic and indifferent towards the implementation of projects bearing on sanitation and hygiene. Where the government showed interest, the health of the African population was often slighted for those of European officials. The evidence reveals a disconnect between what the colonial administration sought to do regarding sanitary reforms and what was practically accomplished. This disconnect seems to relate to disagreeing visions on sanitary matters between the health officials and political officeholders. Colonial health officials appeared empathetic and often complained about deplorable sanitary conditions requiring reforms. Yet, political officials were, often, adamant to commit resources to reform insanitary conditions. Often the reluctance to implement comprehensive sanitary reforms was attributed to fiscal constraints and in some few instances, to the possible political ramification of proposed measures.

If therefore, through the management of sanitation and public hygiene, the colonial administration sought to modernise the Gold Coast, the evidence suggests that whatever modernity that was achieved was a fractured one. For instance, as demonstrated in chapter six, by 1950, colonial reclamation and drainage schemes that were intended to control mosquitoes and maintain salubrious and clean urban spaces were not only in their rudimentary stages, but some had been completely abandoned because of lack of funding and the non-availability of labour to maintain them. Similarly, in chapter four I argued that despite complaints about so-called primitive defecation practices and indiscriminate littering habits amongst the African population and the concomitant measures that were devised to change and supplant the supposed 'uncivilised' toileting practices and change attitudes towards refuse disposal, by 1950 the kind of toilet facilities that were available and the methods that were in place for disposing refuse and keeping public latrines hygienic were far from modern.

Furthermore, as discussed in chapter seven despite the seemingly conscientious attempts to re-order and reorganise supposed insanitary urban and rural spaces through town planning, decongestion, and the sanitary construction of dwelling spaces, by 1950, the question of overcrowding was pervasive, especially in urban centres. And neither were people eager to build to layouts nor conform to preferred type-plans in the erection of dwelling houses. The only field where the colonial administration seemed to have been relatively successful was the provision of potable water. Even so, by 1950, many Gold Coasters, especially, those in rural communities relied on wells and not piped-borne water for their supplies.

The study focused on the late 19th century and terminates in 1950. The temporal limits allowed me to focus solely on the onset of colonial rule and end when effective European control was declining, and Africans were preparing to take over the reins of power. Therefore, a study of the management of sanitation and public hygiene from 1951 until the present will be necessary to elucidate the nature of the sanitary problems during this period and the imprint of colonial rule on measures devised to address them. Such a study is important because it has the potential to explicate the changing discourses on sanitary problems and what forces are driving the changes.

Bibliography

Primary Sources

PRAAD (Accra, Kumasi & Cape Coast)

- 'A Report on the Service Control Scheme at Accra and Takoradi, May 1945', May 1945. PRAAD/ADM5/3/46. PRAAD, Accra.
- 'Bread Bakers to the Chief Commissioner, Ashanti', 27 April 1931. PRAAD/ARG1/14/3/13. Ashanti Regional Archives, Kumasi.
- Central Board of Health. 'Extract from Minutes of the 165th Meeting of the Central Board of Health Held on Monday, the 6th June 1932', 6 June 1932. PRAAD/ADM 23/1/368. Central Regional Archives, Cape Coast
- C. H. Armitage (Ag. CCA). 'Sanitary Rules for the Guidance of Chiefs and Headmen of Villages in Ashanti', November 1909. PRAAD/ARG1/14/3/1. Ashanti Regional Archives, Kumasi.
- Colonial Secretary. Circular No. 59/45. 'Central Board of Health'. Circular No. 59/45, 18 December 1945. PRAAD/ADM 23/1/1746. Central Regional Archives, Cape Coast.
- 'Constitution of the Central Board of Health', n.d. PRAAD/ADM 23/1/2354. Central Regional Archives, Cape Coast.
- 'Extract from Memorandum Submitted to His Excellency the Governor by the Omanhene, Chiefs, and People of Akim Abuakwa at the Durbar Held on the 28.12.1933', 28 December 1933. PRAAD/CSO11/14/205. Accra.
- 'Extract from Minutes of Meeting of Ashanti Health Board Held in the Chief Commissioner Ashanti's Office on Tuesday, March 22nd, 1927', 1927. PRAAD/ARG1/14/3/6. Ashanti Regional Archives, Kumasi.
- 'Extract from the Minutes of the 109th Meeting of the Central Board of Health, Held on 18th December 1928.', 18 December 1928. PRAAD/ADM23/1/2354. Cape Coast Regional Archive.
- 'Extract from the Minutes of the Monthly Meeting of the Kumasi Public Health Board Held on 9th October 1928', 9 October 1928. PRAAD/ARG1/14/3/13. Ashanti Regional Archives, Kumasi.
- 'From Acting Sanitary Superintendent to District Commissioner, Saltpond', 21 July 1945. PRAAD/ADM 23/1/987. Central Regional Archives, Cape Coast.
- 'From Acting Sanitary Superintendent to District Commissioner, Saltpond', 27 July 1945. PRAAD/ADM 23/1/987. Central Regional Archives, Cape Coast.
- 'From Ag. Provincial Commissioner, Cape Coast to Deputy Director of Health Services', 18 September 1937. PRAAD/ADM23/1/948. Central Regional Archives, Cape Coast.
- 'From D. Duff (Director of Medical Services) to the Deputy Director of Health Services: Sanitary Conditions of the Environs of the Mining Areas', 8 June 1936. PRAAD/CSO11/14/264. Accra.
- 'From Deputy Director of Health Service (Selwyn Clarke) to the Director of Medical Services: Mining Areas, Insanitary Conditions of... 10 June 1936', 10 June 1936. PRAAD/CSO11/14/264. Accra.
- 'From District Commissioner, L.W. Judd to the Commissioner, Eastern Province, Ashanti, 4th June 1927', 1927. PRAAD/ARG1/14/3/6. Ashanti Regional Archives, Kumasi.

