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BRITISH COLONIAL STRATEGIES TO CONTROL THE INFLUENZA EPIDEMIC OF 1918
TO 1919 IN ASHANTI

DENNIS BAFFOUR AWUAH

91 Pages

This thesis seeks to examine the strategies and policies that were employed by the British colonial administration to control the influenza epidemic of 1918-1919 in Ashanti. I argue that the varying philosophies of both the colonial administration and the Native population in Ashanti on health and medicine influenced the response trajectory to the disease. It also explores the aspects of Indigenous medical practices which are largely concerned with the religion or beliefs of the people. Before the outbreak of influenza, the colonial administration started a campaign to promote Western medicine while antagonizing Indigenous medicine. To an extent, this made the activities of Indigenous healers unattractive. However, the failure of colonial health interventions to control the spread of the disease paved way for indigenous medical practices to thrive. In this thesis, the activities of Indigenous healers during the outbreak of influenza in Ashanti will be examined.

KEYWORDS: Gold Coast, Ashanti, Indigenous, Indigenous healers, Colonial administration, Influenza Epidemic

BRITISH COLONIAL STRATEGIES TO CONTROL THE INFLUENZA EPIDEMIC OF 1918
TO 1919 IN ASHANTI

DENNIS BAFFOUR AWUAH

A Thesis Submitted in Partial
Fulfillment of the Requirements
for the Degree of

MASTER OF SCIENCE

Department of History

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2022

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BRITISH COLONIAL STRATEGIES TO CONTROL THE INFLUENZA EPIDEMIC OF 1918
TO 1919 IN ASHANTI

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D. B. A.

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CHAPTER I: INTRODUCTION

Background and Historical Context

The history of a nation cannot be documented without considering the pertinent issues that shaped the lives of its people. In the same light, every period in the history of nations is mostly characterized by an event that appears to summarize the prevailing action or distraction of the time. Thus, we have the “age of exploration,” “age of discovery,” “golden age,” and “age of enlightenment” among others.¹ The period 1918-19 marked a turning point in the history of the world as the emergence and the rapid spread of the influenza virus shaped the course of human existence. Kwarteng and Osei-Owusu describe the influenza experience of 1918 as “the greatest epidemic ever of an infectious disease in human recorded history.”² The influenza epidemic of 1918 disrupted the social, economic, and political life of populations across the globe. Scholars estimate that the influenza epidemic of 1918 affected about five hundred million people and killed at least twenty to a hundred million of the world’s population.³

Influenza is a respiratory transmitted infection caused by a virus that is usually transmitted from person to person. According to Killingray, the disease has a short incubation period and spread among people, especially in close quarters areas.⁴ Usually, the disease is transmitted by inhaling droplets generated from the coughs or sneezes of an infected person.⁵ Scholars estimate that the general mortality rates for infectious diseases are usually high for both the young and the

¹ Hughes, Charles C., and John M. Hunter. "Disease and “development” in Africa." *Social Science & Medicine* (1967) 3, no. 4 (1970): 443

²Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919 in Africa and the First World War: Remembrance, Memories and Representations After 100 Years* (Cambridge Scholars Publishing 2018), 145.

³ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 205; Phillips, Howard. "Black October: The impact of the Spanish influenza epidemic of 1918 on South Africa." (1984): 9

⁴ Killingray, David. "A new ‘imperial disease’: The influenza pandemic of 1918–9 and its impact on the British Empire." *Caribbean Quarterly* 49, no. 4 (2003): 31.

⁵ Beach, Brian, Karen Clay, and Martin Saavedra. "The 1918 influenza pandemic and its lessons for COVID-19." *Journal of Economic Literature* 60, no. 1 (2022): 10.

old. However, Killingray and Beach have argued that in 1918 mortality rates for influenza were high among the young and healthy particularly between the ages of 20 and 40 years.⁶ In the Gold Coast, which is modern-day Ghana, adult males between the ages of 20 and 35 suffered brutally from the disease.⁷ Given this, it is sufficient to say that influenza had a huge negative economic impact on countries including the Gold Coast.

