

A Historical Review of Diseases and Disease Prevention in Gold Coast: A Focus on Asante (1900-1957)

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1.1 INTRODUCTION

The history of any community cannot be written without paying attention to the issues that shaped the lives of the people. One of the pertinent issues in history has been disease infestation and how it has been prevented or cured. From the earliest time, man has faced the challenge of meeting his health needs. The constitution of the World Health Organization (WHO) defines health as “the state of physical, mental and social well being and not merely the absence of disease or infirmity”.¹ This definition underlines health as an integral part of what a people need in order to realize their full potential and derive satisfaction from life. Oral traditions have shown that the people of Kumase and Asante as a whole faced the challenge of providing health care from very early times. In fact, all humans have in one way or the other shown resilience in fighting anything that has the potential of threatening their existence including diseases.

The above argument ties in with what Twumasi puts forward in his book, *Medical Systems in Ghana*, when reference is made to Malinowski’s assertion concerning the health needs of man that all the manifold activities of men are directly or indirectly related to man’s health needs which is essential for his survival.² Twumasi has noted that the whole area of medicine as an aspect of human behaviour seems to fit Malinowski’s assertion that human

¹ D. Longley, *Health Care Constitutions*, (London: Cavendish Publishing Ltd, 1996) 1

² P.A Twumasi, *Medical Systems in Ghana*, (Accra: Ghana Publishing Corporation, 1975) 1

institutions are based on individual biological needs.³ Recognizing that the presence of diseases would reduce economic activities and the satisfaction of other social needs, efforts were made during the pre-colonial and colonial eras by the indigenous people of Asante and later, through cooperation with the colonial administration, to meet the health needs of the people.⁴

1.2 METHOD

This paper is qualitative with source of data from both documentary and non-documentary sources. The documentary sources include books, journals and archival sources. Colonial records concerning diseases and disease prevention from the Manhyia Archives in Kumase and the Public Archives and Records Administration (PRAAD) in Kumase and Accra have been used to gather data to enrich and sometimes corroborate secondary documentary sources and oral sources.

The non-documentary sources include hundred oral interviews conducted to cover the period under review, from 1900 to 1960. Persons ranging from the age of fifty upward were randomly selected from Kumase and its environs. The criterion for their selection was based on the belief of their knowledge of the happenings of the Gold Coast as recounted to them by their elders or based on personal experiences and sometimes when they were identified as traditional healers, the perceived efficacy of their medicines was considered. Information gathered from these various sources have been pieced together thematically to form a historical narrative covering the period under review.

2.1 SOCIAL AND ECOLOGICAL APPROACHES TO THE HISTORY OF DISEASES IN WEST-AFRICA, GOLD COAST AND ASANTE SPECIFICALLY.

One of the most important themes in the study of diseases, with direct reference to West Africa, is the book, *Themes in West-African history*, edited by Akyeampong. In this work, McNeil touching on Disease in West-Africa stated:

³ Ibid

⁴ Ibid

In leaving tropical environments behind, our ancestors also escaped many of the parasites and disease organisms to which their predecessors and tropical contemporaries were accustomed. Health and vigour improved accordingly, a multiplication of human numbers assumed a hitherto unparalleled scale.⁵

According to McNeil, the disease epidemiology of the tropics represents a burden on development. He stated that is why Africa remained backward in the development of its civilization when compared to temperate lands like that of America, where prevailing ecosystems were less elaborated and correspondingly less inimical to simplification by human action. The deadly nature of the climate especially at the Gold Coast in the nineteenth century is buttressed by Cruickshank. He noted that there is sickness and fever as well as death in its balmiest gales.⁶

Significantly, several writers have put forward arguments that support the fact that McNeil was right about the rich biodiversity of the tropics and the presence of disease vectors that have afflicted humans and their livestock. Diseases in Africa include those rooted in the physical environment and those introduced through external contacts. He stated that diseases such as malaria spread by the anopheles mosquito, trypanosomiasis which is also known as sleeping sickness by tsetse fly, onchocerciasis which is also known as river blindness caused by the black similium fly and schistosomiasis which is also known as bilharziasis caused by the snail are tropical diseases indigenous to West-Africa. It is essential to note that McNeil did not focus on diseases in the Gold Coast and Asante specifically. Yet, it is essential to note that diseases like malaria and trypanosomiasis were present in Asante.

Akyeampong though not contrasting the argument of McNeil has argued that other diseases were transmitted from host to host with an intermediary carrier without delay. He said many of these diseases have been introduced to West-Africa through external cultural contacts. Examples of such diseases are the common cold, measles, and chicken pox. According to Akyeampong, in present-day West Africa, most of the diseases that were present in 1900 have resurfaced with the notable exception of small pox. This buttresses McNeill's argument that diseases found in Ghana are not only those that are generated from within but also there are those that are brought in through external

⁵ Quoted in E. K. Akyeampong, (Ed.), *Themes in West African History* (Accra: Woeli Publishing Services, 2000) 186

⁶B. Cruickshank, *Eighteen years on the Gold Coast of Africa* (London: Frank Cass & Co. Ltd., 1966)1

contacts. Most importantly, such assertions draw attention to the fact that communities in the Gold Coast especially Asante and those that were hitherto exposed to outside contacts either within Africa or Europe might have communicated diseases among themselves. This notwithstanding, what was seen to have been a major challenge so far as diseases are concerned were those diseases that were generated amongst the indigenous people. Akyeampong supports this argument especially when he stated, in the twentieth century, malaria which is generated as a result of the physical environment, remained the number one killer in Africa accounting for between twenty to thirty percent in school children and for the whole population.⁷ It is important to point out that both McNeil and Akyeampong do not focus on Asante and Kumase specifically. Again, it is also essential to point out that the focus of the writers was on the health conditions generally relating to Ghana and Africa, yet we found out that they treat issues that are generic especially in assessing the health challenges or diseases that infected the people of the Gold Coast. However, it is important to ascertain the kinds of prevalent diseases that were present not only in the Gold Coast but Asante. It is important to also stress that both McNeil and Akyeampong do not point out the various responses or actions undertaken by both the indigenous people and the Colonial Administration in combating or preventing such diseases. Again, it is important to note that the time scale and geographical coverage of Akyeampong's work is too broad for the details of any particular area to be included.

Again, the argument of the presence of diseases in Asante in the nineteenth and twentieth centuries has been buttressed by Maier. Maier noted the presence of diseases in Asante such as malaria that were much related to the environment which were treated by indigenous healers. However, Maier argued that the frequency and types of diseases common in Asante especially in the nineteenth century, which in this stead persisted through the twentieth century, were most difficult to determine empirically. However, what Dupuis puts forward has widely been considered as impressionistic evidence. Dupuis seemed to have had an implicit understanding regarding the climate and atmosphere in the Gold Coast and places adjacent to the settlements of the coast- these were locations he noticed to be unhealthy. However, the observation made by Dupuis point to the fact that the place called Asante was

⁷ E. K. Akyeampong (Ed.), *Themes in West African History* (Accra: Woeli Publishing Services, 2000)186

healthier than the coast.⁸ The account of Dupuis shows that climatic factors contributed to the relative health of the inhabitants of Asante and moreso to a greater variety of food crops, fruits and general diet in the forest.⁹ With respect to the forest, Dupuis was significantly talking about remote Asante but not Kumase.¹⁰ Irrespective of this observation, W. Hutton is noted to have observed that Kumase was bordered by an old swampy land, which the British captain Brackenbury thought to be unhealthy even though he recognized its redeeming feature of providing good water supply for the town.¹¹

The serenity of Kumase was adequately emphasized. It was argued that regular rainfall in Asante cleaned the air, soil and dwelling places frequently, which made regular bathing possible and eventually reduced the incidence of tick, louse and fecal-borne diseases in the nineteenth century.¹² Significantly, it was shown that there was a smaller percentage of relapsing fever, cerebro spinal meningitis, small pox, yellow fever, yaws, tuberculosis, onchocerciasis, schistosomiasis and leprosy than in other regions of the Gold Coast.¹³ The diseases enumerated by these authors are an attestation to the fact that several of the diseases witnessed in the twentieth century existed in the centuries before. It is essential to note that this information is relevant especially in undertaking a study in the history of medicine on the people of Asante. Again, it is important to note that authors like Dupuis and Maier seem to have placed much emphasis on Asante; hence, it is significant to make reference to them especially when a study of the history of medicine in Asante is being undertaken.

The first European doctor, Tedlie, who visited Asante in 1817, has been extensively referred to by Addae (1997) and Maier (1979) to have vaguely recorded diseases such as syphilis, yaws, ulcers, scald-heads and gripping pains in the bowels. It has been noted that fevers were most prevalent countrywide after the periodical rains. Rheumatism was noted to be a common complaint as well as internal inflammation during the rainy season. Meredith is also noted to

⁸ Ibid

⁹ Ibid

¹⁰ J. Dupuis, *Journal of Residence in Asante* (London: H Colburn, 1824)

¹¹ D. Maier, Nineteenth-Century Asante Medical Practices, *Comparative Studies in Society and History*, Vol. 21, No. 1, (Jan., 1979) 63

¹² Ibid

¹³ Ibid

have listed leprosy and dysentery.¹⁴ Maier has noted that in Asante, Tedlie treated single cases of stricture of urethra, edematous feet and an ulcerated palate among some upper class Asante who came to him for help.¹⁵

The arguments of McNeill, Akyeampong and Maier as contrasting as they might be clearly point to the fact that present in Asante were several diseases which were either stimulated by the environment or were communicated from outside Asante to the indigenous people. In essence, there was present in Asante diseases which, though might have been vaguely named or described, demanded an effort to cure and to better still forestall future occurrences. Often, expatriate writers, observers and commentators place emphasis on European efforts at combating and preventing diseases in the Gold Coast. It is therefore pertinent to find out through this study the efforts of the indigenous people to cure or prevent the occurrence of diseases in Asante.