- 'From Hammah III to the Ag. District Commissioner, Saltpond', 13 June 1944. PRAAD/ADM23/1/987. Central Regional Archives, Cape Coast.
- 'From J. Quist-Therson to Governor Allan Burns, 17th June 1943', 1943. PRAAD/CSO11/14/326. Accra.
- 'From L. J. Mothersill (Assistant District Commissioner, Navrongo) to Chief Commissioner, Northern Territories, 2 August 1934', 1934. PRAAD/CSO11/14/208. Accra.
- 'From Medical Officer of Health, L. G. Eddy to the President, Sekondi Town Council', 8 December 1943. PRAAD/CSO 11/14/376. Accra.
- 'From Omanhene Ayanmaim to District Commissioner, Saltpond', 29 August 1945. PRAAD/ADM23/1/987. Central Regional Archives, Cape Coast.
- 'From Omanhene of Mankessim to the District Commissioner, Saltpond.', 20 August 1943. PRAAD/ADM23/1/987. Central Regional Archives, Cape Coast.
- 'From the Director of Medical Service to Colonial Secretary, September 1936', September 1936. PRAAD/CSO11/14/264. Accra.
- 'From the District Commissioner to the Bantamahene, Kumasi, 14th May 1942', 1942. PRAAD/ARG6/14/3. Ashanti Regional Archives, Kumasi.
- 'From the Medical Officer of Health, Kumasi to the District Commissioner, Kumasi, 12 May 1942', 1942. PRAAD/ARG6/14/3. Ashanti Regional Archives, Kumasi.
- Government of the Gold Coast. 'Annual General Report for the Period 1st April 1925 to 31st March 1926'. Accra: Government Printing Department, 1926. GH/PRAAD/ADM5/1/84.
- . 'Municipal Reports for the Year 1927-1928'. Annual Departmental Report. Accra: Government Printing Department, 1928. PRAAD/ADM5/1/86. Accra.
- . 'Regulations Made by the Governor in Council under Section 38 of the Towns Ordinance', 1935. PRAAD/ADM/1/2237. Central Regional Archives, Cape Coast.
- . 'Report on Ashanti for the Year 1928-1929'. Annual Departmental Report. Accra: Government Printing Department, 1929. PRAAD/ADM5/1/86. Accra.
- . 'Report on the Kumasi Public Health Board for the Year Ended 31st March 1927'. Annual Departmental Report. Accra: Government Printer, 1927. GH/PRAAD/ADM5/1/84.
- . 'Report on the Medical and Sanitary Department for the Financial Year 1928-1929'. Annual Departmental Report. Accra, 1929. PRAAD/ADM5/1/86. Accra.
- . 'Report on the Medical Department for the Year 1932-33'. Accra: Government Printer, 1933. GH/PRAAD/ADM5/1/128.
- . 'Sekondi Municipal Annual Report for the Year 1926-1927'. Departmental Report. Accra: Government Printer, 20 May 1927. GH/PRAAD/ADM5/1/84.
- . 'Accra Municipal Annual Report for the Financial Year Ended 31st March 1927.' Annual Departmental Report. Accra: Government Printing Department, 1927. PRAAD/ADM5/1/84. Accra.
- Guggisberg (Governor), F. G. 'Gold Coast Colony: Rule No. 2 of 1924 under the Towns Ordinance', 29 January 1924. ADM23/1/503. Central Regional Archives, Cape Coast.
- Howell, W M. 'Health Week, Kumasi: From 24th to 30th November 1929', 1929. PRAAD/ARG6/14/1. Ashanti Regional Archives, Kumasi.
- . 'This Spitting Habit', n.d. PRAAD/ARG6/14/2. Ashanti Regional Archives, Kumasi.

- Jos. Kobbina. 'Report on Sanitary Conditions in Beposo, Bank, Mampong Akronfuso, Oyoko, Juaben, Kasam, Safo, Ntonso, & Odumasi', 8 February 1935. ARG6/14/3. Ashanti Regional Archives, Kumasi.
- 'Memo: Formation and Duties of Committees', n.d. PRAAD/ARG1/14/3/1. Ashanti Regional Archives, Kumasi.
- 'Memo: From Medical Officer of Health to Occupier of Bungalow No. 48, Kumasi', 1931. ARG1/14/3/15. Ashanti Regional Archives, Kumasi.
- 'Memo: From the Deputy Director of Sanitary Services to the Director of Medical Services', 1927. ARG1/14/3/6. Ashanti Regional Archives, Kumasi.
- 'Memo from the Provincial Commissioner's Office (Central Province) to the District Commissioner, Cape Coast', 22 May 1933. PRAAD/ADM23/1/595. Central Regional Archives, Cape Coast.
- 'Memorandum of Points to Be Made Subject of Inspection and Report by Sanitary Committees', n.d. PRAAD/ARG1/14/3/1. Ashanti Regional Archives, Kumasi.
- 'Provincial Commissioner, Eastern Province to Chief Commissioner, Ashanti', 11 May 1931. ARG1/14/3/13. Ashanti Regional Archives, Kumasi.
- 'Minutes of a Meeting of the Saltpond Sanitary Committee Held on Friday, August 8th, 1930', 1930. PRAAD/ADM23/1/2436. Central Regional Archives, Cape Coast.
- 'Minutes of Meeting No. 6/32 of the Sanitary Committee Held at the District Commissioner's Office, Winneba on Thursday 16th August 1932', 1932. PRAAD/ADM23/1/368. Central Regional Archives, Cape Coast.
- 'Minutes of Meeting of the Provincial Health Board Held at Cape Coast on the 6th October 1927', 1927. ADM23/1/368. Cape Coast Regional Archive.
- 'Minutes of Meeting of the Salt Pond Sanitary Committee Held on Monday 3rd November 1930', November 1930. PRAAD/ADM23/1/2436. Central Regional Archives, Cape Coast.
- 'Minutes of the Provincial Health Board Held at Cape Coast on the 31st August 1927', 1927. ADM23/1/368. Central Regional Archives, Cape Coast.
- 'Regulations Made by the Governor in Council under Sub-Section (1) of Section Twenty-Seven of the Towns Ordinance', June 1930. GH/PRAAD/CSO5/1/15
- Simpson, W. J. 'Report by Professor W. J. Simpson on Sanitary Matters in Various West African Colonies and the Outbreak of Plague in the Gold Coast'. London: Her Majesty's Stationary Office, June 1909. GH/PRAAD/ADM5/3/12. Accra.
- Simpson, William. 'Report on the Outbreak of Plague in the Gold Coast, 1924', 31 December 1924. GH/PRAAD/ADM5/3/23.
- 'The Petition of Acting Ga Mantse and Sub-Chiefs of Accra and Christiansborg', 22 July 1929. PRAAD/ADM11/1/290. Accra.
- Town and Country Planning Board. 'Circular, TCPB/1/48', 7 December 1948. PRAAD/ADM 23/1/1746. Central Regional Archives, Cape Coast.
- Town and Country Planning in the Gold Coast, Bulletin no.2, 30th September 1949. PRAAD/ADM5/4/80.
- 'W. C. F. Robertson, Ag. Colonial Secretary to Provincial Commissioners', 15 August 1908. PRAAD/ARG1/14/3/1. Ashanti Regional Archives, Kumasi.

Balme Library, Africana Section, Legon

- Government of the Gold Coast. 'Annual Report for 1898'. Annual. Colonial Reports - Annual. London: Darling & Son Ltd., 1899.
- . 'Annual Report on the Gold Coast for the Year 1946'. London: His Majesty's Stationery Office, 1948.
- . 'Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1935-36'. Annual. Colonial Reports. London: Her Majesty's Stationery Office, 1936.
- . 'Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1931-32'. Annual. Colonial Reports. London: His Majesty's Stationery Office, 1933.
- . 'Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1934-35'. Annual. Colonial Reports. London: His Majesty's Stationery Office, 1936.
- . 'Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1936-1937'. London: His Majesty's Stationery Office, 1937.
- . 'Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1938-39'. Annual. London: Her Majesty's Stationery Office, 1939.
- . 'Gold Coast Report for 1909'. Colonial Reports - Annual. London: Darling & Son Ltd., 1910.
- . 'Gold Coast Report for 1911'. Annual. London: His Majesty's Stationery Office, 1912.
- . 'Gold Coast Report for 1913'. Annual. London: Printed under the authority of His Majesty's Stationery Office by Barclay and Fry Ltd., 1914.
- . 'Gold Coast Report for 1914'. Annual. London: Printed under the authority of His Majesty's Stationery Office by Barclay and Fry Ltd., 1915.
- . 'Gold Coast Report for 1929-1930'. Annual. London: His Majesty's Stationery Office, 1930.
- . 'Gold Coast Report for 1930-1931'. Annual. Colonial Reports. London: His Majesty's Stationery Office, 1932.
- . 'Gold Coast Annual Report for 1895'. Annual. Colonial Reports. London: Eyre and Spottswode, 1897.
- . 'Gold Coast Annual Report for 1896'. Annual. Colonial Reports. Darling & Son Ltd., 1897.
- . 'Gold Coast Annual Report for 1897'. Annual. Colonial Reports. London: Darling & Son Ltd., 1898.
- . 'Legislative Council Debates: Session 1939, No.1'. Accra: Government Printer, 1939.
- . 'Gold Coast Legislative Council Debates: Session 1927-1928'. Government Printer, 3 March 1927.
- Simpson, William J. 'Report on the Sanitary Condition of the Mines and Mining Villages in the Gold Coast Colony and Ashanti'. London; Dunstable; Watford: Waterlow and Sons Ltd., 24 November 1924.