Historically, the term influenza was coined from the Italian word for “influence” to reiterate the belief in the influence of the stars on events and health.⁸ Mueller, argues that the etymology of the word only changed over time to mean ‘the influence of the cold’ to explain some epidemics that occurred during European winter.⁹ This explains the origin and period of the disease and how it became a major event in world history. The documentation of the traces of the influenza virus dates as far back as the fourth century BC, when Greek philosopher, Hippocrates wrote of a disease that was characterized by cough and pneumonia.¹⁰ Records have shown that in 1493, the year after Christopher Columbus had arrived on the Caribbean Island, the influenza virus disrupted the lives of at least thousands of the Native population.¹¹ Although the influenza epidemic has been referred to as the most devastating and worst outbreak in 1918, most historians agree that there were a series of epidemics that had occurred in earlier centuries. Hardman contends that the first global outbreak of influenza began in Asia in 1580 and later spread across North Africa, Europe, and the Americas.¹² The “Spanish Influenza,” as it is often labeled did not originate from

⁶ Killingray, David, *A new ‘imperial disease’: The influenza pandemic of 1918–9 and its impact on the British Empire*, 31; Beach, Brian, Karen Clay, and Martin Saavedra, *The 1918 influenza pandemic and its lessons for COVID-19*, 10.

⁷ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 213

⁸ Hardman, Lizabeth, *Influenza Pandemics* (Gale, Cengage learning USA 2011), 8

⁹ Mueller D. Juergen, *The Spanish Flu 1918-1998: Reflections on the Influenza Pandemic of 1918-1919 after 80 Years* (History Department, University of Hannover 2008), 3.

¹⁰ Hardman, Lizabeth, *Influenza Pandemics*, 10.

¹¹ Hardman, Lizabeth, *Influenza Pandemics*, 8

¹² Hardman, Lizabeth, *Influenza Pandemics*, 37

Spain. Scholars like Crosby, Phillips, and Mueller believe that unlike in other countries in Europe, reports of the disease outbreak were not curbed by any wartime censorship in Spain thus the public perception that the disease started in Spain.¹³ Again, Kwarteng and Osei-Owusu interpret the diseases' connection to Spain through the killing of an estimated eight million people in Spain as early as May 1918 before spreading to other areas.¹⁴ Eventually, the name became fully established as it had penetrated other places. Hardman believes that the influenza epidemic emerged from Asia in late 1917 or early 1918 and subsequently moved westward to Europe and North America in the first half of 1918.¹⁵ In America, Crosby records that the disease first appeared in March, and spread through almost the entire army by May.¹⁶ The commentary on influenza has shown that the presence of the disease among the military aided the fast spread of the disease across regions and continents. Akyeampong believes that American soldiers from Kansas carried the virus to Europe during the First World War. Subsequently, factors such as the movement of soldiers from one military camp to another and the return of servicemen from the battlefield aided the spread of influenza.¹⁷ Some historians agree that the presence of the influenza of 1918 hastened the end of the First World War because many troops were infected leading to massive deaths in the last months of the war. The disease spread profusely among civilian populations across Europe in countries like France, Italy, Spain, Great Britain, and Germany.¹⁸

¹³ Crosby, Alfred W, *Epidemic and peace, 1918* (Greenwood Press, Westport: Connecticut, USA 1976), 26; Phillips, Howard, *Black October: The impact of the Spanish influenza epidemic of 1918 on South Africa* (Published PhD Thesis 1984), 8.

¹⁴ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in *"Africa and the First World War: Remembrance, Memories and Representations After 100 Years*, 146.

¹⁵ Hardman, Lizabeth, *Influenza Pandemics*, 40

¹⁶ Crosby, Alfred W, *Epidemic and peace*, 1918, 26; Phillips, Howard, *Black October: The impact of the Spanish influenza epidemic of 1918 on South Africa*, 1984, 25

¹⁷ E. K Akyeampong, (Ed.), *Themes in West African History* (Accra: Woeli Publishing Services, 2000), 200

¹⁸ Crosby, Alfred W, *Epidemic and peace*, 1918, 27.

Most African countries experienced the disease in August 1918 as a result of the growing global and economic maritime network which brought about new infectious diseases which were hitherto foreign to the continent.¹⁹ The first African country to record influenza was Sierra Leone in August 1918. Subsequently, sporadic activities facilitated a rapid spread of the disease to other territories of British West Africa.²⁰ Phillips argues that once established in the ports of various African territories, the disease spread quickly to the country's inland through colonial infrastructure, particularly the railway systems.²¹ In South Africa and Nigeria, from Sierra Leone, influenza spread and penetrated the interior through railway networks, boats, and roads.²² This indicates that colonial infrastructure made an unenviable contribution in transporting the disease in British colonies in Africa. Further confirmation is given by Kwarteng and Osei-Owusu who argue that European ships aided the introduction of the disease in the Gold Coast.²³

As the disease traveled to certain areas in Africa, local names were given to it depending on the circumstances surrounding it. For instance, Killingray explains that among Christians in Sierra Leone the disease was referred to as “‘Man-Hu’- meaning What is it?” due to the disease's heavy death toll which they believed was an obscure divine visitation.²⁴ Mueller adds that in Dakar, the disease was first named ‘Brazilian Influenza’ due to four Brazilian warships developing serious infections in the harbor of Darkar.²⁵ A similar local name was given in Kenya where the

¹⁹ E. K Akyeampong, (Ed.), *Themes in West African History*, 198.