Bosman (1967) writing in the eighteenth century also described the environment in the Gold Coast which he referred to as the Coast of Guinea. His description seems to fit the assertions and claims made by Dupuis, Beecham and others. He was particularly concerned about the way of life of the indigenous people and how this invariably affected Europeans living in such jurisdictions. Bosman noted that the available diet in the Coast besides fish was dry lean hen.¹⁶ The best that the sick could get at the Coast was culinary vegetables and spoon-meats.¹⁷ Again, he emphasized that the indigenous people suffered from diseases as a result of mismanagement that were present in their daily lives. Here, he postulated that they were supposed to avoid excess eating and drinking.¹⁸ The indigenous people were seized with dangerous and too often mortal diseases.¹⁹ It is important to note that the argument of Bosman seem to fit much with the Coast rather than the interior including Asante, yet his writing does not create such delimitation since the people at the colony were not totally or wholly disconnected from Asante in terms of contact and communication. Bosman hinted that the indigenous people lavished it out with palm wine and brandy

¹⁴ Ibid

¹⁵ Ibid

¹⁶ W., Bosman, *A new and Accurate Description of the Coast of Guinea* (UK: Frank Cass & Co. Ltd., 1967)106

¹⁷ Ibid

¹⁸ Ibid

¹⁹ Ibid

both when taken in excess are pernicious.²⁰ This was not the only inconvenience the indigenous people caused themselves. The drinking habit of the indigenous people did not allow them to have sufficient money to buy the required food; they were only left with the supply of bread, oil and salt or at best with fish and therefore in the European view point it was not expected that the indigenous people would be healthy.²¹ Such drinking to stupor was accentuated especially when one had a large salary. With little strength left in them from falling, the ill air and the adieu health led them to the after-life.²² It is important to ascertain whether the writings of Bosman had a bearing on some of the developments on health education on the part of the Colonial Administration that would emerge at the Gold Coast and Asante in particular especially in the first half of the twentieth century.

The argument for the unhealthiness of the environment shared by Addae, Maier, Dupuis, Bosman and others need not be overemphasized. Although in certain instances Asante, and for that matter, Kumase, is given the credit for some environmental serenity, the contrasts drawn by Bosman in describing the environment at the Coast throws much light on the argument made by the school of thought that the environment of West Africa and particularly the Gold Coast was mostly unhealthy. Bosman distinguished one place at the coast from another. He argued that there were places where the wind blows continually and very fresh where the indigenous people had the least stench, these areas were considered to be undoubtedly the healthiest.²³ This notwithstanding, the Europeans including Bosman himself, was not surprised when they realized that the indigenous population did not easily succumb to death due to ill environment. This was attributable to the fact that the indigenous people were born into such air, hence, their ability to withstand such stench and were not easily infected with diseases.²⁴ In contrast, diseases with high prevalence in the country were noted to be small pox and worms and the former was devastating.²⁵ Significantly, there is a lacuna, Bosman's assertions and observations are not accurate description of what was happening in Asante and Kumase in particular. Again, much attention was not paid to the major prevention strategies that were

²⁰ Bosman, *A new and Accurate Description of the Coast of Guinea*, 106

²¹ Ibid

²² Ibid

²³ Bosman, *A new and Accurate Description of the Coast of Guinea*, 107-108

²⁴ Ibid

²⁵ Ibid

put in place to forestall such environmental hazards and epidemics at the interior including Asante. It is important to also note that Bosman's work covered the eighteenth century.

Significantly, one of the writers who seemed to have paid close attention to Kumase in his writing was Anti (1996). His description of the physical environment of Kumase especially in the nineteenth century points to the fact that the environment of Kumase was appalling. He hinted that on the western part of the king's palace (Kofi Kakari's palace) was the "quarters of ghosts" where decapitated bodies were thrown. It was an open space where there were big tall shady trees under which dead bodies were left.²⁶ Some of the dead bodies have been described by Anti to be putrefied, bloated, swollen, discoloured and loathsome. There were others with worms upon which vultures roost, eating and feeding on them to make the sorrows of the dead everlasting and their pains eternal.²⁷ Anti does not argue that such occurrence was motivated by custom yet he gives a clue to the purpose such practice was intended to serve. The death described by Anti although horrific seemed to have a cataclysmic impact on the entire population, that is, the stench of the carcasses could have increased the health hazard of the people of Kumase.

The findings of Anti focused on the eighteenth and nineteenth centuries respectively, hence he did not give ample evidence to suggest that the quarters of ghosts was still operational in the twentieth century Asante especially from 1902 to 1957. Yet, it is understood that anything of such magnitude or similar to the description of the eighteenth and nineteenth centuries in the twentieth century could have created an alarming disease situation in Asante. Since Anti had no health argument in view with respect to the quarters of ghosts he makes a further assertion that the sanitation of Kumase was not as bad as one could imagine.²⁸ He hints that there were some private latrines dug deep under fairly big round hollow supporting pillars, and from time to time boiling water was poured into them to kill flies and other insects. This was an attestation of the observations made by Dupuis and his contemporaries. Anti buttresses the assertion that by the eighteenth century, there were not only private latrines but there were public ones to meet the needs of the entire community especially the poor in Kumase who could not construct their own.

²⁶ A.A, Anti, *Kumase in the Eighteenth and Nineteenth Centuries* (Accra: Graphic Corporations, 1996)16

²⁷ Ibid

²⁸ Ibid

Another extensive effort made by the indigenous people as noted by Anti was the dumping of refuse at the outskirts of the township that was burnt every morning.²⁹ The observations made by Dupuis, the attestations made by Maier and Anti point towards the need to ask questions in the twentieth century Asante and Kumase on how the health of the indigenous people was managed or the process put in place to forestall the occurrences of diseases or epidemics. Although Kofi Kakari's quarters of ghosts is a variation, significantly, a retrospective analysis of the seventeenth and eighteenth century Kumase suggests a deliberate policy or plan among the indigenous population to keep their community free from filth.

Another remarkable work is *Health in Colonial Ghana, Disease, Medicine and Socio-Economic Change*. In this work Patterson focuses on the first half of the twentieth century. However, he shares a similar thought with earlier writers like Dupuis and with twentieth century contemporaries like Maier and Akyeampong. Patterson has argued that infectious diseases have accompanied human movement throughout history. He noted that explorers, merchants, soldiers, pilgrims, refugees and migrants have carried plagues, measles, small pox, typhus, tuberculosis, syphilis, malaria, yellow fever, cholera and a host of deadly afflictions around the world. This expressly buttresses the case of rampant transmission of diseases through human interaction and movement. He further elucidated that technological, economic, and political changes have encouraged contacts between pathogens, their vectors and susceptible populations for centuries. He said, long established diseases tend to be less deadly.³⁰

Significantly, the area of present-day Ghana had been inhabited by village agriculturalists for at least a millennium and probably much longer. He said these farmers were in daily contact with hundreds of people who could readily exchange diseases spread by aerial droplets or by direct contact. In addition, the author touched on the fact that the people suffered from diseases as a result of water contaminated with human waste. Also, settlements, clearings for farms provided habitats for other diseases and their vectors. Patterson argued that Ghanaian societies especially in the early twentieth century were afflicted with microbial and multicellular parasites. Some of the infections were

²⁹ Ibid

³⁰ D.K, Patterson, *Health in Colonial Ghana, disease, medicine and socio-economic change, 1900-1955* (USA: Crossroad Press, 1981)

askaris, filarial, hookworms, tapeworms, guinea worm, schistosomiasis, yaws, leprosy, yellow fever, dengue, pneumonia, tropical ulcer, amebic and bacillary dysentery. Patterson argued that malaria was holo-endemic throughout Ghana. An increasing mobile population in the twentieth century brought about enhanced risks of disease transmission. People entered unfamiliar disease environments, where they encountered new pathogens or new strains of familiar ones. They carried pathogens and vectors to potential new hosts and habitats, thus helping to break down previous isolation and made the country into a more homogeneous epidemiological unit. The question of human interaction is an essential aspect of studying modes of diseases transmission amongst human population, but it is essential to point out that although human interactions have promoted the spread of different diseases in different regions, it is possible that through such interactions knowledge of different medicines was also imbibed by different groups of people especially the people of Asante.

Patterson's work leaves a gap to be filled. Just as he placed emphasis on the ubiquity of diseases due to movement, it is expected that transmission of knowledge about how to cure such diseases could also have been possible and the probable tests of the response of the indigenous people of the Gold Coast towards such diseases and epidemics in the twentieth century could have been possible. Furthermore, Patterson stated that the concentration of hospitals, water supply systems and immunization efforts in urban areas helped to reduce the health menace of the cities but in Ghana, like elsewhere in historical periods, early urban growth exacted a high toll on human life and well being. This particular argument put forward by Patterson creates an impression that population growth in urban areas puts a lot of pressure on the available European medical posts hence reducing their efficiency. Firstly, it follows the argument that European medicine was predominantly urban based. This suggests that Indigenous medicine would thrive in such areas as European medicaments were not present. Secondly, it shows that by the overconcentration of human population in urban areas like Kumase, disease transmission could have been rampant.