British Online Archives

- 'Enclosure 15 in Gold Coast No. 318 of 25th July 1898: Sanitary and Medical Report of the Gold Coast Colony for the Year Ended 31st December 1897'. Annual, 1898. British Online Archive.
<https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- 'Enclosure: Acting Governor Hodgson to Lord Knutsford', 26 July 1889. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- Eyles, Dr. 'Enclosure 4 in No. 5: Sanitary Report of Cape Coast and Elmina for the Year Ending 31st December 1885', 1886. British Online Archive.
<https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- Government of the Gold Coast. 'Report on the Medical Department for the Year 1943'. Accra: Government Printing Department, 1944. British Online Archive.
<https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Departmental Reports 1900: Report of the Principal Medical Officer for the Year 1900'. London: Waterlow & Sons Limited, Printers, London Wall, 1901.
- . 'Enclosure 16 in the Gold Coast No. 257 of July 1899: Medical Report on the Gold Coast for the Year Ended 31st December 1898', 1899. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Gold Coast Annual Report, 1950'. London: Her Majesty's Stationery Office, 1952. British Online Archive.
<https://microform.digital/boa/documents/7272/gold-coast-1950-1954>.
- . 'Gold Coast Medical and Sanitary Report for 1889'. London: Her Majesty's Stationery Office, 1890. British Online Archive.
<https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Gold Coast Sanitary and Medical Report for 1887 and 1888'. London: Her Majesty's Stationery Office, 1889. British Online Archive.
<https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1902'. London: Waterlow and Sons Ltd., 1903. British Online Archive.
<https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Report of the Medical Department for the Year 1952'. Accra: Government Printing Department, 1954.
<https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report of the Ministry of Health, 1953'. Gold Coast, Accra: Government Printer, 1955. British Online Archive.
<https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1952'. Gold Coast, Accra: Government Printing Department, 1954. British Online Archive.

- <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Reports on the Medical and Sanitary Department for the Year 1919'. Accra: Government Press, 1920. British Online Archive. <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.
- . 'Sanitary and Medical Reports for 1886 and 1887'. Annual. Her Majesty's Colonial Possessions. London: Eyre and Spottswode, 1888. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Sanitary and Medical Reports, March 1887'. Quarterly. Her Majesty's Colonial Possessions. London: Eyre and Spottswode, 1887. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Annual Medical and Sanitary Report on the Gold Coast Colony for the Year Ended 31st December 1901', 1902. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1903'. London: Waterlow & Sons Limited, Printers, London Wall, 1904. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1905'. Annual. London, 1906. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1906'. London: Waterlow and Sons Ltd., 1907. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1907'. London: Waterlow and Sons Ltd., 1908. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1908'. Annual. Accra: Government Printer, 1909. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1909'. Gold Coast: Government Printer, 1910. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1910'. London: Waterlow & Sons Limited, Printers, London Wall, 1911. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- . 'Medical and Sanitary Report for the Year 1911'. London: Waterlow and Sons Ltd., 1912. British Online Archive. <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.
- . 'Medical and Sanitary Report for the Year 1912'. London: Waterlow & Sons Limited, Printers, London Wall, 1913. British Online Archive.

- <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.
- . 'Medical and Sanitary Report for the Year 1913'. London: Waterlow and Sons Ltd., 1914. British Online Archive. <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.
- . 'Medical and Sanitary Report for the Year 1914'. London: Waterlow and Sons Ltd., 1915. <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.
- . 'Medical and Sanitary Report for the Year 1915'. London: Waterlow and Sons Ltd., 1916. British Online Archive. <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.
- . 'Medical and Sanitary Report for the Year 1918'. Waterlow and Sons Ltd., 1919. British Online Archive. <https://microform.digital/boa/documents/7343/sanitary-and-medical-1911-1919>.
- . 'Report of the Medical Department for the Year Ending 1st April 1922 - 31st March 1923'. Annual. Accra: Government Printing Department, 1923. British Online Archive. <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical and Sanitary Department for the Period 1928-1929'. Gold Coast, Accra: Government Printing Department, 1929. British Online Archive. <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical and Sanitary Department for the Period April 1924 - March 1925'. Gold Coast, Accra, 1925. British Online Archive. <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical and Sanitary Department for the Period April 1925 - March 1926'. Gold Coast, Accra: Government Printer, 1926. British Online Archive. <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical and Sanitary Department for the Period April 1926 - March 1927'. Gold Coast, Accra: Government Printer, 1927. British Online Archive. <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical and Sanitary Department for the Period April 1927 to March 1928'. Gold Coast, Accra: Government Printer, 1928. British Online Archive. <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical and Sanitary Department for the Year 1929-1930'. Gold Coast, Accra: Government Printer, 1930. British Online Archive. <https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.
- . 'Report on the Medical Department for the Period April 1923 - March 1924'. Gold Coast, Accra: Government Printer, 1924. British Online Archive. <https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.

- . 'Report on the Medical Department for the Period January 1922 - March 1923'. Gold Coast, Accra: Government Press, 1923.
<https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical Department for the Year 1920'. Gold Coast, Accra: Government Press, 1921. British Online Archive.
<https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical Department for the Year 1921'. Gold Coast, Accra: Government Press, 1922. British Online Archive.
<https://microform.digital/boa/documents/7344/sanitary-and-medical-1920-1929>.
- . 'Report on the Medical Department for the Year 1930-31'. Gold Coast, Accra: Government Printer, 1931. British Online Archive.
<https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.
- . 'Report on the Medical Department for the Year 1931-32'. Gold Coast, Accra: Government Printer, 1932. British Online Archive.
<https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.
- . 'Report on the Medical Department for the Year 1932-33'. Gold Coast, Accra: Government Printer, 1933. British Online Archive.
<https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.
- . 'Report on the Medical Department for the Year 1933-34'. Gold Coast, Accra: Government Printer, 1934. British Online Archive.
<https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.
- . 'Report on the Medical Department for the Year 1933-1934'. Gold Coast, Accra: Government Printer, 1934. British Online Archive.
<https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.
- . 'Report on the Medical Department for the Year 1934'. Gold Coast, Accra: Government Printer, 1935. British Online Archive.
<https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.
- . 'Report on the Medical Department for the Year 1935'. Gold Coast, Accra: Government Printer, 1936. British Online Archive.
<https://microform.digital/boa/documents/7345/sanitary-and-medical-1929-1935>.
- . 'Report on the Medical Department for the Year 1936'. Gold Coast, Accra: Government Printer, 1937. British Online Archive.
<https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1937'. Gold Coast, Accra: Government Printer, 1938. British Online Archive.
<https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1938'. Gold Coast, Accra: Government Printer, 1939. British Online Archive.