²⁰ Tomkins, Sandra M. "Colonial Administration in British Africa during the Influenza Epidemic of 1918–19." *Canadian Journal of African Studies/La Revue Canadienne des Études Africaines* 28, no. 1 (1994):64

²¹ Phillips, Howard, *Black October: The impact of the Spanish influenza epidemic of 1918 on South Africa*, 8

²² E. K Akyeampong, (Ed.), *Themes in West African History*, 200; Phillips, Howard, *Black October: The impact of the Spanish influenza epidemic of 1918 on South Africa*, 9

²³ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in “*Africa and the First World War: Remembrance, Memories and Representations After 100 Years*, 147

²⁴ Killingray, David, *A new ‘imperial disease’: The influenza pandemic of 1918–9 and its impact on the British Empire* (*Caribbean Quarterly* 49, no. 4 (2003): 34.

²⁵ Mueller D. Juergen, *The Spanish Flu 1918-1998: Reflections on the Influenza Pandemic of 1918-1919 after 80 Years* (History Department, University of Hannover 2008), 5

disease was referred to as ‘Nairobi Throat’. In Lagos and South Africa, it was nicknamed ‘Black October’ since the disease reached its peak in October. In the Gold Coast, the outbreak was first referred to as ‘Mowure Kodwo’ in remembrance of the death of one Mr. Kodwo from the Mouri/Moree village who was believed to be the first to have died from the disease.²⁶ Again in the Gold Coast, Kwarteng and Osei-Owusu have noted that some sections of the local people referred to the disease as “mfruensa.”

In the Gold Coast, Patterson argues that the first case of the influenza infection was recorded on board an American vessel from Freetown on August 31, 1918.²⁷ It should be noted that the Gold Coast has been involved in three known epidemic diseases between the late nineteenth century and 1960, thus the influenza of 1918 was not a new phenomenon in the country. Scholars like Patterson and Scott contend that the first pandemic which appeared to have originated from Russia reached the country in 1891.²⁸ The second, which spread rapidly from Europe invaded the Gold Coast in 1918. Scholars have acknowledged that this second pandemic which lasted from 1918 to 1919 in the Gold Coast is considered the greatest pandemic in the history of pandemics. The third and final pandemic was the “Asian Influenza” which occurred before 1960 and is believed to have begun in the East.²⁹ Patterson postulates that the colonial administration’s response to the 1918-19 influenza epidemic, in the beginning, was passive. He acknowledges that a call was made from the Governor of Sierra Leone to his counterpart in Accra to inform him of

²⁶ Mueller D. Juergen, *The Spanish Flu 1918-1998: Reflections on the Influenza Pandemic of 1918-1919 after 80 Years*, 5.

²⁷ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 206

²⁸ Scott, David. *Epidemic Disease in Ghana 1901-1960* (Oxford University Press 1965), 187. The work of Patterson gives significant information on the early occurrence of pandemics in the Gold Coast. Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 206

²⁹ Scott, David, *Epidemic disease in Ghana, 1901-1960* (London; New York: Oxford University Press 1965), 187

identified traces.³⁰ However, by the time information concerning the disease reached Cape Coast, it was late as almost every ship that came from Sierra Leone to the Gold Coast had been infected. Killingray suggests that perhaps the colonial administration felt the influenza was neither a notifiable nor imperial disease, thus was not necessary to announce its presence.³¹ According to the Gold Coast medical and sanitary report for 1918, the colonial administration did not take any special steps to isolate passengers on board the ship. Rather, passengers were advised to have their clothes washed and disinfected through exposure to the sun's rays.³² Other instructions that were given to different stations and local authorities including chiefs were maintaining personal hygiene, free ventilation, and admission of sunlight. Again, the Sanitary Staff visited houses and outlined to the people the various public health measures to control the spread of the disease. However, this was short-lived as two-thirds of the Inspectors were infected and had to halt any possible movements.³³ As a result of the deficient steps taken to combat influenza, the disease affected all the towns and cities in the Gold Coast and neither the local chiefs nor the British officials could prevent it.³⁴

Concerning the outbreak of the disease in the Gold Coast, it appears none of the epidemiological historians of the Gold Coast except Kwarteng and Osei-Owusu have alluded to a contrary perspective of how the disease broke out in the British colony. The duo makes a compelling and invaluable argument for another possibility that may have led to the introduction of the disease in the Gold Coast. According to the authors, the return of the African servicemen who fought alongside troops in Europe during the First World War may have contributed to the

³⁰ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983):206

³¹ Killingray, David. "A new 'imperial disease': The influenza pandemic of 1918–9 and its impact on the British Empire." *Caribbean Quarterly* 49, no. 4 (2003): 33.