Patterson has put forward that except for deforestation, there was relatively little environmental change in the period before 1955, which affected human health. Commercial lumbering began in the 1880s and has been an important industry ever since. Significantly, deforestation allows sunlight to reach pools of water creating favourable breeding

conditions for *Anopheles gambiae*, the major vector for falciparum malaria. Water development projects such as dams, fish farms and irrigation schemes always have the potential to alter local disease environments. However, little work of such nature was done prior to 1955. It has been stated that the completion of the Akosombo Dam and the filling of Lake Volta have had important ecological effects on the country. Just as deforestation stimulated the breeding of certain disease vectors, Patterson has set the tone for the need to investigate the challenges this environmental change brought on some specific groups of people at the Gold Coast. Most importantly, concentration of health centres in urban areas like Kumase might have encouraged the use of indigenous techniques to combat health challenges those at the hinterlands were faced with as a result of ecological change or deforestation. Moreso, Patterson does not look into details, the potential social cost in dealing with such ecological change that burdened the Colonial Administration, especially with issues pertaining to deforestation in combating of trypanosomiasis in the north and most importantly the forest regions of Asante. Due to the presence of diseases in the environment of the indigenous people there were several concerns that emerged before and within the period under study. The need for existence or survival was a well-noted belief amongst the people of Asante.

Frierman and Janzen have also argued in their work *Social Basis of Health and Healing in Africa* that Africa's population remained comparatively stable under early colonial rule.³¹ However, by the 1920s, malaria, small pox, sleeping sickness and the influenza pandemic contributed to a high death rate. Other scourges, such as sexually transmitted diseases and the effects of famine in lowering vitality and hence reproductive capacity, also contributed to population decline in Africa.³²

As a result of the public health implications of this article, sections of Frierman and Janzen's book, specifically those dealing with small pox in Kenya and tuberculosis in South Africa authored respectively by Mark Pawson and Randall Packard, provide useful information. They argue that Population movement aided the spread of these two

³¹ S. Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, Sept. 22, 1992)

³² Ibid

diseases, small pox and tuberculosis.³³ The argument that population movement caused the transfer of disease from one area to the other within Africa including the Gold Coast has been earlier made by D.K Patterson.³⁴ Again, population movement as a result of drought in Kenya by the turn of the twentieth-century aided the spread of small pox.³⁵ The spread of tuberculosis in South Africa was attributed to the return of migrants who had been infected in the towns and were returning to their homes.³⁶ The spread of diseases due to population movement in communities in Africa including Asante has been confirmed by several writers.

3. DISCUSSIONS

3.1 Disease Combat in Asante: Colonial and Indigenous Responses

The historical narrative that follows emanates from interviews, archival sources and secondary written sources. Significantly, present in Asante from 1902 to 1957 were different medical therapies. This was based on the fact that both the indigenous people and the Colonial Administration in Asante were confronted with several health challenges. Like elsewhere in Africa the general health of the indigenous people was lowered by the constant toll of such diseases as malaria, yaws, dysentery, bronchial infections, the bubonic plague among others.³⁷

3.2 Bubonic Plague

In 1908 and 1924, bubonic plague occurred in Ghana including Asante. The disease is known to have been caused by bacteria that normally infect wild rodents. The plague was introduced into Ghana on two separate occasions. It was brought to Accra in 1908 by infected rats that landed in cargos at the port. In 1924, infected rats at the port of Sekondi introduced the plague. In all Sekondi had 120 cases and 92 deaths. Rats conveyed plagues up to the railway to Kumase. At the end of March 1924, Dr. Selwyn Clarke, the able Medical Officer of Health who led an anti-rat drive, began a massive slum clearance and re-housing efforts and had over hundred thousand of Haffkin's vaccines

³³ Ibid

³⁴ Patterson, *Health in Colonial Ghana, disease, medicine and socio-economic change*, 40-45

³⁵ S. Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa*

³⁶ Ibid

³⁷ PRAAD, Accra, ADM 11/1/156, Human Trypanosomiasis Committee and best means of combating, 1935.

administered in Kumase and nearby towns.³⁸ Admittedly, the scourge of the plague seemed to have overpowered indigenous medicaments and the efforts of indigenous healers.³⁹

The disease was largely confined to the poor, overcrowded Zongo areas and nearly all the cases and death were among migrants from the north or from Nigeria. The Kumase epidemic was over by September but sporadic cases were discovered for several months afterward. One hundred and sixty-five cases were reported in Kumase with 146 deaths. In Kumase, the disease was transmitted along the lines of communication. The major measure that was employed in fighting this disease was through the destruction of the rats that were the major carriers of the plague. At this stage, it was not only based on colonial drive but the indigenous people in Kumase saw the need to prevent rats from invading their compounds⁴⁰ Again, by September 1947, in Kumase and its environs, 1008 rats were caught and destroyed. This practice became widespread in Asante in the twentieth century. For example, from 1942 to 1947, 1012 rats were caught and destroyed in Kumase and its environs⁴¹. To emphasize, the number of rats the indigenous people destroyed were countless once it was handed down to them by the Colonial Administration the need to destroy rats, they had the occasion to assiduously do so.⁴² The danger rats posed at the time rather served as a major motivating factor for the indigenous people to respond efficiently to the call of the British Colonial Administration to kill rats. Again, during the outbreak of the plague in 1924, the then Senior Medical Officer of Health, Dr. Selwyn-Clarke in conjunction with the Kumase Public Health Board (KPHB), advised keepers of animals especially those who kept horses at the Zongos to desist from it because keeping horses within the township was noted to be unhealthy. According to Dr. Clarke, they contributed to the spread of the plague in case the rats and the mice fed on the refuse of the horses. Keepers of animals, especially horses were made to situate their pens at the outskirts of the Kumase Township.⁴³

³⁸ Patterson, *Health in Colonial Ghana: Disease, Medicine and socio-economic change, 1900-1955*, 47

³⁹ Interview with Nana Tenkorang Wadie, Dichemso, December 2006.

⁴⁰ Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Report of the medical Officer of Health, Kumase, September 1942., Interview with Maame Akua Nsiah (84 years), resident in Kumase, 15th January, 2008

⁴¹ Manhyia Archives of Ghana, Kumase, MAG 1/1/35 Report of the medical Officer of Health, Kumase, September 1947

⁴² Interview with Maame Akua Nsiah (84 years), resident in Kumase, 15th January, 2008

⁴³ PRAAD, Accra, ADM 1/2/1/66, Correspondence between Katsina and the District Commissioner, Ashanti, April 1934

3.3 The Disease Burden and Malaria

Significantly, the period 1933 to 1935 was noted not to have had widespread epidemics. As compared with previous years, the general health of the indigenous people of the Gold Coast and specifically Asante was unsatisfactory.⁴⁴ The invaliding and death rate figures for African officials attested to that, although the figure for the number of deaths per thousand of patients treated in hospitals, dispensaries, among others, remained the same as in 1933-1934.⁴⁵ This record was noted to be partly due to the efforts of the Medical Department and all its branches in the Colony including Asante and Kumase specifically.

Table 1.1 House Visits by Health Inspectorate

Date	Number of House Visits
1932	1,590,647
1933	1,735,501
1934	1,929,507

Source: PRAAD, Accra, ADM 1/2/1/66, Correspondence between Katsina and the District Commissioner, Ashanti, April 1934

The records of the hospitals and dispensaries showed an increase over the previous year of nearly two percent in the total of in-and-out patients treated, while the number of house to house visits carried out by the inspectorate of the Health Branch rose from 1,590,647 in 1932 and 1,735,501 in 1933 to 1,929,507 in 1934.⁴⁶ It is noteworthy that within the same period, as elsewhere in Africa, the general health of the indigenous people was greatly lowered by the consistent toll of such diseases as malaria, yaws and dysentery especially amongst the infant population.⁴⁷ Again,

⁴⁴ PRAAD, Kumase, ADM 11/1/1560, Human Trypanosomiasis Committee and the best means of combating

⁴⁵ Ibid

⁴⁶ Ibid

⁴⁷ Ibid

within the period malaria was noted to be the number one killer disease in Africa.⁴⁸ Amongst the Akan, and for that matter Asante, the disease was known as *Atiridi* in adults but *Asabera* in children. Learmouth has argued that one of the causative agents of malaria; plasmodium falciparum is the malaria parasite with widespread distribution in the tropics especially in Africa. The blood and tissue of men are invaded by certain species of plasmodium.⁴⁹

During epidemic seasons in Asante there were temporary increase in abortions a reduction in conception and a consequential reduction in birth rates among the indigenous people.⁵⁰ From 1936 several symptoms in children including hot skin, high fever, or cold and shivering, and vomiting were diagnosed to be malaria.⁵¹ Children of indigenous Asante who died out of the disease passed out in the form of fit of convulsion, which was attributed to witchcraft.⁵² Here, the experts that were consulted for treatment were herbalists and TBAs. There was the reliance on the use of concoctions and decoctions made of stems, roots and leaves of trees. Some were efficacious to the extent that those who reported their cases to these indigenous healers were healed. Others also used enemas especially when it was believed that the disease was intestinal.⁵³ In the twentieth century, every discovery of new case in malaria was treated with seriousness. For example, the discovery of two cases of oval malaria in Kumase in 1933 was considered worthy of special notice. Every annual report noted the severity and ubiquity of malaria. There were surveys showing high parasitemia in school children in urban areas like, Accra, Kumase, Sekondi, Cape Coast and Koforidua.⁵⁴

In 1943, the Director of Medical Service noted that malaria occurred everywhere yet there was little evidence that any sustained work was undertaken by the Colonial Administration amongst the population.”⁵⁵ Two factors might

⁴⁸ Ibid

⁴⁹ Howe, M. G, Ed., *A world Geography of Human Diseases* (London: Academic press, 1977) 68