- <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1939'. Gold Coast, Accra: Government Printer, 1940. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1940'. Gold Coast, Accra: Government Printer, 1940. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1941'. Gold Coast, Accra: Government Printer, 1942. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1942'. Gold Coast, Accra: Government Printing Department, 1943. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1943'. Gold Coast, Accra: Government Printing Department, 1944. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1944'. Gold Coast, Accra: Government Printing Department, 1945. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1945'. Gold Coast, Accra: Government Printing Department, 1946. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1948'. Gold Coast, Accra: Government Printing Department, 1949. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1949'. Gold Coast, Accra: Government Printing Department, 1950. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1950'. Gold Coast, Accra: Government Printing Department, 1952. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Report on the Medical Department for the Year 1951'. Gold Coast, Accra: Government Printing Department, 1953. British Online Archive. <https://microform.digital/boa/documents/7346/sanitary-and-medical-1936-1955>.
- . 'Sanitary and Medical Report, November 1887'. Quarterly, 1887. British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

- . 'Sanitary and Medical Report, September 1887'. Quarterly, 1887.
<https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1990>.
- . 'Sanitary and Medical Reports, June 1887'. Quarterly. Gold Coast, 1887.
 British Online Archive. <https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- McCarthy, J D. 'Enclosure 1 in No. 5: Sanitary Report on the Station of Accra for the Year Ending 31st December 1885', 1886. British Online Archive.
<https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.
- Registrar of Deaths' Office. 'Report on the Public and Private Cemeteries of the Colony for 1895'. Gold Coast, Accra, 1896. British Online Archive.
<https://boa.microform.digital/documents/7348/public-cemeteries-1895-1907>.
- 'Report on the Cape Coast Town Council for the Financial Year 1945-1946', 1946
 1945. British Online Archive.
<https://microform.digital/boa/documents/7282/municipal-annual-reports-1934-1949>.
- Rowland, J W. 'Enclosure 6 in No. 5: Sanitary Report on the Station of Axim for the Year Ending 31st December 1885', 1886. British Online Archive.
<https://boa.microform.digital/documents/7342/sanitary-and-medical-1886-1910>.

Published Manuscripts used as Primary Sources

- Allen, Marcus. *The Gold Coast or A Cruise in West African Waters*. London: Hodder and Stoughton, 1874.
- Barbot, Jean. *Barbot on Guinea: The Writings of Jean Barbot on West Africa 1678-1712, Vol. II*. Edited by Paul Hair. Second 176. Hakluyt Society, 1992.
- Bosman, Willem. *A New and Accurate Description of the Coast of Guinea, Divided into the Gold, the Slave, and the Ivory Coasts*. Sir Alfred Jones, 1705.
- Bowdich, Thomas Edward. *Mission from Cape Coast Castle to Ashantee: With a Descriptive Account of That Kingdom*. New Edition. Griffith & Farran, 1873.
- Boyle, Frederick. *Through Fanteeland to Coomassie, a Diary of the Ashantee Expedition*. London, Chapman and Hall, 1874.
<http://archive.org/details/throughfanteela00boylgoog>.
- Brackenbury, Henry, and George Lightfoot Huyshe. *Fanti and Ashanti, Three Papers Read on Board the S. S. Ambriz on the Voyage to the Gold Coast*. Edinburgh and London: W. Blackwood and Sons, 1873.
<http://archive.org/details/FantiAshanti00Brac>.
- Burton, Richard Francis. *Wanderings in West Africa from Liverpool to Fernando Po*. London: Tinsley brothers, 1863.
<http://archive.org/details/wanderingsinwest02burtiala>.
- . *Wanderings in West Africa from Liverpool to Fernando Po*. London: Tinsley brothers, 1863. <http://archive.org/details/wanderingsinwest02burtiala>.
- Cardinal, A W. *The Natives of the Northern Territories of the Gold Coast: Their Customs, Religion and Folklore*. London; New York: George Routledge & Sons Ltd; E.P. Dutton & Co., 1891.
- Cruikshank, Brodie. *Eighteen Years on the Gold Coast of Africa: Including an Account of the Native Tribes, and Their Intercourse with Europeans*. Hurst and Blackett, 1853.

- Duff, William Sir. *Report to the Governor on a Survey of Water Resources in Ashanti with Recommendations for Introducing a Piped Water Supply to Kumasi*. Accra: Government of the Gold Coast, 1914.
- Dupuis, Joseph. *Journal of a Residence in Ashantee, Comprising Notes and Researches Relative to the Gold Coast and the Interior of Western Africa*. London: Henry Colburn, 1824.
- Eiloart, Ernest. 'The Land of Death: A Pamphlet Addressed to the Members of Both Houses of Parliament with Some Observations on the Present Mode of Making Selections for Colonial Appointments'. Hatchards, Piccadilly, 1887. <http://www.jstor.org/stable/60230332>.
- Gordon, Sir Charles Alexander. *Life on the Gold Coast*. London: Baillière, Tindall, & Cox, 1874.
- Griffith, William Brandford. *Ordinances of the Gold Coast, Vol. I*. London: Stevens and Sons, 1898.
- . *Ordinances of the Gold Coast, Vol. II*. London: Stevens and Sons, 1898.
- James Africanus B. Horton. *Physical and Medical Climate and Meteorology of the West Coast of Africa: With Valuable Hints to Europeans for the Preservation of Health in the Tropics*. London: John Churchill & Sons, 1867. <http://archive.org/details/physicalandmedi00hortgoog>.
- Lennox, David. 'Inaugural Address at the Opening of School of Hygiene and Sanitation, Accra', 1944. School of Hygiene and Sanitation Library, Accra.
- Meredith, Henry. *An Account of the Gold Coast of Africa with a Brief History of the African Company*. London: Longman, Hurst, Rees, ORME and Brown, Paternoster Row, 1812.
- Marees, Pieter De. *Description and Historical Account of the Gold Kingdom of Guinea (1602)*. Translated by A. Van Dantzig and Adam Jones. Oxford University Press, 1987.
- Rattray, R S. *Ashanti*. London: Oxford University Press, 1923.

Secondary Sources

- Adams, Frank Kwesi. *Odwira and the Gospel: A Study of the Asante Odwira Festival and Its Significance for Christianity in Ghana*. OCMS, 2010.
- Addae, Stephen Kojo. *The Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960*. Edinburgh; Durham USA: Durham Academic Press, 1997.
- Adu-Gyamfi, Samuel. 'A Historical Study of the Impact of Colonial Rule on Indigenous Medical Practices in Asante: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumase, 1902-1957'. Ph.D., Faculty of Social Sciences, College of Art and Social Sciences, Kwame Nkrumah University of Science and Technology, 2010.
- Akyeampong, Emmanuel Kwaku. 'Disease in West African History'. In *Themes in West Africa's History*, edited by Emmanuel Kwaku Akyeampong, 186–207. Oxford: James Currey Publishers, 2006.
- Amponsah, Nana Akua. 'Colonising the Womb: Women, Midwifery, and the State in Colonial Ghana'. Ph.D., University of Texas, 2011.
- Anderson, Warwick. *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines*. New edition Durham, NC: Duke University Press Books, 2006.