³² Gold Coast Medical Department, *Medical and Sanitary Report for the year 1918*, 27.

³³ Gold Coast Medical Department, *Medical and Sanitary Report for the year 1918*, 27.

³⁴ Patterson, K. David, *The influenza epidemic of 1918–19 in the Gold Coast*, 1983, 208

outbreak and massive spread of the disease in the Gold Coast, particularly in the Ashanti and Northern territories.³⁵

Geographically, Ashanti is located in the south-central part of modern-day Ghana. In this thesis, Ashanti is used in representing a people, a kingdom, and an empire. In Ashanti, the earliest cases of influenza were recorded in Kumasi on September 23rd, 1918, and the disease spread quickly across the entire region.³⁶ It is reported that the disease reached its height by the first week of October in both Kumasi and Obuasi. The southern and central provinces recorded more mortality rates than the northern province.³⁷ It is important to note that accurate figures for the number of people who died from the 1918 epidemic could not be established, but most scholars have estimated that about 60,000 people died in the Gold Coast and Ashanti alone.³⁸ According to the medical and sanitary report for 1918, out of a total population of 450,000 in Ashanti, there were 9,000 deaths.³⁹ Patterson and Pyle have emphasized that official records on the mortality rate of influenza in most countries were generally incomplete, however, in colonies in Africa, the available records were either unknown or miscalculated.⁴⁰ This shows that the records on the mortality consequences of the disease are sketchy and unprecise due to inaccuracies in record keeping.

³⁵Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in *"Africa and the First World War: Remembrance, Memories and Representations After 100 Years*, 147.

³⁶ Kumasi historically called 'Coomasie', was the traditional capital of Ashanti and the seat of its ruler, Asantehene. This area also became the seat of the British colonial administrator. Historically, Kumasi was the commercial and industrial city of Ashanti where most social, cultural, and political activities were undertaken. Patterson, K. David. *The influenza epidemic of 1918-19 in the Gold Coast*, 1983: 208; Scott, David, *Epidemic and Disease in Ghana. 1901-1960*, 188.

³⁷ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between the Chief Commissioner of Asante and the Secretary in Accra on the Influenza-Epidemic

³⁸ Patterson, K. David. "The influenza epidemic of 1918-19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 213

³⁹ Gold Coast Medical Department, *Medical and Sanitary Report for the year, 1918*.

⁴⁰ Patterson, K. David, and Gerald F. Pyle. "The geography and mortality of the 1918 influenza pandemic." *Bulletin of the History of Medicine* 65, no. 1 (1991):13

Admittedly, several studies relating to health in the Gold Coast have been tackled, yet it appears there is little or no extensive specialized knowledge on the colonial and Indigenous responses to the 1918-19 influenza in Ashanti. Like other parts of the Gold Coast, historians have treated diseases in Ashanti to form an integral part of disease epidemiology in the Gold Coast. However, Philips states that “epidemic diseases, when they become decisive in peace or war should not be downplayed if historians want the human experience to make sense.”⁴¹ Thus, it is important to assess the impact of a disease that disrupted the socio-economic framework of particularly the West African region of Ashanti.

Scholarly contributions to Western medicine have acknowledged that Indigenous peoples over the years have demonstrated detailed knowledge and understanding of the factors that influence their health and illness. In Ashanti, Adu-Gyamfi has noted that the Indigenous people of Ashanti and later through cooperation with the British colonial administration made efforts during the pre-colonial and colonial eras to solve the health needs of the people.⁴² The major tool that was used during the pre-colonial era was “traditional” medical therapies whereas from 1902 onwards after Ashanti control had been toppled by the British, the colonial administration accentuated European medication. During the twentieth century, Konadu asserts that Indigenous African healing systems were considered the dominant and highly utilized medical approach in countries in Southern and Eastern Africa, stretching from Ethiopia, Tanzania, South Africa, and Zambia to Cameroon, Nigeria, and the Gold Coast.⁴³

⁴¹ Phillips, Howard, *Black October: The impact of the Spanish influenza epidemic of 1918 on South Africa*, 1984, 2.