⁵⁰ Ibid

⁵¹ Manhyia Archives of Ghana, Kumase, MAG 1/1/35: A short talk to African Mothers Broadcast, Accra by Dr. Duff, Director of Medical Service 1st July, 1936

⁵² A short talk to African Mothers Broadcast, Accra 1st July 1936, 8pm by Dr. Duff, Director of Medical Service. Interview with Maame Akua Nsiah (84 years), resident in Kumase, 15th January, 2008

⁵³ Interview with Kwaku Gyewahom, New-Tafo, Kumase, 10th December, 2007

⁵⁴ Akyeampong, K.E, (Ed.), *Selected Themes in West-African History*, 2000, 193-194

⁵⁵ PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935

have worsened the malaria burden during the colonial period. The major vectors, *A Gambiae* and *A Funestus*, were common everywhere except in dense forests. However, when the forest was cleared these insects especially *A Gambiae* established themselves.⁵⁶ Also, logging, food production, the extension of cocoa farms and road and railway construction all created clearing where vectors could breed. Borrow pits where earth was removed for roads, railroad also served as breeding grounds for mosquitoes that caused malaria. Malaria was one of the major causes of infant death in Asante. Although the figures were low in urban Asante, the unreported cases could have been very alarming in the 1940s.⁵⁷

In Asante, the Colonial Administration controlled malaria through the use of insecticides against the anopheles and better housing. Deliberate malaria eradication was mainly through the use of residual insecticides against adult anopheles. An example was the use of DDT, and other anti-laval measures, prophylactic and curative drugs.⁵⁸ Also, general standards of hygiene including the separation of cattle shed from houses especially when it was believed that the vectors are *zoophilic*.

In a colonial broadcast made by Dr. Duff, the Director of Medical Service on 1st July, 1936, the people of the Gold Coast including Asante were charged to kill mosquitoes at sight because they were the enemies of both parents and their children. The indigenous response especially in Asante was quite sporadic. It became a common phenomenon in Asante among the indigenous people, that both the young and old found the cause to kill mosquitoes at sight.⁵⁹ Hannah Adei has hinted that growing up in a village called Hweremoase in the 1940s she saw her peers kill mosquitoes at sight. The reason for killing mosquitoes was not necessarily based on medical reasons but because of the pains they felt when bitten.⁶⁰

⁵⁶ Ibid

⁵⁷ Manhyia Archives of Ghana, Kumase, MAG1/1/35, Report of the medical Officer of Health, Kumase, September 1942

⁵⁸ G. Melvyn Howe Ed., *A world Geography of Human Diseases*, 77

⁵⁹ Interview with Hannah Adei, at her residence, Dichemso, Kumase, 11th June 2008

⁶⁰ Ibid

The Colonial government made efforts to drain swamps, fill up pits and holes in the big towns including Kumase. Also, in 1936, what was regarded as a powerful remedy to the disease was introduced by the Colonial Administration to the indigenous people.⁶¹ Quinine was believed to hold the antidote to the disease without any ill effect on either children or adults. A massive educational campaign was employed through radio broadcast and through opinion leaders to educate mothers, the young and the old on the correct usage of quinine⁶².

Further enquiries among the indigenous people of Asante have shown that one of the noticeable drugs in use in Asante in the late 1930s and beyond to cure malaria was quinine.⁶³ One of my interviewees hinted that she has used quinine before and has never used any indigenous medicine for treatment. The response of 84 year old Akua Nsiah, attests to the lifestyle of a group of citizens, Asante, who were caught up in the full tide of social and cultural change due to western influence.

The Colonial Administration made quinine available in all dispensaries, hospitals, clinics and drug stores. Provision was made for mothers who could not visit doctors or any health posts. Every Post Office and postal agency in the country sold government quinine tablets at especially cheap rate. In addition, to ensure that people bought the quinine then considered to be the right for the treatment of malaria, graphic details as to the nature of the drug and how it was packaged were made known to the general public. Significantly, instructions or inscriptions pertaining to the correct usage of the drug was translated into various local dialects including, Ga, Fanti, Twi, Ewe and Hausa.⁶⁴ From 1902 to 1957, inhabitants of Asante villages were highly non-literates. Therefore, it became a paramount role for the few educated kin groups to help to translate or better still, read what was translated in Twi to the sick to ensure proper usage of quinine or any other drug that was introduced by the Colonial Administration into Asante.

⁶¹ Manhyia Archives of Ghana, Kumase, MAG 1/1/35, African Mothers Broadcast, Accra, by Dr. Duff, Director of Medical Service, 1st July, 1936

⁶² Ibid

⁶³ Interview with Maame Akua Nsiah (84 years), at her residence, Krofrom, Kumase, 15th January, 2008

⁶⁴ Manhyia Archives of Ghana, Kumase, MAG 1/1/35, African Mothers Broadcast, Accra, by Dr. Duff, Director of Medical Service, 1st July, 1936

Pregnant women were advised by the Colonial government to take quinine under strict instruction of a Medical Officer. It was strongly recommended by the Colonial government that expectant mothers took a tablet of government quinine daily or half a tablet morning and evening for three or four weeks before and after the birth of a child. Dr. Duff advised that quinine was good for the womb and it ensured that the mother recovered fast after her delivery. Also, Dr. Duff argued that if malaria attacked a pregnant woman it could cause miscarriage and perhaps death.⁶⁵ Such educational awareness from the Colonial Administration was mostly communicated through interpreters to non-literate dwellers in Kumase and its environs.

Again, the Colonial Administration introduced the use of mosquito nets. Pregnant women and parents including their children were admonished to sleep in their own mosquito nets to prevent mosquito bites and eventual infection with the malaria parasite.⁶⁶ Available information does not allude to the fact that there was a free distribution of mosquito nets by the Colonial Administration. However, oral evidence suggests that there was widespread use of mosquito nets by European or expatriate communities both in Asante and elsewhere and indigenous people who could afford had access to them.⁶⁷

Also, there was the separation of Europeans from African carriers of malaria that is, segregation was adopted as the official policy of the British West Africa Colonial government at the beginning of the twentieth century. The Medical and Sanitary Report of the Gold Coast in 1903 confidently stated,

Segregation which is the greatest efficacy in preventing the spread of malaria is now carried out in building residence for European Officials in nearly every station in the colony, and the remarkable fall in the death rate speaks for itself.⁶⁸

⁶⁵ Manhyia Archives of Ghana, Kumase, MAG 1/1/35, African Mothers Broadcast, Accra, by Dr. Duff, Director of Medical Service, 1st July, 1936

⁶⁶ Ibid

⁶⁷ Interview with Maame Akua Nsiah (84 years), at her residence, Krofrom, Kumase, 15th January, 2008. Interview with Hannah Adei, at her residence, Dichemso, Kumasi, 11th June 2008

⁶⁸ Akyeampong, (Ed.), *Selected Themes in West-African History*, 2000, 197-198

Segregation as an European mechanism to curtail malaria in itself meant little or nothing to the indigenous people of Asante. In determining the sick role in Asante, it has been found out that the sick were precluded from taking part in the recurrent social activity, they were quarantined.⁶⁹ Although prevention of transmission of an infected person to another was not the motive, the derived benefits included that. Twumasi emphasizes that:

The characteristics of the sick role in the society are that in so far as he is legitimately recognized as a sick person, he is temporarily relieved of his obligations of his work activities. If he is a father he is not obliged to attend work to support his family or take part in the decision making process of his various social groups. This role is legitimated by the elders of the family and it is reinforced by the traditional medicine man, when the case comes to him at his medicinal shrine.⁷⁰

In Asante, several measures were employed to curb the malaria surge. Sanitary workers were charged by the Colonial Authorities to inspect houses. From 1941 to 1942, 18,068 houses were inspected in Kumase. Significantly, within this period only thirteen houses were found to have the mosquito larvae.⁷¹ Towns were divided into sanitary districts by the Colonial Administration under the control of special Sanitary Inspectors. These inspectors or their subordinates entered and searched every home at least once every week with or without a prior notice. Rainwater in discarded containers, hollows of trees and puddles as well as water stored for household use were checked.⁷² Offenders escaped with a caution but were usually taken to magistrate courts and fined. At certain instances, the Colonial Administration passed ordinances to ensure that people in Asante kept their environment clean. There was the Mosquito Ordinance, which became the guiding principle for sanitary conditions and those who breached it were liable to a fine. From 1946 to 1947, seven people were fined a total of three pounds in Kumase for having mosquito

⁶⁹ Twumasi, *Medical Systems in Ghana*, 34

⁷⁰ *Ibid*

⁷¹ Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Report of the medical Officer of Health, Kumase, September 1942

⁷² *Ibid*

larvae in their houses.⁷³ Similarly, traditionally, it was the role of chiefs in Asante to call for clean up in their communities. In emphasis, the role of the chief included both the physical and social well being of his subjects.

Again, in Asante and for that matter Kumase, the Colonial Administration formed the anti-mosquito brigade. The brigade filled marshy and lowly areas with indestructible refuse with top dressing of earth, oiled such water bodies as swamps, drains, and ponds. This prevented the growth of mosquito larvae.⁷⁴ Significantly, it was the indigenous hand that worked to achieve this end. But by far we understand that it was under the strict supervision of the Colonial Administration who also had their own medical interests to take care of.