- . 'Excremental Colonialism: Public Health and the Poetics of Pollution'. *Critical Inquiry* 21, no. 3 (Spring 1995): 640–69.
- Armstrong, David. 'Public Health Spaces and the Fabrication of Identity'. *Sociology* 27, no. 3 (1 August 1993): 393–410. <https://doi.org/10.1177/0038038593027003004>.
- Azevedo, Mario J. 'Public Health in Africa: Theoretical Framework'. In *Historical Perspectives on the State of Health and Health Systems in Africa, Volume I*, 1–77. African Histories and Modernities. Springer International Publishing, 2017. https://doi.org/10.1007/978-3-319-32461-6_1.
- Barcan, Ruth. 'Dirty Spaces: Separation, Concealment, and Shame in the Public Toilet'. In *Toilets: Public Rest Rooms and the Politics of Sharing*, edited by Harvey Molotch and Laura Noren, 25–46. New York and London: NYU Press, 2010.
- Baronov, David. *The African Transformation of Western Medicine and the Dynamics of Global Cultural Exchange*. 1 edition. Temple University Press, 2008.
- Bashford, Alison. *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*. Palgrave Macmillan, 2004.
- Beinart, William, and Lotte Hughes. *Environment and Empire*. 1 edition. Oxford etc.: Oxford University Press, 2009.
- Berridge, Virginia, Martin Gorsky, and Alex Mold. *Public Health in History*. 1 edition. Maidenhead: Open University Press, 2011.
- Berry, Sarah. 'Hegemony on a Shoe String: Indirect Rule and Access to Agricultural Land.' *Africa: Journal of the International African Institute*, 62, no. 3 (1992). 327-55
- Bigon, Liora. 'Between Local and Colonial Perceptions: The History of Slum Clearances in Lagos (Nigeria), 1924-1960.' *African & Asian Studies* 7, no. 1 (February 2008): 49–76. <http://0-search.ebscohost.com.ujlink.uj.ac.za/login.aspx?direct=true&db=a9h&AN=30083305&site=ehost-live&scope=site>.
- . 'Bubonic Plague, Colonial Ideologies, and Urban Planning Policies: Dakar, Lagos, and Kumasi'. *Planning Perspectives* 31, no. 2 (2016): 205–26.
- . 'Sanitation and Street Layout in Early Colonial Lagos: British and Indigenous Conceptions'. *Planning Perspectives* 20 (July 2005): 247–69.
- Bohman, Anna. 'Framing the Water and Sanitation Challenge: A History of Urban Water Supply and Sanitation in Ghana 1909-2005'. Umea University, 2010.
- . 'The Presence of the Past: A Retrospective View of the Politics of Urban Water Management in Accra, Ghana'. *Water History* 4, no. 2 (July 2012): 137–54. <https://doi.org/10.1007/s12685-011-0047-2>.
- Brown, James, W. 'Increased Intercommunication and Epidemic Disease in Early Colonial Ashanti'. In *Disease in African History: An Introductory Survey and Case Studies*, edited by David Patterson K. and Gerald Hartwig W., 180–206. Duke University Centre for Commonwealth and Comparative Studies 4. Durham, N. C.: Duke University Press, 1978.
- Brown, James Wilson. 'Kumasi, 1896-1923: Urban Africa during the Early Colonial Period'. Doctor of Philosophy, University of Wisconsin, 1972.
- Brown, Spencer H. 'Public Health in Lagos, 1850-1900: Perceptions, Patterns, and Perspectives'. *The International Journal of African Historical Studies* 25, no. 2 (1992): 337–60.
- . 'Public Health in U.S. and West African Cities, 1870-1900'. *The Historian* 56, no. 4 (Summer 1994): 685–98.

- Burke, Timothy. *Lifebuoy Men, Lux Women: Commodification, Consumption, and Cleanliness in Modern Zimbabwe*. Duke University Press, 1996.
- Cell, John W. 'Anglo-Indian Medical Theory and the Origins of Segregation in West Africa'. *The American Historical Review* 91, no. 2 (1986): 307–35.
<https://doi.org/10.2307/1858136>.
- Chakrabarti, Pratik. *Medicine and Empire: 1600-1960*. Basingstoke: Palgrave Macmillan, 2014.
- . *Medicine and Empire, 1600-1960*. Basingstoke: Palgrave MacMillan, 2014.
- Chakrabarty, Dipesh. 'Open Space/Public Place: Garbage, Modernity and India'. *South Asia: Journal of South Asian Studies* 14, no. 1 (1 June 1991): 15–31.
<https://doi.org/10.1080/00856409108723146>.
- Claridge, William Walton. *A History of the Gold Coast and Ashanti from the Earliest Times to the Commencement of the Twentieth Century, Vol. 1*. London: J. Murray, 1915. <http://archive.org/details/historyofgoldcoa00clarrich>.
- Cohen, William, A. 'Introduction: Locating Filth'. In *Filth, Dirt, Disgust and Modern Life*, edited by William Cohen A. and Ryan Johnson, vii–xxvii. Minneapolis; London: University of Minnesota Press, 2005.
- Cole, Festus. 'Sanitation, Disease and Public Health in Sierra Leone, 1895-1922: Case Failure of British Colonial Health Policy'. *The Journal of Imperial and Commonwealth History* 43, no. 2 (2015): 238–66.
<https://doi.org/10.1080/03086534.2014.974901>.
- Comaroff, John & Jean. *Ethnography and The Historical Imagination*. 1 edition. Boulder: Routledge, 1992.
- Cook, G C. 'What Can the Third World Learn from the Health Improvements of Victorian Britain?' *Postgraduate Medical Journal* 81, no. 962 (1 December 2005): 763. <https://doi.org/10.1136/pgmj.2005.033506>.
- Cooper, Frederick. 'Conflict and Connection: Rethinking Colonial African History'. *The American Historical Review* 99, no. 5 (1994): 1516–45.
- . *Decolonization and African Society: The Labor Question in French and British Africa*. 1 edition. Cambridge: Cambridge University Press, 1996.
- Corbin, Alain. *The Foul and the Fragrant: Odour and the French Social Imagination*. Reprint edition. Harvard University Press, 1988.
- Crook, Tom. 'Sanitary Inspection and the Public Sphere in Late Victorian and Edwardian Britain: A Case Study in Liberal Governance'. *Social History* 32 (November 2007).
- Crozier, Anna. 'Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa, 1890-1939'. *The Journal of Imperial and Commonwealth History* 35, no. 3 (2007): 393–415.
- Curtin, Philip D. "'The White Man's Grave: Image and Reality, 1780-1850'. *The Journal of British Studies* 1, no. 1 (1961): 94–110.
<http://www.jstor.org/stable/175101>.
- . *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century*. 1 edition. Cambridge: Cambridge University Press, 1989.
- . 'Medical Knowledge and Urban Planning in Tropical Africa'. *The American Historical Review* 90, no. 3 (June 1985): 594.
<https://doi.org/10.2307/1860958>.
- . 'The End of the "White Man's Grave"? Nineteenth-Century Mortality in West Africa'. *Journal of Interdisciplinary History* 21, no. 1 (1990): 63.
<https://doi.org/10.2307/204918>.