⁴² Adu-Gyamfi, Samuel, *A Historical Study of The Impact of Colonial Rule on Indigenous Medical Practices in Ashanti: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumasi, 1902-1957* (PhD diss., 2010), 3

⁴³ Konadu, Kwasi. “Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and encounters with (Medical) Anthropology.” *African Studies Quarterly* 10, no. 2 and 3 (2008): 45

Thesis statement

This thesis seeks to examine the strategies and policies that were employed by the British colonial administration to control the 1918-1919 influenza epidemic in Ashanti. It highlights the colonial administration's beliefs (Eurocentric) regarding medicine as well as the African belief systems concerning health and medicine. The thesis seeks to further examine how the varying philosophies of the colonial administration and the Natives on medicine influenced the response trajectory to the disease.

Fig.1.0. below shows the location of the West African region of Ashanti on the political map of Ghana.



Fig.1.0. The Political Map of Ghana ⁴⁴

⁴⁴ Political Map of Ghana. Accessed on January 1, 2022 on https://www.nationsonline.org/oneworld/map/ghana_map.htm

Ghana is a country in West Africa, located on the coast of the Gulf of Guinea, and shares its international boundary with Côte d'Ivoire in the west, Burkina Faso in the north, and Togo in the east. Trade activities with the Western world including the Portuguese, Dutch, and British among others from the 15th century saw the influx of Europeans on the coast of the Gold Coast and eventually inland. In the late nineteenth century, Britain fought and conquered Ashanti following a series of wars that eventually broke the camel's back.⁴⁵ The British declared Ashanti a colony in 1902 and began the implementation of colonial policies including health policies in the region. Below is Fig 2.0. showing the areas in Ashanti in which colonial activities were centered.

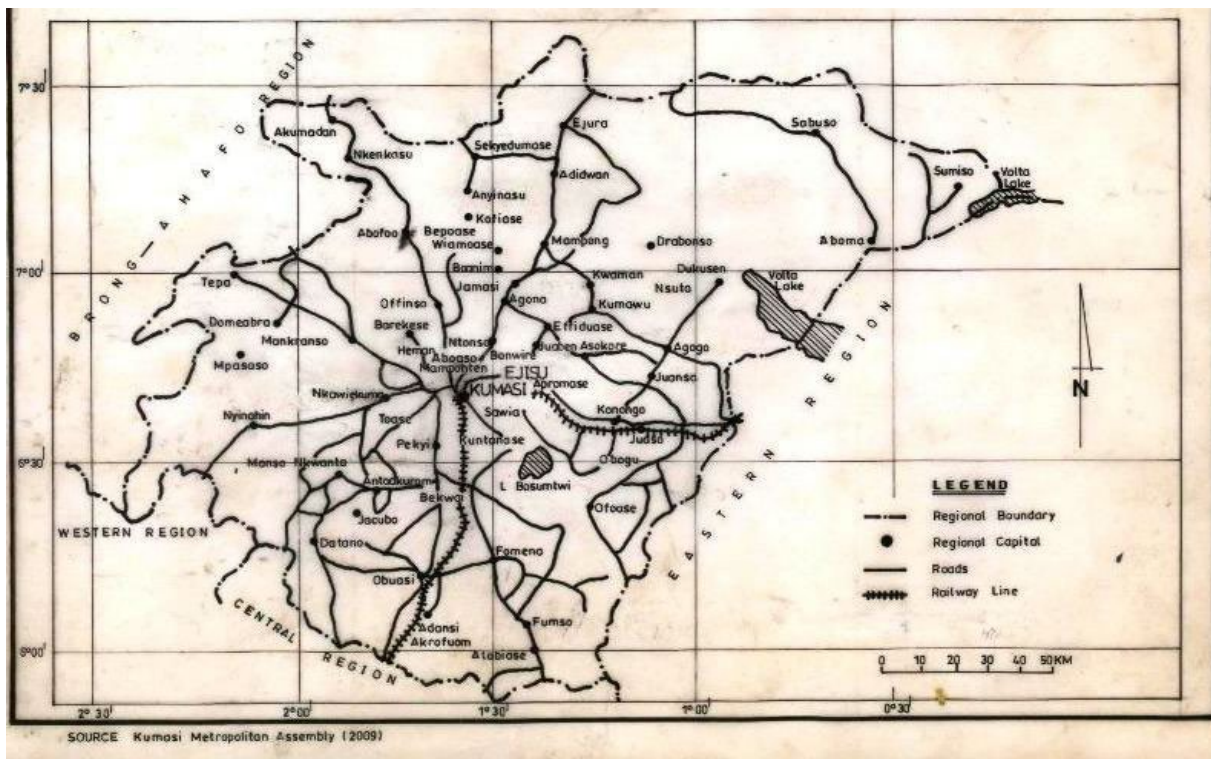


Fig. 2.0. Areas in Ashanti that became influenced by colonial administration's health policies.⁴⁶

⁴⁵ Abaka, Edmund, and Kwame Osei Kwarteng (Eds.), *The Asante World*, (Routledge, 2021) 1

⁴⁶ Adu-Gyamfi, Samuel, *A Historical Study of The Impact of Colonial Rule on Indigenous Medical Practices in Ashanti: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumasi, 1902-1957* (Published PhD diss., 2010), 25

Aim and Research Questions

The study aims at examining with ample historical evidence how varying philosophies of the colonial administration and the Natives on medicine influenced the response trajectory to the influenza epidemic in Ashanti. The following questions were relied on to achieve the aim of the study.