3.4 Trypanosomiasis

By 1903, the case and vector of human trypanosomiasis, which is also known as sleeping sickness, were known. Though the disease is an ancient one, since the nineteenth and twentieth centuries, its basic behaviour has been the same.⁷⁵ Beginning in 1909, Dr. Alan Kinghorn spent a year surveying central Asante and portions of Brong Ahafo. He found only 106 cases out of 1800 people examined. In 1912, Dr. W.M Wad completed a thorough survey of Western Asante. In this area, people were aware of sleeping sickness and attempted to treat it. Out of 39,742 people examined in 196 villages, 102 were infected. Most of the victims were migrants from the northern territories. Vegetation that harboured the fly which caused sleeping sickness was cleared.⁷⁶ Trypanosomiasis was virtually eliminated in Lawra, Wa and Tumu districts. However, despite a small outbreak in the 1950s was largely confined to few areas in the south, Mamprusi and other scattered locations in the north. Control of the northern epidemic reduced the incidence in Asante because fewer of the labourers going south were infected with trypanosomiasis.⁷⁷

⁷³ Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Report of the medical Officer of Health, Kumase, September 1947

⁷⁴ Manhyia Archives of Ghana, Kumase, MAG 1/1/4A, Kumase Public Health Board Gold Coast Colony, Estimates of revenue and Expenditure, 1927-1928

⁷⁵ PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935. Patterson, D. K, *Health in Colonial Ghana, Disease, Medicine and Socio-economic change, 1900-1955*, 1881, 44

⁷⁶ Ibid

⁷⁷ Ibid

In Districts like Damango, which had very little sleeping sickness, many cases were imported from Asante by returning migrant workers. While the spread of the disease was associated with rivers in the north, in Asante its distribution was linked to the road network. By September 1942, there were forty-one reported cases resulting in two deaths in Asante. However, by December 1947, there were two reported cases; both victims did not survive the scourge of the disease.⁷⁸

With regard to the forest regions including Asante, an imminent danger was pointed out by one entomologist, Dr. Morris who concluded that the vectors that cause sleeping sickness, *G. longipalpis* was probably second to *G. palpalis* in the distribution of the disease at the Gold Coast.⁷⁹ It was known that the forest of the Gold Coast was receding from both north and south. This recession was due principally to the practice of shifting cultivation, assisted by the mining communities, induced a secondary type of scrub, which was very difficult to deal with, but eminently suited the colonization of *G. longipalpis*.⁸⁰

Primarily, the control of Trypanosomiasis was the spraying of the vector, which causes the disease with insecticides and the defensive clearing of the vegetation, which the vectors reside in. On 29th August 1940, The Assistant Director of Medical Service, Kumase, informed the District Commissioner of Asante that Dr. McPherson who had a considerable experience in treating Trypanosomiasis would address the urgent need for taking preventive measures in Asante against the spread of the disease.⁸¹

⁷⁸ Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Reports of the Medical Officer of health Kumase, 1942

⁷⁹ PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935. Morris, *On the Biomedics and the importance of G. Longipalpis Wied, in the Gold Coast*, Bulletin of Entomological Research, Vol. 25 Part 3, September, 1934., *G. Palpalis and G. longipalpis*

⁸⁰ Ibid

⁸¹ Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Correspondence between the Assistant Director of Medical Service, Kumase and the District Commissioner, *Asante*,

One of the propositions put forward for the eradication of the menace of the human trypanosomiasis was the need for an improved system of indigenous farming, that is, the reduction in shifting cultivation to control *G. longipalpis*. Such a system was not only intended to ward off the vector, as put forward by Dr. Morris, it was at the same time to serve as a means of improving the food value of the crops of the farmers, thus, raising the general standard of health of the indigenous people.⁸² The Acting Director of Agriculture giving evidence before the Trypanosomiasis Committee stated that the problem of shifting cultivation was not to be noted as insoluble but rather there was the need to learn from the success of green manuring in Nigeria.⁸³

Again, by 1940, there were proposed rules to help curb the spread of the disease but it was not obligatory for any person to undergo a course of treatment for Trypanosomiasis. Significantly, the rules applied to only the indigenous people who, of their own free will, started treatment. The rule ensured that those who offered themselves for treatment continued until the Medical Officer discharged them.⁸⁴ These rules were applied in places like Kumase, Mampon, Dwaben, Esumeja, Kokofu, Nsuta, Adanse, Kumawu, Offinso, Edweso, Agona, Banda and Wenkyi in the Bono Ahafo region which formed part of northern Asante. The others included Mo, Abeasi, Nkoranza, Gyaman, Berekum, Techiman and Dormaa or Wampamu in the Brong Ahafo.

The proposed rules were made by the Native Authority in the Asante Confederacy Council with the approval of the governor under sub-section 15 of the Native Authority Ordinance, Cap 79. It was enshrined that the rules would apply to the whole Native Authority area. Again, it was stated, here to emphasize, that whoever began the treatment of human trypanosomiasis had to continue the treatment without intermission until discharged as cured by the medical authority. In addition, any person who contravened the rules was liable on conviction to imprisonment with

⁸² PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935.

⁸³ Ibid

⁸⁴ Manhyia Archives of Ghana, Kumase, MAG 1/1/162A, Rule 27 of 1940 published in Gazette 71 of 2nd November 1940

or without hard labour for a term not exceeding three months.⁸⁵

After taking into consideration the immense difficulties involved in clearing the territories of Asante especially when it was noted that the cutting down of economic crops such as cocoa could double the cost of clearing in Asante which was already five times higher than the northern territories, the Committee for trypanosomiasis still proposed the formation of paid gangs assisted with communal labour organized by the indigenous people. However, colonial action over a wider area was to be deferred until an expert survey of Asante threw further light on the extent to which the various districts in Asante were infected.⁸⁶

On 15th October, 1941, Dr. Saunders proposed to make a preliminary survey at some of the suburbs of Kumase namely, Patasi, Dakodwom, Kwadaso, Amakom, Aboabo, Dichemso and New Tafo, Tafo, Suame, and Kaase to investigate cases of sleeping sickness. The team started work on Monday, 20th October, 1941. The sleeping sickness survey team took blood tests of the inhabitants. They were charged not to take any fee or render any tests or engage in any other medical service apart from running of tests on sleeping sickness patients.⁸⁷ A comprehensive report was obtained at the end of the survey. At Patasi, ninety-five people were examined but only two people were infected. Also, at Kwadaso one hundred and forty-five people were examined, seven people were infected. One of the infected persons was an *Odikro* who has been described by the archival document as an old and feeble man. Another report which came in on 23rd October 1941 stated that at Dakodwom, seventy-three people were examined but two were infected. At Asokwa one hundred and twenty people were examined, eight were infected.⁸⁸

Again, in spite of the good work done by the medical team, they were not successful at some of the places they went

⁸⁵ Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Section 15 of the Native Authority Ordinance, Cap 79. Regulations made by the Governor in Council under Section 18 of the Infectious diseases Ordinance, Gazetted in 1935.

⁸⁶ Manhyia Archives of Ghana, PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating – Recommendations as to clearing in Asante.

⁸⁷ Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Report of Dr. Saunders, 21st October, 1941

⁸⁸ Ibid

because of the attitude of the indigenous people. Dr. Saunders is noted to have reported in 1941 that he had trouble at the village called Aboabo. He said the inhabitants did not come for treatment. Dr. Saunders further proposed that as the place is by a railroad to Accra, it was important that the people were examined. At Mo, Dr. Saunders encountered a similar problem. He also suggested a further survey at Adiebeba, Ahodwo, Tuase, Nhyiaeso and Adiembra.⁸⁹ Nevertheless, it was noted by the Colonial Administration that the indigenous people were ignorant of the true nature of the disease and that became their greatest obstacle in dealing with it. Superstition and semi-religious accounts of the origin of trypanosomiasis and of the process by which an individual could be infected abound. The Colonial Administration called for a gradual enlightenment of the indigenous people by means of persistent although not blatant propaganda.⁹⁰ Significantly, rule number 27 of 1940 of the Gold Coast empowered a chief to compel a trypanosomiasis patient undergoing treatment at the hospital to complete the course of treatment. For example, in Bekwai trypanosomiasis patients were compelled by the authorities at the Bekwai Hospital to report to the *Bekwaihene* to guarantee that such patients will report at the hospital until they were cured.⁹¹

Patients were mostly quarantined. Also, in cases where people were examined in villages, they were referred to hospitals for further treatment. By 26th February 1943, it came to the notice of the Chief Commissioner that the *Asantehene* and the Confederacy Council were unhappy about the scourge of trypanosomiasis in Asante.⁹² As a result of this, the Chief Commissioner was asked by the Asante Confederacy Council to recommend an amendment under Native Law and Custom Order making it an offence to refuse to report to the Native Authority the occurrence of any infectious or contagious disease. Again, all District Commissioners in Asante were charged to make it known in their districts especially to persons or Officers in charge of Infectious Disease Regulation to report cases of sleeping sickness or any other infectious disease and to also make known to the people the penalties attached to the

⁸⁹ Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Report of Dr. Saunders, 21st October, 1941

⁹⁰ PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935.

⁹¹ Manhyia Archives of Ghana, Kumase, MAG 1/1/162A, Rule 27 of 1940 published in Gazette 71 of 2nd November 1940, page 24. Regulations made by the Governor in Council under Section 18 of the Infectious diseases Ordinance, Gazetted in 1935.