- Dawson, Marc H. 'Disease and Population Decline of the Kikuyu of Kenya, 1890 - 1925'. In *African Historical Demography*, II:121–38. Edinburg, Scotland: Centre of African Studies, University of Edinburg, 1981.
- . 'Socio-Economic Change and Disease: Small Pox in Colonial Kenya, 1880-1920'. In *The Social Basis of Health and Healing in Africa*, edited by Steven Feierman and John M Janzen, 90–103. Berkeley. Los Angeles. London: University of California Press, 1992.
- Deacon, Harriet. 'Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town'. *Journal of Southern African Studies* 22, no. 2 (1996): 287–308. <http://www.tandfonline.com/doi/abs/10.1080/03057079608708492>.
- De-Graft Johnson, J. C. 'The Fante Asafu., *Journal of International African Institute*, 5 no 3 (1932): 307-322.
- Douglas, Mary. *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*. London: Routledge, 2001.
- Drew, Jane, Maxwell Fry, and Harry L. Ford. *Village Housing in the Tropics: With Special Reference to West Africa*. Routledge, 2013.
- Dumett, Raymond. 'Disease and Mortality among Gold Miners of Ghana: Colonial Government and Mining Company Attitudes and Policies, 1900-1938'. *Soc. Sci. Med.* 37, no. 2 (1993): 213–32.
- Dumett, Raymond E. *El Dorado in West Africa: The Gold-Mining Frontier, African Labor, and Colonial Capitalism in the Gold Coast, 1875-1900*. Athens: Ohio University Press; Oxford: J. Currey, 1998.
- Dumett, Raymond E. 'The Campaign against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898 - 1910'. *African Historical Studies* 1, no. 2 (1968): 153–97. <http://www.jstor.org/stable/216391>.
- Echenberg, Myron J. *Black Death, White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914-1945*. Heinemann, 2002.
- Epprecht, Marc. 'The Native Village Debate in Pietermaritzburg, 1848-1925: Revisiting the 'Sanitation Syndrome''. *Journal of African History*, 58, no. 2 (2017): 259-83.
- Feierman, Steven. 'Struggles for Control: The Social Roots of Health and Healing in Modern Africa'. *African Studies Review* 28, no. 2/3 (June 1985): 73. <https://doi.org/10.2307/524604>.
- Feinberg, Harvey M. 'New Data on European Mortality in West Africa: The Dutch on the Gold Coast, 1719–1760'. *The Journal of African History* 15, no. 03 (1974): 357–371. http://journals.cambridge.org/article_S0021853700013530.
- Foster, Philip J. *Education and Social Change in Ghana*, London: Routledge & Kegan Paul Ltd., 1965.
- Foucault, Michel. *Discipline & Punish: The Birth of the Prison*. Translated by Allan Sheridan. 2nd edition. New York: Vintage Books, 1995.
- . *Security, Territory, Population - Lectures at the College de France, 1977-78*. Edited by Michel Senellart. Translated by Graham Burchell. New York: Palgrave Macmillan, 2009.
- . *The History of Sexuality, Vol. 1: An Introduction*. Translated by Robert Hurley. Reissue edition. New York: Vintage, 1990.
- . 'The Politics of Health in the Eighteenth Century'. In *The Foucault Reader*, edited by Paul Rabinow, 273–89. New York: Pantheon Books, 1984.

- Frenkel, Stephen, and John Western. 'Pretext or Prophylaxis? Racial Segregation and Malarial Mosquitoes in a British Tropical Colony: Sierra Leone'. *Annals of the Association of American Geographers* 78, no. 2 (1988): 211–28.
- Fuest, Veronika. *Demand-Oriented Community Water Supply in Ghana: Policies, Practices and Outcomes*. Berlin: LIT Verlag Münster, 2006.
- Gale, T. S. 'Official Medical Policy in British West Africa'. Doctor of Philosophy, University of London, School of Oriental and African Studies, 1972.
- Gale, Thomas S. 'Segregation in British West Africa'. *Cahiers d'Études Africaines* 20, no. 80 (1980): 495–507. <http://www.jstor.org/stable/4391717>.
- Gale, Thomas S. 'The Struggle against Disease in the Gold Coast: Early Attempts at Urban Sanitary Reform'. *Transactions of the Historical Society of Ghana*, New Series, 16, no. 2 (1995): 185–203.
- Gandy, Matthew. *The Fabric of Space: Water, Modernity, and the Urban Imagination*. Cambridge: The MIT Press, 2014.
- Geest, Sjaak van der. 'Hygiene and Sanitation: Medical, Social and Psychological Concerns'. *CMAJ: Canadian Medical Association Journal* 187, no. 17 (17 November 2015): 1313–14. <https://doi.org/10.1503/cmaj.150588>.
- Gershenson, Olga, and Barbara Penner. 'Introduction: The Private Life of Public Conveniences'. In *Ladies and Gents: Public Toilets and Gender*, edited by Olga Gershenson and Barbara Penner, 1–32. Philadelphia: Temple University Press, 2009.
- Gocking, Roger. *The History of Ghana*. West Port, Connecticut: Greenwood Press, 2005.
- Goerg, Odile. 'From Hill Station (Freetown) to Downtown Conakry (First Ward): Comparing French and British Approaches to Segregation in Colonial Cities at the Beginning of the Twentieth Century'. *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines* 32, no. 1 (1998): 1–31. <https://doi.org/10.2307/486222>.
- Greene, Sandra E. *Sacred Sites and the Colonial Encounter: A History of Meaning and Memory in Ghana*. 1st edition. Bloomington: Indiana University Press, 2002.
- Gundona, Sylvester. 'Coping with this Scourge: The State, Leprosy, and the Politics of Public Health in Colonial Ghana, 1900- Mid-1950s'. Ph.D., University of Texas, 2015.
- Hamlin, Christopher. 'Nuisance and Community in Mid-Victorian England: The Attractions of Inspection'. *Social History* 38, no. 3 (2013): 346–79.
- Harvey, William Burnett. *Law and Social Change in Ghana*. Princeton, New Jersey: Princeton University Press, 1966.
- Hayford, J. E. Casely. *Gold Coast Native Institutions: With Thoughts upon a Healthy Imperial Policy for the Gold Coast and Ashanti*. Frank Cass & Co. Ltd., 1970.
- Headrick, Daniel R. *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*. 1 edition. Oxford University Press, 1981.
- Home, R K. 'Town Planning and Garden Cities in the British Colonial Empire 1910-1940'. *Planning Perspectives* 5, no. 1 (1990): 23–37.
- Hooker, Claire. 'Hygiene - Hygiene and Public Health, 1700–1945'. Accessed 5 May 2017. <http://science.jrank.org/pages/9722/Hygiene-Hygiene-Public-Health-1700-1945.html>.
- . 'Sanitary Failure and Risk Pasteurisation, Immunisation and the Logics of Prevention'. In *Contagion: Historical and Cultural Studies*, edited by Alison Bashford and Claire Hooker, 129–49. London; New York: Routledge, 2001.