First, what was the Indigenous conceptualization of health, disease, and medicine? The study investigated how Indigenous archives of Ashanti cultural knowledge conceptualized and interpreted diseases, medicine, and healing.

Also, what policies and strategies were adopted by the colonial administration in Ashanti during the influenza epidemic? The study highlighted the policies and strategies that were adopted by the colonial administration to combat the influenza epidemic of 1918 to 1919 in Ashanti and why some of the policies were unsuccessful.

In addition, how did the Native population respond to the influenza epidemic of 1918 to 1919? The thesis examined how Indigenous understanding of diseases affected the responses of the Native population to the influenza of 1918 to 1919 in Ashanti.

Theoretical Assumption

A study such as this, that deals with the understanding of concepts that influences human decisions and actions requires a model. This paper uses an ethno-epidemiological perspective to describe and analyze the Indigenous belief systems of Ashanti that influenced the people's understanding of diseases and health, particularly the influenza epidemic of 1918 and 1919. To generate an ethnomedical description and explanation of the conflict of ideas that were activated at the time of the epidemic, the study considers Arthur Kleinman's explanatory model as the best fit. It is worth considering, that Kleinman's explanatory model focuses on patients and

practitioners. Yet, it is useful to this study because it presents an umbrella definition of the differences in interactions between different social groups in terms of diseases and medicine.

The explanatory model looks at the understanding of episodes of sickness and their treatment that are employed by different practitioners. According to Kleinman, the study of the explanatory model explains how practitioners understand and treat diseases.⁴⁷ In considering this model, Kleinman argues that every disease has an explanatory model yet the explanation for each disease episode is marshaled in response to that disease.⁴⁸ This means explanatory models deal with specific explanations about disease episodes rather than general beliefs. Additionally, the model indicates that the explanatory model is based on a cognitive system that directs the reasoning of its practitioners along certain lines within its social group. The knowledge or ideas acquired by a particular group in understanding and treating disease episodes are influenced largely by their way of life (culture). In the case of the influenza epidemic of 1918 in Ashanti, the thesis looks at how the people of Ashanti understood the presence of the disease and their responses to the colonial policies. It highlights how Indigenous belief systems and culture influenced the people's understanding of the influenza epidemic. Additionally, George Luber acknowledges that an individual's setting can influence his explanatory model. For instance, he argues that an anthropologist who is familiar with Native customs and accompanied by a Native collaborator is likely to provide an accurate explanatory model for an illness.⁴⁹

In an argument that considers two different groups with varying philosophies about a disease episode, it is worth considering the best approach to elicit an accurate explanation model.

⁴⁷ Kleinman, Arthur, *Patients, and healers in the context of culture* (University of California press, 1980), 105

⁴⁸ Kleinman, Arthur, *Patients, and healers in the context of culture*, 104

⁴⁹ Luber, George E, *An Explanatory Model for the Maya Ethnomedical Syndrome Cha'lam tsots* (Journal of Ecological Anthropology) 3, no. 1 (1999): 16

Kleinman presents two main models within the explanatory model: the practitioner model and the lay model. According to Kleinman, the practitioner model considers explanations given by those engaged in the clinical processes to their patients whereas the lay model looks at a self-reflective model of an individual. The practitioner model represents the colonial administration and its policies which they explained and treated influenza through their understanding of sickness which was largely based on science. According to Luber, the home elicited model or lay model helps to obtain an accurate description of an individual's model. The home elicited model "usually represents a more accurate and full disclosure of the patient's model."⁵⁰ Oral traditions of African societies show that knowledge of Indigenous medicine was passed on from one generation to another. Adu-Gyamfi has argued that the functions of society are determined by their set objectives, which emanate from their needs and are mostly influenced by their way of life or culture.⁵¹ Adu-Gyamfi's argument certifies the assertion that Ashanti's Indigenous culture influenced the way the society was organized to meet certain needs. Thus, the current study suggests the lay model as the best fit in the case of the influenza epidemic in Ashanti.

The model thus shows that to formulate and implement healing strategies in societies, it is important to understand the standardized and uniform practices and observances of the people living in the society. Again, it indicates that healing strategies tailored towards explaining an individual explanatory model should take specific rather than holistic approaches.