⁹² Ibid

failure to report such cases.⁹³

On 21st September, 1943, Captain Holden R.A.M.C made a trypanosomiasis survey at Kwadaso, Owhimasi, Adumanu, Kokoso, Abase, Apatrapa, Bokankye, Tanoso, and Esuyeboa all in Kumase and its environs. The others included Ampabame, Abrepo, Boanim and Yankomase. In this survey, reported cases were treated at the African Hospital.⁹⁴ Also, the Military Authorities at the 52nd General Hospital carried out a survey of sleeping sickness in old soldiers' settlements like Esuyeboa, Tanoso, Abuakwa, Asonomaso, Manhyia, Akropon, Afrofrom, Dadiase, Bokankye, Apatrapa, Abase, Adumanu and Owhim. Again, on 7th September, 1945, it was proposed that Kumase villages should be re-surveyed. A centre was opened by the Colonial Administration at Abrepo in 1945 to cater for cases that came from areas within five miles radius of Kumase and places that were not surveyed. Significantly, the survey of villages for trypanosomiasis persisted up to the 1950s.⁹⁵

Table 1.2 Human Trypanosomiasis Cases Treated at the Various Hospitals set up by the Colonial Administration in Asante, 1928-1934

Date	In-Patient	Outpatient
1928-1929	15	13
1929-1930	40	28
1930-1931	35	1
1931-1932	76	46
1932-1933	167	113

⁹³ Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Correspondence between the Office of the *Asantehene* and the Chief Commissioner, 1945

⁹⁴ Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Correspondence between Captain R.A.M.C Holden and the Native Administration, 1945

⁹⁵ Ibid

Source: Report of Meeting of Local Committee on Anti—Trypanosomiasis Measures held at Kumasi in June, 1935.

Significantly, table 5.2 represents the toll of human trypanosomiasis within the period under study. The table might not be considered as a definite proof of the alleged large increase of the disease but when it was found out by the Colonial Administration that the indigenous people looked upon the disease as a curse and consequently refrained from reporting it or obtaining treatment from modern health care facilities but rather patronizing the services of indigenous practitioners, it was certain to conclude that trypanosomiasis was certainly on the increase.⁹⁶ In the northern territories where chiefs refrained from reporting deaths to the Colonial Authorities based on the fact that the indigenous people considered such deaths as abominable, hence, those who died by the disease were not given befitting burial.⁹⁷ In 1934, four Europeans and two hundred and fifty-two indigenous people were treated in Kumase.⁹⁸

Records have shown that the majority of the cases appeared to be amongst the labourers from the north, however, from available information it was certain that a considerable number of Asante were treated and further, the disease was well known amongst the indigenous population of Asante for years.⁹⁹ This notwithstanding, it was noted that many cases were reported from Sunyani and Kintampo areas but only very few from Bekwai and Obuasi.¹⁰⁰ This is because the infection rates in these towns were high.

3.5 Cerebrospinal Meningitis (CSM)

Another disease which is known to have infected the people of Asante within the first half of the twentieth century is

⁹⁶ PRAAD, Accra, ADM 11/1/1560, Report of Meeting of Local Committee on Anti—Trypanosomiasis Measures held at Kumase in June 1935.

⁹⁷ PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935.

⁹⁸ PRAAD, Accra, ADM 11/1/1560, Report of Meeting of Local Committee on Anti Trypanosomiasis Measures held at Kumase in June 1935.

⁹⁹ Ibid

¹⁰⁰ Ibid

Cerebro Spinal Meningitis (CSM). Its symptoms included fever, stiffness of neck, pains in the head, ears and the spinal column. These pains were severe during the night.¹⁰¹ Traces of cases of CSM were found in some villages and towns in Asante including Kumase. On 15th May, 1950, according to the report of Dr. A Brack, a Medical Officer of Health at the Basel Mission Hospital, Agogo in Asante, there were cases of CSM in Dwaso. Again, on 9th May, 1950, there was a reported case of CSM at Dompouse, a village in Adanse. In the same year, there were several reports from the General Hospital in Kumase on cases of CSM. In the same period, the South Wing Hospital at Kumase also reported several CSM cases.¹⁰²

The disease affected both the young and the old with the average age ranging from fifteen to thirty-five. However, infants and toddlers were also infected. Some of the patients survived, especially in cases where patients reported at the hospital before the symptoms took a dramatic turn, significantly attesting to the fact that indigenous remedies were not very effective in dealing with the disease.¹⁰³ The disease was found among migrants in Asante and Kumase in particular. For example, on 26th February 1950, it was reported by the Medical Officer that two migrants from the north, Yakubu Kotokoli, and Basana Grushie who were resident in Adanse suffered from CSM, twelve year old Yakubu succumbed to CSM on 3rd March 1950. Also in the same period, Seidu Busanga and Amadu Kanjaga migrants from the north but residents of Kumase were both reported to have suffered from CSM. Again, on 19th February 1950, a twenty-eight year old migrant resident in Kumase died of CSM on admission at the South Wing General Hospital in Kumase. Also, on 28th January, 1952, the Medical Officer of Health of the South Wing General Hospital Kumase reported two cases of twenty-one year olds, one Efua Nsohwo, and Satima Kanjaga. Both were admitted on 17th January 1952, but Satima succumbed to CSM on the day of admission.¹⁰⁴

In addition, on 28th February 1952, the Medical Officer of Health, Kumase reported that, Amadu Kanjaga, a prisoner

¹⁰¹ PRAAD, Kumase, ADM 3/2/5, Correspondence from the Health Department Juaso to the Medical Officer of Health, Kumase, 1950

¹⁰² PRAAD, Kumase, ADM 3/2/5, Report of Dr. A Brack, a Medical Officer of Health at the Basel Mission Hospital, Agogo in Asante, 1950

¹⁰³ PRAAD, Kumase, ADM 3/2/5, Report of the Medical Officer of Health, General Hospital Kumase, 1950

¹⁰⁴ PRAAD, Kumase, ADM 3/2/5, Report from the Medical Officer of Health, South Wing Hospital, Kumase, 28th January, 1952

at the *Asantehene's* prison had contracted CSM on 24th February, 1952. The reported case at the prison was something to be worried about because of the probability that the disease could be communicated amongst prisoners in the same cell and the entire prison community including the prison officers.¹⁰⁵

CSM was not only devastating but it had the potential to wipe out the youth who had energy to help in the developmental process of their respective communities in Asante. Within the period under study, several measures were employed by the Colonial Administration either to prevent, curtail or to cure people of CSM and its debilitating effects. In an instance where there was a reported case of an outbreak of CSM in an area or community, the Sanitary Overseer was charged by the Colonial Administration to conduct daily inspection of all contacts for a week and reported any case of symptoms amongst the indigenous people with the least possible delay. On 26th February, 1952, as a result of a reported case of Yaa Afre a native of Twedie in Asante, the Sanitary Overseer of the station was instructed to conduct daily inspection of the station for a week and reported any case of fever among the population. The chief of Twedie and the school teachers were advised to cooperate with the Sanitary Officer whilst he duly discharged his duties.¹⁰⁶ People who were infected with the disease were properly quarantined to avoid infecting other people in the community.¹⁰⁷ This in essence ensured that several people did not contract the disease through daily contact with the infected. Also, patients were given tablets by the Medical Authorities to help cure the disease. The Colonial Administration introduced the use of sulphanilamide tabs, which were given to infected persons to treat the disease. In addition, the temperatures of patients were checked at regular intervals to find out the progress they were making in their treatment. Mostly, temperatures of CSM patients were beyond hundred degrees Celsius. On 11th February 1951, there were seventeen reported cases at Afrantwo near Kumase. The patients were isolated and were discharged on 10th February 1951 after discovering that their temperatures had come to the normal level.¹⁰⁸

¹⁰⁵ Ibid

¹⁰⁶ PRAAD, Kumase, ADM 3/2/5, Measures that were adopted by the Medical Officers of Health to control CSM., 1952

¹⁰⁷ Ibid

¹⁰⁸ PRAAD, Kumase, ADM 3/2/5, Correspondence between the Health Department Dwaso to the Medical Officer of Health Kumase, 1952

Chiefs, elders and the inhabitants of Asante, and for that matter Kumase, were advised by the Medical Officer of Health, that they should open their doors and windows to ensure free flow of air. It was to ensure that rooms were well ventilated to prevent infection.¹⁰⁹ In contrast, it was observed that Cerebro Spinal Meningitis reported from out-stations was not shown in the Weekly Infectious Disease Returns. These omissions could have had serious repercussions on the Consolidated Weekly Epidemiological Information.¹¹⁰

Earlier, on 18th December, 1945, based on the Infectious Disease Ordinance, Cap 59, codified by the Colonial Administration, travel restrictions were imposed on the indigenous people of Asante to prevent the spread of CSM. However, persons whose duties required that they travel extensively along the road especially from Bamboi northwards were to apply for passes at the office of the Medical Officer of Health, Kumase. In 1930s, several restrictions were placed on labourers moving from the north to Asante and the ban was removed only when the Medical Authorities in Asante found out that the northern epidemic had reduced drastically. For example, in 1939, Zongo headmen in Asante received reports that the outbreak of CSM had reduced in the northern territories and no restrictions were further placed on labourers returning to their homes.¹¹¹

3.6 Small Pox

Smallpox is also one of the diseases, which infected the indigenous people of Asante. Howe refers to Christie that fewer diseases have been dreaded throughout the world than small pox.¹¹² It was observed that if the disease was suspected in the patient before he gets his rash then successful steps could be quickly taken to protect those around him. Also, patients who do not develop the skin rash were considered not infectious.¹¹³ Virus escapes from the body of the smallpox patient mainly from his mouth and throat served as the main way in which smallpox spreads.