- Hoppe, Kirk Arden. 'Lords of the Fly: Colonial Visions and Revisions of African Sleeping-Sickness Environments on Ugandan Lake Victoria, 1906-61'. *Africa* 67, no. 1 (1997): 86–105.
- Hutton, William. *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, Longman, Hurst, Rees, Orme, and Brown, 1821.
<http://archive.org/details/avoyagetoafrica01huttgoog>.
- Issa, Amina. 'Malaria and Public Health Measures in Colonial Urban Zanzibar, 1900–1956'. *Hygiea Internationalis* 10, no. 2 (2011): 35–51.
- Jackson, Shannon, and Steven Robins. 'Making Sense of the Politics of Sanitation in Cape Town'. *Social Dynamics* 44, no. 1 (2018): 69–87.
- Jaques, A. A. 'Teaching of Hygiene in Native Primary Schools'. *Journal of International African Institute* 3, no. 4 (1930): 501–5.
- Johnson, Ryan. 'Historiography of Medicine in British Colonial Africa'. *Global South SEPHIS E-Magazine*, 2010.
- . 'Mantsemei, Interpreters and the Successful Eradication of Plague: The 1908 Plague Epidemic in Colonial Accra'. In *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960*, edited by Amna Khalid, 135–53. New York and London: Routledge, 2012.
- Jones, Branwen Gruffydd. 'Civilising African Cities: International Housing and Urban Policy from Colonial to Neoliberal Times'. *Journal of Intervention and State Building* 6, no. 1 (2012): 23–40.
- Killingray, David. 'A New 'Imperial Disease': The Influenza Pandemic of 1918-9 and Its Impact on the British Empire'. *Caribbean Quarterly*, 2003, 30–49.
<http://www.jstor.org/stable/40654422>.
- Kimble, David. *A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1925*. Oxford: Oxford University Press, 1963.
- Laporte, Dominique. *History of Shit*. Translated by Nadia Benabid and Rodolphe el-Khoury. Reprint edition. Cambridge, Mass. London: The MIT Press, 2002.
- Legg, Stephen. 'Beyond the European Province: Foucault and Postcolonialism'. In *Space, Knowledge and Power: Foucault and Geography*, edited by W Jeremy Crampton and Stuart Elden, 265–89. England: Ashgate, 2007.
- . *Spaces of Colonialism: Delhi's Urban Governmentalities*. Blackwell Publishing, 2007.
- Lugard, F. D. *The Dual Mandate in British Tropical Africa*, 1922.
<http://archive.org/details/in.ernet.dli.2015.20995>.
- Lupton, Deborah. *Medicine as Culture: Illness, Disease and the Body*. 3 edition. SAGE Publications Ltd, 2012.
- Lyons, Maryinez. *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940*. Cambridge History of Medicine. Cambridge: Cambridge University Press, 1992.
- McCaskie, Thomas C. 'Death and the Asantehene: A Historical Mediation'. *Journal of African History* 30, no. 3 (1989): 417–44.
- McCaskie, Tom, C. 'Water Wars in Kumasi, Ghana'. In *African Cities: Competing Claims on Urban Spaces*, edited by Francesca Locattelli and Paul Nugent, 3:135–55. African-European Group for Interdisciplinary Studies. Leiden, Netherlands; Boston, MA: Brill, 2009.

- Maier, Donna. 'Nineteenth-Century Asante Medical Practices'. *Comparative Studies in Society and History* 21, no. 01 (1979): 63–81.
http://journals.cambridge.org/abstract_S0010417500012652.
- Maxwell, John. 'Ashanti: Kumasi—The Garden City of West Africa'. *Journal of the Royal African Society* 27, no. 107 (1928): 219–233.
<http://www.jstor.org/stable/716347>.
- May, H. O'Hara. 'Cleanliness and Prevention of Disease'. *The Teachers' Journal* 4 (1933): 202–6.
- Metcalfe, George Edgar. *Great Britain and Ghana: Documents of Ghana History, 1807-1957*. London: Published on behalf of the University of Ghana by T. Nelson, 1964.
- Miescher, Stephan F. "'Nkrumah's Baby": The Akosombo Dam and the Dream of Development in Ghana, 1952-1966.' *Water History* 6, no. 4 (December 2014): 341–66. <https://doi.org/10.1007/s1268>.
- Moore, Alison. 'Colonial Visions of "Third World Toilets": A Nineteenth-Century Discourse That Haunts Contemporary Tourism'. In *Ladies and Gents: Public Toilets and Gender*, edited by Olga Gershenson and Barbara Penner, 105–25. Philadelphia: Temple University Press, 2009.
- Morrissey, John. 'Foucault and the Colonial Subject: Emergent Forms of Colonial Governmentality in Early Modern Ireland'. In *at the Anvil: Essays in Honour of William J. Smyth*, edited by Patrick K Duffy and William Nolan. Dublin: Geography Publications, 2012.
- Moyes, Samantha. 'The Making of the Every day: A Study of Habits in Colonial Ghana (Gold Coast) during the Early Twentieth Century'. Université d'Ottawa/University of Ottawa, 2014.
<https://www.ruor.uottawa.ca/handle/10393/31712>.
- Murunga, Godwin R. 'Inherently Unhygienic Races: Plague and the Origins of Settler Dominance in Nairobi, 1899 -1907'. In *African Urban Spaces in Historical Perspective*, edited by Steven J. Salm and Toyin Falola, 98–130. Rochester, NY: Rochester University Press, 2005.
- Newell, Stephanie. 'Dirty Familiars: Colonial Encounters in African Cities'. In *Global Garbage: Urban Imaginaries of Waste, Excess, and Abandonment*, edited by Christoph Lindner and Miriam Meissner, 1–15. Routledge Research in Sustainable Urbanism. London New York: Routledge, 2016.
- Ngalamulume, Kalala. 'Keeping the City Totally Clean: Yellow Fever and the Politics of Prevention in Colonial Saint-Louis-Du-Sènegal, 1850–1914'. *The Journal of African History* 45, no. 02 (2004): 183–202.
http://journals.cambridge.org/abstract_S0021853703008636.
- Nilsson, David. 'The Unseeing State: How Ideals of Modernity Have Undermined Innovation in Africa's Urban Water Systems'. *NTM Zeitschrift Für Geschichte Der Wissenschaften, Technik Und Medizin* 24, no. 4 (1 December 2016): 481–510. <https://doi.org/10.1007/s00048-017-0160-0>.
- Njoh, Ambe J. 'Colonial Philosophies, Urban Space, and Racial Segregation in British and French Colonial Africa'. *Journal of Black Studies* 38, no. 4 (19 March 2007): 579–99. <https://doi.org/10.1177/0021934706288447>.
- . 'Ideology and Public Health Elements of Human Settlement Policies in Sub-Saharan Africa'. *Cities* 26 (2009): 9–18.
<https://doi.org/10.1016/j.cities.2008.11.03>.
- . *Planning Power: Town Planning and Social Control in Colonial Africa*. London; New York: UCL, 2007.

- . *Urban Planning and Public Health in Africa: Historical, Theoretical and Practical Dimensions of a Continent's Water and Sanitation Problematic*. Farnham, Surrey: Ashgate, 2012.
- . 'Urban Planning as a Tool of Power and Social Control in Colonial Africa'. *Planning Perspectives* 24, no. 3 (2009): 301–17. <https://doi.org/10.1080/02665430902933960>.
- Njoh, Ambe J, and Fenda A. Akiwumi. 'The Impact of Colonization on Access to Improved Water and Sanitation Facilities in African Cities'. *Cities* 28 (2011): 452–60.
- Oladiti, Abiodun Akeem, and Ajibade Samuel Idowu. 'The Interplay of Town Planning and Colonialism: The Contributions of Albert Thompson to Urban Development in Lagos, 1920–1945'. *Social Evolution and History* 16, no. 2 (2017): 126–42.
- Oluwasegun, Jimoh Mufutau. 'The British Mosquito Eradication Campaign in Colonial Lagos, 1902-1950'. *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines* 51, no. 2 (2017): 217–36.
- Pace, R. D, W A Plahar, and J Y Lu. 'Status of Traditional Food Preservation Methods for Selected Ghanaian Foods'. *Food Reviews International* 5, no. 1 (1989): 1–12.
- Pachai, Bridglal. 'An Outline of the History of Municipal Government at Cape Coast'. *Transactions of the Historical Society of Ghana* 8 (1965): 130–60.
- Packard, Randall M. 'Industrialisation, Rural Poverty in Tuberculosis in South Africa, 1850-1950'. In *the Social Basis of Health and Healing in Africa*, edited by Steven Feierman and John M. Janzen, 104–30. Berkeley. Los Angeles. London: University of California Press, 1992.
- . 'The "Healthy Reserve" and the "Dressed Native": Discourses on Black Health and the Language of Legitimation in South Africa'. *American Ethnologist* 16, no. 4 (1989): 686–703. <http://onlinelibrary.wiley.com/doi/10.1525/ae.1989.16.4.02a00050/full>.
- . *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa*. University of California Press, 1989.
- Parker, John. *Making the Town: Ga State and Society in Early Colonial Accra*. Portsmouth, NH; Oxford; Cape Town: Heinemann; James Currey; David Philip, 2000.
- . 'The Cultural Politics of Death and Burial in Early Colonial Accra'. In *Africa's Urban Past*, edited by David M Anderson and Richard Rathbone, 205–21. Oxford: James Currey, 2000.
- Patterson, David K. *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*. Waltham, Mass: African Studies Assn, 1981.
- . 'Health in Urban Ghana: The Case of Accra 1900-1940'. *Soc. Sci. Med.* 13, no. B (1979): 251–68.
- . 'River Blindness in Northern Ghana, 1900-50'. In *Disease in African History: An Introductory Survey and Case Studies*, edited by David K. Patterson and Gerald Hartwig W., 88–117. Duke University Centre for Commonwealth and Comparative Studies 4. Durham, N. C.: Duke University Press, 1978.
- Patterson, David K., and Gerald Hartwig W. 'The Disease Factor: An Introductory Overview'. In *Disease in African History: An Introductory Survey and Case Studies*, 3–24. Duke University Centre for Commonwealth and Comparative Studies 4. Durham, N. C.: Duke University Press, 1978.