⁵⁰ Luber, George E, *An Explanatory Model for the Maya Ethnomedical Syndrome Cha'lam tsots*, 16

⁵¹ Adu-Gyamfi, Samuel, *A Historical Study of The Impact of Colonial Rule on Indigenous Medical Practices in Ashanti: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumasi, 1902-1957*, (PhD diss., 2010), 18.

Method of Study

Historical records have shown that the sources required for the study of historical epidemiology are oftentimes limited and when available lack accuracy. This is evident in the case of the influenza epidemic of 1918 in Africa as several of the available data lack detailed and accurate demographic and medical data. For this thesis, I used the qualitative research approach to explain the motivation behind the actions of the colonial administration as well as the Natives. Again, this approach helped to understand Native interactions and how they responded to their natural environment. The source materials that were used were archival sources including reports, letters, publications, and oral histories. Primary materials that consist of strictly archival sources were obtained from two archives in Ghana. The archival records were obtained from two archives: the Public Records and Archives Administration (PRAAD), and the Manhyia Archives of Ghana (MAG) in Accra and Kumasi respectively. In Accra, I obtained information on the medical and sanitary reports for 1918 and 1919 on the Gold Coast. Accra was and is the colonial capital of Ghana and the seat of the Colonial Secretary during the colonial era. Colonial laws on medicine and sanitation were first implemented in this area. These were subsequently preserved in the national archives, established by the colonial government in 1946. Other materials that were accessed from the national archives include epidemiological surveys on the general health status of the people of the Gold Coast in 1918 and 1919. I used these data to ascertain the scenery and impact of the disease in the Gold Coast and Ashanti. Again, the reports facilitated an understanding of the general health interventions that were implemented by the colonial government to prevent or cure different diseases in the Gold Coast in 1918 and 1919.

The other archival materials were gleaned from Manhyia archives in Kumasi. Kumasi was the colonial capital of Ashanti and the seat of the Ashanti imperial palace until it was conquered

for the first time in 1874 by British forces. After its formal occupation by the British in 1896, Ashanti's imperial power was subtly recognized while European political power became dominant. The Manhyia Palace, which was and is currently the home to the King of Ashanti also housed the Manhyia Records Office (presently named Manhyia archives) was an establishment of the Ashanti Research Project. Materials that are found in the Manhyia archives include files of the old Native Authorities and State Councils, the records of the Native Tribunals and Native Courts, and records of the Ashanti Confederacy (and later Asanteman) Council.⁵² In Manhyia, I used information on the correspondence between the colonial government and the health officials at the time of the disease. These include letters from district officers, provincial officers, provincial medical officer, and the chief commissioner of Ashanti on the influenza epidemic. I used these documents to analyze and understand the impact of colonial hegemony in the area of medicine and the roles that the Asantehene council played in that stead. I also used these documents to show, in various ways, how colonial administrators defined and understood the outbreak of influenza in the Gold Coast. Due to the overarching circumstances of COVID 19 with the restrictions put on travels, I sought assistance from archivists, friends, and colleagues in Ghana to facilitate the collection of data.

Again, the ethno-epidemiological explanatory model, reports, and publications on culture and health were useful in this thesis. In this study, Arthur Kleinman's ethno-epidemiological explanatory model was useful in the sense that it helped in explaining the Indigenous understanding of health, illness, and use of African medical therapies and why this influenced the people's response to the influenza epidemic.

Other useful sources for this thesis are published works about the history of medicine, anthropology, and medical sociology. Some of the major works include David Patterson who

⁵² Manhyia Archives, Kumasi, Ghana. <http://www.manhyiaarchives.com/about.php> Accessed on September 1, 2021.

focuses on the spread and impact of the 1918 influenza epidemic on the Gold Coast.⁵³ Sandra Tomkins talks about British policymaking and perceptions of African responses to the 1918 influenza epidemic.⁵⁴ Kwarteng and Osei-Owusu discuss the colonial impact of the 1918 influenza epidemic on the Gold Coast and Ashanti.⁵⁵ Adu-Gyamfi and others have done a comparative study of the colonial policies adopted by the British colonial administration during the influenza epidemic of 1918 in Ashanti and the measures taken by governments in the twenty-first century to fight COVID-19. Emmanuel Akyeampong reviews some of the epidemiological and physiological challenges in West Africa and how Africans adapted to such challenges. He also looks at the religious interactions in West Africa before the twentieth century.⁵⁶ Gale has written on the medical policy that was adopted in West Africa by the colonial government from 1870 to 1930.⁵⁷ Kwasi Konadu has looked at Indigenous knowledge and beliefs in African societies.⁵⁸ David Arnold has focused on imperial medicine and its impact on Indigenous societies.⁵⁹ Patrick Twumasi presents a comparative study of Indigenous medical knowledge and modern medicine.⁶⁰ Stephen Addae looks at the impact of Western medicine in the Gold Coast.⁶¹

These scholarly materials corroborate the primary data to make insightful analyses on the occurrence of the influenza epidemic in Ashanti.