¹⁰⁹ PRAAD, Kumase, ADM 3/2/5, Medical Directives from the Medical Officer of Health, Kumase to the people of *Asante*, 1952

¹¹⁰ PRAAD, Kumase, ADM 3/2/5, Correspondence between Medical Department, Accra and Assistant Director of Medical Service, Kumase, 20th March 1952

¹¹¹ PRAAD, Kumase, ADM 3/2/5, Infectious Disease Ordinance, Cap 59, 18th December, 1945

¹¹² Howe, (Ed.), *A world Geography of Human Diseases*, 255

¹¹³ Ibid

Similarly, it was noted that when skin spots break down or scabs are shed virus escapes and contaminates the environment, bed, clothes, and floor dust. Viruses were also known to be excreted in a patient's urine.¹¹⁴

Infected laundry could be dangerous to those who handle it, a patient's room could also be contaminated with virus and remain so for several days. Although, small pox normally spreads by face to face contact of one patient to an uninfected person, there are rare occasions when the virus could be wafted in a current of air, smuggled around in a bundle of clothes or inhaled in the dust of a patient's bedroom.¹¹⁵ Christie argued that smallpox smoulders inside a mud-hut or house and passes slowly from one unvaccinated member of the family to another and sometimes to some other person in a neighbouring hut.¹¹⁶ A vaccination or a previous attack is the major likelihood of preventing infection.

In the early days of The Smallpox Eradication Scheme, pockets of infection persisted in remote African villages including those in Asante. Field vaccinators were unwilling to travel to a vaccination assembly point and were also unwilling, to at first, penetrate the interior.¹¹⁷ When there was communication between villages or when infected traders journeyed with their produce to the neighbouring market townships, smallpox was spread.¹¹⁸ In 1942, the Medical Officer of Health in Asante noted that several cases of smallpox were noted in Kumase. The populace was notified of the outbreak of the disease through the beating of gong-gong by court criers in the suburbs.¹¹⁹ A unit was set for the administration of vaccines at market places and anybody with any trace of spots on his body and in particular, on the face, reported himself or through a messenger at once to the medical authorities.¹²⁰ This was significant because smallpox spreads almost exactly the same way everywhere. The virus passes from a respiratory mucous membrane to its close contacts; there is an incubation period of 12 days and if contacts could be traced,

¹¹⁴ Howe, (Ed.), *A world Geography of Human Diseases*, 255

¹¹⁵ Ibid

¹¹⁶ Ibid

¹¹⁷ Ibid

¹¹⁸ Ibid

¹¹⁹ Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Correspondence between the District Commissioner's office and the *Asantehene*, March 1944

¹²⁰ Ibid

vaccinated and kept under surveillance, the medical team could eventually catch up with the slow-spreading virus which must then die out in its new environment.¹²¹

On 21st February, 1942, a notice was sent to the *Asantehene* from the Chief Commissioner's Office with the notice that passengers who intended to travel on any of the passenger trains leaving Kumase were to be vaccinated or to produce satisfactory proof of vaccination. Again, as a result of a suspected outbreak of smallpox at Abofuo in the Offinso division the Medical Officer of Health in Asante moved teams to carry out vaccination in some villages including Abofuo, Brofoyedru, Akomadan, Nkenkansu and Kobreso, all in the Offinso Division. Vaccinators were also sent to Anyinasu at the Edweso Division. The others were sent to Afrantwo, Sekyeredumase and Kyekyewere.¹²² The efforts undertaken by the Colonial Administration to curb smallpox was essential because there was always the need to throw a ring of vaccinated contacts around each possible infected person and community. When the vaccination is done the virus cannot break the cycle in a fully vaccinated person. In contrast, mass vaccination was not necessary since vaccination and surveillance were only necessary for those who have been exposed to the virus.¹²³

However, on 25th February, 1946, the Senior Health Officer proposed to have an extra vaccinator available. He was sent to the villages in and around Kumase to protect any person who had not been vaccinated. The villages noted for these operations were Bremang, Aboabo, Old and New Amakom, Suame, New Tafo, Kaneanko, Asunkwa, Patase, Abrepo and Toase. The chiefs in these villages were encouraged by the Colonial Administration to give their support to the vaccinator whilst he dispensed his duty.¹²⁴

¹²¹ Howe (Ed.), *A world Geography of Human Diseases*, 264

¹²² Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Correspondence between District Commissioner's Office, Kumase and the *Asantehene* with copies to *Offinsohene* and Chief of Sekodumase.

¹²³ Howe, (Ed.), *A world Geography of Human Diseases*, 264

¹²⁴ Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Correspondence between the District Commissioner' office and the *Asantehene*, March 1944

3.7 Bronchial Infections

As a result of insanitary conditions prevalent in some of the villages in and around Kumase, several people including children suffered from bronchial infections. The disease was however prevalent during the cold and wet seasons. According to W.M Howells, Senior Health Officer of the Gold Coast, during the year 1937, out of every thousand deaths registered in the Gold Coast, 165 were due to non-tuberculous diseases of the respiratory system and 94 were due to pulmonary tuberculosis.¹²⁵

On 24th August, 1941, the Senior Health Officer identified the outbreak of whooping cough at Anwomase. He said almost all the children at the village had bronchial colds complicated by malaria. The condition was due to abnormal cold and wet weather aggravated by the local sanitary conditions, which were most unsatisfactory.¹²⁶ The disease was transmitted from person to person commonly by what is known as droplet infection. Although the non-tuberculous diseases of the respiratory system are not infectious like smallpox, they may by means of droplet infection, become epidemic, strike down a large percentage of the population and cause many deaths. This situation normally happened during the rainy season in Ghana including Asante. It is during this period that the people crowded together for warmth and closed all the ventilation openings in their rooms.¹²⁷

The consequent dangers associated with the mass phlegm or sputum forcibly expelled from the chest of a person suffering from pulmonary tuberculosis indiscriminately on pavements, in public buildings and vehicles, and even on the walls and into the corners of living rooms are grievous. According to Ian Sutherland (1977), tuberculosis was, until the advent of chemotherapy, much feared as a common and lethal disease. It was referred to as a white plague and as the captain of the men of death. Infection of man with human *tubercle bacilli* is principally by the inhalation

¹²⁵ Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer

¹²⁶ Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Whooping Cough Outbreak at Anwomase, 1941

¹²⁷ Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer, 1941

of a bacillus coughed up by patients with pulmonary tuberculosis.¹²⁸ As a result, pulmonary tuberculosis is the commonest form of the disease. According to the Senior Medical Officer, Dr. Howells, such sputum from a person suffering from a tuberculous infection of the lungs might contain hundreds or thousands of the *Baccillus tuberculosis*, the germ that causes the disease. These minute fragments of germs could float in the air of a room for a long time and might bring infections to many people.¹²⁹ In 1940s, it was advised by the Senior Medical Officer Dr. W.M Howells that if a mass of sputum is exposed to the direct rays of the sun, the drying process is rapid, and the life of the germs of infection is comparatively short. However, in a dark, poorly ventilated room, the process is gradual and a mass of sputum or expectoration may give off germ-carrying fragments for a prolonged period.¹³⁰

Again, it was re-iterated by the Colonial Administration that promiscuous spitting by a person suffering from pulmonary tuberculosis meant infection of many other persons and, as a direct result, increased numbers of deaths.¹³¹ In the “highly civilized” countries, it was found out that as soon as a person was found to be suffering from pulmonary tuberculosis, he was given a pocket spitting-flask.

This is a small bottle containing a little disinfectant fluid and provided with a tightly fitting cap. Significantly, it is not good for a person suffering from pulmonary tuberculosis to swallow his sputum; hence, the patient was advised to bring out the flask, remove the cap, spit into the bottle, replace the cap and return the flask to his pocket. Daily, the flask was emptied, the contents were burnt and the flask was disinfected.¹³²

For the purpose of wiping his mouth, an infected person was advised to carry about with him a supply of paper handkerchiefs sufficient for the day. When one was used, it was not thrown away, but it was placed in a container

¹²⁸ Howe (Ed.), *A world Geography of Human Diseases*, 175

¹²⁹ Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer

¹³⁰ Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer, 1941

¹³¹ Ibid

¹³² Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer, 1941., In His presentation on the Spitting Habit, W.M. Howells made comparison between the way tuberculosis was handle in Britain, which was the Colonizing country of the Gold Coast.

carried in the pocket, and at night, all the used paper handkerchiefs were burnt and the container was disinfected. These measures were promoted by the Colonial Administration amongst the indigenous people of the Gold Coast including Asante to ensure that persons suffering from tuberculosis of the lungs did a great deal to prevent themselves from becoming a danger to the public. The Senior Medical Officer was of the view that legal measures would not help control the spitting habit of the people of the Gold Coast including Asante. However, he argued that all highly “civilized countries” had stringent regulations against the practice of spitting in public places whether they were suffering from pulmonary tuberculosis or not. Any contravention of these regulations was punished with heavy fines.¹³³

In the case of the Gold Coast, the Senior Medical Officer stated that apart from the fact that bad spitting habits spread diseases, spitting is a filthy habit and public opinion in such a country as Great Britain, the colonial masters, did as much to curtail it as had any legal measure. The legal measure could not be fruitful in Ghana including Asante because there was too wide a gap between the lettered and the unlettered in the society. However, it was proposed that some years of education was necessary. It was believed that as education spread, public opinion as in Great Britain would tend to bring the less thoughtful members of the general public into line. Then, legal measures would be required to curb the persistently thoughtless offenders who should and often do know better.¹³⁴

In the 1950s, teachers in the country including Asante were advised to use their influence to educate their pupils to free their minds from the negative spitting habits they had acquired from their parents, clan heads, and uncles, siblings among other members of the nucleus and extended family and the community at large. It was realized that, if the dangers of the bad spitting habit was explained to pupils, they would influence the coming generation to discontinue the ill-spitting habit.¹³⁵