- Patterson, K. David. 'Disease and Medicine in African History: A Bibliographical Essay'. *History in Africa* 1 (1974): 141–48. <https://doi.org/10.2307/3171766>.
- . 'The Influenza Epidemic of 1918–19 in the Gold Coast'. *The Journal of African History* 24, no. 04 (1983): 485–502. http://journals.cambridge.org/abstract_S0021853700028012.
- Pellizzi, Francesco. *Res: Anthropology and Aesthetics, 55/56: Absconding*. Harvard University Press, 2010.
- Pellow, Deborah. 'The Power of Space in the Evolution of an Accra Zongo'. *Ethnohistory* 38, no. 4 (1991): 414–50.
- Petersen, Allan, and Deborah Lupton. *The New Public Health: Health and Self in the Age of Risk*. London: Sage, 1996.
- Pickstone, John V. 'Dearth, Dirt and Fever Epidemics: Rewriting the History of the British "Public Health", 1780-1850'. In *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, edited by Terence Ranger and Paul Slack, 125–48. New York: Cambridge University Press, 1992.
- Porter, Dorothy. *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times*. London; New York: Routledge, 1999.
- . *The History of Public Health and the Modern State*. Amsterdam: Rodopi, 1994.
- Quarcoopome, Samuel S. 'Municipal Administration at Accra'. *Research Review* 14, no. 2 (1998): 96–106.
- Quayson, Ato. *Oxford Street, Accra: City Life and the Itineraries of Transnationalism*. Durham, NC: Duke University Press Books, 2014.
- Roberts, Jonathan. 'Korle and the Mosquito: Histories and Memories of the Anti-Malaria Campaign in Accra, 1942–5'. *The Journal of African History* 51, no. 03 (2010): 343–365. http://journals.cambridge.org/abstract_S0021853710000502.
- . 'Sharing the Burden of Sickness: A History of Healing in Accra, Gold Coast, 1677 to 1957'. Ph.D., Dalhousie University, 2015. <https://dalspace.library.dal.ca/handle/10222/56339>.
- Rosen, George. *A History of Public Health*. Revised expanded edition. Johns Hopkins University Press, 2015.
- Sarpong, Peter. *Girls' Nubility Rites in Ashanti*. Ghana Pub. Corp., 1977.
- Schiffer, B. Harriet. 'Local Administration and National Development: Fragmentation and Centralisation in Ghana.' *Canadian Journal of African Studies* 4, no. 1 (1970): 57-75.
- Scott, David. 'Colonial Governmentality'. *Social Text*, no. 43 (1995): 191–220. <https://doi.org/10.2307/466631>.
- . *Epidemic Disease in Ghana, 1901-1960*. London; First edition. Oxford University Press, 1965.
- Shaloff, Stanley. 'The Gold Coast Water Rate Controversy 1909-1938'. *Institute of African Studies Research Review* 3 (1972): 21–34.
- Sparks, Stephen. 'Playing with Public Health: The Search for Control in South Durban, 1860 - 1932'. *Journal of Natal and Zulu History* 20 (2002): 1–28.
- Spitzer, Leo. 'The Mosquito and Segregation in Sierra Leone'. *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines* 2, no. 1 (1968): 49–61.

- Swanson, Maynard W. "'The Asiatic Menace': Creating Segregation in Durban, 1870-1900'. *The International Journal of African Historical Studies* 16, no. 3 (1983): 401. <https://doi.org/10.2307/218743>.
- . 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909'. *The Journal of African History* 18, no. 03 (1977): 387-410. http://journals.cambridge.org/abstract_S0021853700027328.
- The University of Warwick. 'Elected Mayors and City Leadership: Summary Report of the Warwick Commission', 2012. <http://www2.warwick.ac.uk/research/warwickcommission/electedmayors/summaryreport/history/>.
- Todd, Ian Scott. 'Dirty Books: Modernism and the Toilet'. *Modern Fiction Studies* 58, no. 2 (2012): 191-213. <http://www.jstor.org/stable/26287335>.
- Van Der Geest, Sjaak. 'Akan Shit: Getting Rid of Dirt in Ghana'. *Anthropology Today* 14, no. 3 (June 1998): 8-12.
- . 'The Night-Soil Collector: Bucket Latrines in Ghana'. *Postcolonial Studies: Culture, Politics, Economy* 5, no. 2 (2002): 197-206. <http://www.tandfonline.com/doi/pdf/10.1080/1368879022000021092>.
- Vaughan, Megan. *Curing Their Ills: Colonial Power and African Illness*. 1 edition. Stanford, Calif.: Stanford University Press, 1991.
- Viljoen, Russel. 'Medicine, Health and Medical Practice in Precolonial Khoikhoi Society: An Anthropological-historical Perspective ¹'. *History and Anthropology* 11, no. 4 (January 1999): 515-36. <https://doi.org/10.1080/02757206.1999.9960924>.
- Waite, Gloria. 'Public Health in Pre-Colonial East-Central Africa'. *Soc. Sci. Med.* 24, no. 3 (1987): 197-208.
- Walther, Daniel J. 'Race, Space and Toilets: "Civilization" and "Dirt" in the German Colonial Order, 1890s-1914*'. *German History* 35, no. 4 (14 November 2017): 551-67. <https://doi.org/10.1093/gerhis/ghx102>.
- Weinstein, Tanya. Review of *Review of The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940*, by Maryinez Lyons. *The International Journal of African Historical Studies* 26, no. 3 (1993): 645-47. <https://doi.org/10.2307/220486>.
- Wells, Julia M. 'Sun Huts, Sun Downers, and Tropical Hygiene: Managing Settler Bodies and Minds in British East and South-Central Africa, 1890-1939'. *African Historical Review* 48, no. 1 (2016): 68-91.
- Youde, Jeremy. *Biopolitical Surveillance and Public Health in International Politics*. New York: Palgrave Macmillan, 2010.
- Zdatny, Steven. 'The French Hygiene Offensive of the 1950s: A Critical Moment in the History of Manners'. *The Journal of Modern History* 84, no. 4 (December 2012): 897-932. <https://doi.org/10.1086/667596>.