3.8 Leprosy

¹³³ Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer, 1941

¹³⁴ Ibid

¹³⁵ Ibid

Again, another infectious disease which infected the people of Asante by the first half of the twentieth century was leprosy. In 1927, the Medical Officer of Health stated that leprosy, in his opinion, was largely on the increase in Asante principally due to the influx of people from the northern territories.¹³⁶ Several measures were taken by chiefs and the Colonial Administration to contain the situation in Asante. Leprosy was in Asante especially Kumase in the 1930s. The *Asantehene* became very concerned about the rate of infection and how the streets of Kumase were being filled with lepers.¹³⁷

On 27th February, 1936, a letter was sent from the Office of the *Asantehene* to the Acting District Commissioner of Kumase, calling for the removal of lepers off the streets of Kumase. This was necessitated by the fact that a large number of lepers moved about in Kumase. Based on the contagious nature of the disease, it was feared that if the Colonial Administration did not take immediate steps to remove them from the Kumase township and detain them in the Contagious Disease Hospital, in the shortest possible time, the disease would spread through Kumase and the whole township would become a city of lepers.¹³⁸

In contrast, the demand for the removal of lepers by the *Asantehene* did not receive the necessary and urgent response from the Colonial Administration. The Acting District Commissioner denounced the call of the *Asantehene* because the health authorities did not possess powers to segregate lepers. However, the Commissioner suggested that lepers in Kumase should be persuaded to go to the Kumase Leprosarium for treatment. The treatment of lepers was clearly restricted to the Kumase Leprosarium.¹³⁹ However, among the indigenous population the disease was considered as a curse which came upon an individual and his household as a result of a misdemeanour on the part of the individual or his family. The notable cause of the disease was not known to the indigenous people of Asante. Treatment was based on recourse to shrines and herbalists whose medicine was rather considered by the indigenous

¹³⁶Manhyia Archives of Ghana, Kumase, MAG 1/17/1A, Report of the Medical Officer of Health, Kumase, 1927

¹³⁷ Ibid

¹³⁸ Manhyia Archives of Ghana, Kumase, MAG 1/1/46, Correspondence between the *Asantehene*'s Office and the District Commissioner, February 1936

¹³⁹ Manhyia Archives of Ghana, Kumase, MAG 1/1/46, Correspondence between the *Asantehene*'s Office and the District Commissioner, February 1936

people as more efficacious than the modern medicine introduced by the Colonial Administration.¹⁴⁰

The disease had dire social consequences. Those infected by the disease in Asante were not only removed from their kin groups.¹⁴¹ Thus, even when a member of the kin group has been cured and reintegrated into the family and the community at large, the stigma of the disease lingered with the family.¹⁴² The more redeeming feature for those who suffered from leprosy from the social and psychological costs was the church which had gained foothold in Asante especially in the 1940s and the Indigenous Healers rather than the medical machinery set up by the Colonial Administration.¹⁴³

Again, another redeeming effort put in place by the Colonial Administration was the establishment of settlements for lepers in Asante. Most importantly, between 7th and 23rd January, 1948, the Medical Officer of Health in Asante, A. M. Kelrie visited various towns and villages in Asante to meet chiefs and the indigenous people to find out their attitude towards leprosy, which the archival records have noted to be chronic during the 1940s in Asante. Some of the people he met included those who were suffering from leprosy, Colonial government officials, missionaries and other non-Africans who could tell their experience with lepers.¹⁴⁴

Kelrie travelled from Kumase to Lake Bosomtwe near Kumase. He visited seven lakeside villages where he examined lepers who were brought to him. The rate of leprosy in the lakeside area was very high. The reports of Kelrie stressed that except in few places where some of the indigenous people were suspicious of his intentions, the *Odikros* and the people in the villages he visited in Asante were anxious and co-operated with him in an effort to

¹⁴⁰ Interview with Opanin Kwabena Amoah, Breman, Kumase, 20th January, 2007

¹⁴¹ Ibid

¹⁴² Ibid

¹⁴³ Ibid

¹⁴⁴ Manhyia Archives of Ghana, Kumase, MAG 21/1/6, Correspondence between the Medical Department, Accra and the Ashanti Confederacy Council, 27th January, 1948

combat leprosy.¹⁴⁵ However, some of the people he met wished for legal powers to compel lepers to be segregated. But within the period segregation or compulsion was noted to have failed in places where they were instituted. It was noted that if compulsion was used people infected would not report for treatment¹⁴⁶ It was a noticeable fact that segregation of lepers was essentially in the interests of the Asante community and specifically, Kumase as well as the lepers themselves. It was known by the Colonial Medical Authorities in Asante that leprosy could be cured but the cure requires patience on the part of both the patient and the doctor. It was observed by the Colonial Administration in Asante that if lepers were kept together they would be saved from the long marches to treatment centres and their cure would be properly effected by living a life of sufficient supervision under the doctors to ensure that they were fully cured.¹⁴⁷

4.0 CONCLUSION

It is justifiable to say that throughout human history men have been faced with the challenge of preserving their health care. However, the case of the Gold Coast and Asante specifically draws our attention to the fact that certain tropical diseases as well as those communicated from elsewhere has been with human for a very long time and men from time past have made efforts to prevent or cure them. For there to be reoccurrence of such diseases as stated in the discussion within the territory called Ghana and even some of the regions of Africa suggest that we as people have not changed our lifestyle, transformed our environment and have not learnt much lessons from the past. In spite of technological and scientific breakthroughs even in the twenty-first century we are yet to admit as a people that health care is not only biological but also attitudinal.

Again it is essential to note that the need for health care providers to understand the medical field they are sent to deliver or provide health care. Arguably, there are still persons within the continent of Africa including Ghana who are stuck to their old ways and will take time to accept new trends of doing things including medical care. It is also pertinent to conclude that the fight against diseases especially those that have been found to be best handled with indigenous herbal or medical expertise be handled by indigenous healers with close collaboration with modern orthodox medical practitioners. The training of such indigenous medical practitioners would have to be based on the conscientious efforts of governments, owners of capital and the practitioners themselves with the understanding that medical practice and provision of cure to diseases would continue to be pluralistic.

It is imperative to understand the need to articulate healthcare information in the local indigenous dialects of respective communities where health care is to be provided or where epidemics have to be prevented or stalled from spreading to other communities. Traditional and opinion leaders who still wild traditional power must first be educated in their palaces and houses and should be encouraged to endear themselves in throwing their weight behind health educators, regulators and practitioners.

¹⁴⁵ Ibid

¹⁴⁶ Ibid

¹⁴⁷ Ibid

REFERENCES

Secondary Sources

- Longley D., (1996), *Health Care Constitutions*, London: Cavendish Publishing Ltd
- Twumasi, P.A, (1975), *Medical Systems in Ghana*, Accra: Ghana Publishing Corporation
- Akyeampong, E. K, Ed. (2000), *Themes in West African History* Accra: Woeli Publishing Services,
- Cruickshank, B., (1966) *Eighteen years on the Gold Coast of Africa* London: Frank Cass & Co. Ltd.
- Maier D. (1979) "Nineteenth-Century Asante Medical Practices", *Comparative Studies in Society and History*, Vol. 21, No. 1,
- Anti, A.A (1996), *Kumase in the Eighteenth and Nineteenth Centuries*, Accra: Graphic Corporations
- Patterson D.K, (1981) *Health in Colonial Ghana, disease, medicine and socio-economic change, 1900-1955*, USA: Crossroad Press
- J. Dupuis, (1824) *Journal of Residence in Asante* London: H Colburn
- D.K, Patterson, (1981) *Health in Colonial Ghana, disease, medicine and socio-economic change, 1900-1955* USA: Crossroad Press
- Frierman S. and Janzen J.M., Eds. (1992), *The Social Basis of Health and Healing in Africa*, Berkeley: University of California Press
- Howe, M. G, Ed., (1977) *A world Geography of Human Diseases*, London: Academic press

Primary Sources

- Manhyia Archives of Ghana, Kumase, MAG 1/17/1A, Report of the Medical Officer of Health, Kumase, 1927
- Manhyia Archives of Ghana, Kumase, MAG 1/1/46, Correspondence between the Asantehene's Office and the District Commissioner, February 1936
- Manhyia Archives of Ghana, Kumase, MAG 21/1/6, Correspondence between the Medical Department, Accra and the Ashanti Confederacy Council, 27th January, 1948
- Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer, 1941
- Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Whooping Cough Outbreak at Anwomase, 1941
- Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Correspondence between District Commissioner's Office, Kumase and the Asantehene with copies to Offinsohene and Chief of Sekodumase.

PRAAD, Kumase, ADM 3/2/5, Infectious Disease Ordinance, Cap 59, 18th December, 1945

PRAAD, Kumase, ADM 3/2/5, Measures that were adopted by the Medical Officers of Health to control CSM., 1952

PRAAD, Kumase, ADM 3/2/5, Correspondence between the Health Department Dwaso to the Medical Officer of Health Kumase, 1952

PRAAD, Kumase, ADM 3/2/5, Medical Directives from the Medical Officer of Health, Kumase to the people of Asante, 1952

PRAAD, Kumase, ADM 3/2/5, Correspondence between Medical Department, Accra and Assistant Director of Medical Service, Kumase, 20th March 1952 PRAAD, Kumase, ADM 3/2/5, Report from the Medical Officer of Health, South Wing Hospital, Kumase, 28th January, 1952

PRAAD, Accra, ADM 11/1/1560, Report of Meeting of Local Committee on Anti—Trypanosomiasis Measures held at Kumase in June 1935.

PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935.

Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Report of Dr. Saunders, 21st October, 1941

Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Correspondence between the Assistant Director of Medical Service, Kumase and the District Commissioner, Asante,

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