⁵³ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983)

⁵⁴ Tomkins, Sandra M. "Colonial Administration in British Africa during the Influenza Epidemic of 1918–19." *Canadian Journal of African Studies/La Revue Canadienne des Études Africaines* 28, no. 1 (1994).

⁵⁵ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in *"Africa and the First World War: Remembrance, Memories and Representations After 100 Years.*

⁵⁶ Akyeampong, Emmanuel Kwaku (Ed.) *Themes in West Africa's history*, 2006

⁵⁷ Gale, T. S., *Official medical policy in British West Africa 1870-1930* (PhD diss., School of Oriental and African Studies University of London 1972)

⁵⁸ Konadu, Kwasi B, *Indigenous medicine and knowledge in African society* (Routledge, 2007)

⁵⁹ Arnold, David (Ed.), *Imperial medicine and indigenous societies* (Manchester: Manchester University Press, 1988)

⁶⁰ Twumasi, Patrick A. "Colonialism and international health: A study in social change in Ghana." *Social Science & Medicine. Part B: Medical Anthropology* 15, no. 2 (1981)

⁶¹ Addae, Stephen. *The evolution of modern medicine in a developing country: Ghana 1880-1960* (Durham Academic Press 1996)

Significance of the Study

Epidemics arouse concerns of governments and organizations to devise solutions that could solve the challenges that the world face in healthcare. The interventions by governments in 2020 to stop the spread of the COVID 19 virus yielded some results. Yet, some countries in Africa like South Africa, Tunisia, and Egypt continued to witness severe mortality consequences. This study provides immense information on the British colonial administration's interventions in Ashanti in 1918 with an analysis of how colonial motives influenced the implementation of policies in Ashanti. In addition, the historical background of the 1918 influenza epidemic in Europe, America, and Africa presented in this study is to educate readers on how colonial framework including war-time shipping resulted in an epidemiological transition in the world's health history. Moreover, the study highlights how the understanding of belief systems of people affects their response to health interventions and events including diseases. This would expose possible constraints to the implementation of governments and stakeholders' interventions in some countries, particularly in Africa. It is intended that this thesis will create awareness among policymakers to employ the central theme of historical studies, continuity, and change over time, to solve the societal problems we have today. To effectively do so is to involve historians in the policy-making process to guide future policy interventions.

Chapter Outline

The thesis is organized into five chapters. The first chapter comprises the introduction which presents a background to the study and historical context, thesis statement, aim, and research questions, theoretical assumption, method of the study, the significance of the study, and organization of the study. The background and historical context of the outbreak of influenza in countries in Europe, North America, and Africa were very important to the study since they helped

to trace the origins of the disease. Emphasis is placed on the Gold Coast and Ashanti because that is the area of the study.

The second chapter presents an extensive review of relevant scholarly works including articles, books, and related interdisciplinary topics. Importantly, this chapter draws from the works of significant scholars in the field to indicate or highlight the culture, religious belief system, and conceptualization of diseases by the colonial administration and the Indigenous people of Ashanti. The review of scholarly works in this chapter was organized thematically to highlight contributions by some scholars in the field and aspects of their research that needs further research.

Chapter three discusses the policies and strategies that were adopted by the colonial administration to combat the influenza epidemic in Ashanti and why some of the policies were unsuccessful.

The fourth chapter examined the responses from the Natives of Ashanti and how their Indigenous belief systems impacted colonial policies.

The final chapter provides a conclusion and a summary of all the discussions.

CHAPTER II: HISTORIOGRAPHY

Any considerations of diseases in Africa especially infectious diseases during the colonial period must of course look at authorities whose works have projected extensively on the health environment in Africa. Notable scholars include David Patterson, Stephen Addae, Patrick Twumasi, and David Arnold. These scholars have not only looked at the impact of European public health policies in Africa, but they have also emphasized the role of local theories and cures in solving the health conditions among Indigenous peoples. In spite of this, their contributions seem to be subjected to the effects of colonial health interventions in British colonies in Africa rather than the attitude of some Africans towards those interventions and the outcome of such actions. Admittedly, there is some mention of Africans' attitude towards European health interventions, yet these arguments have rarely captured the results of such actions. The literature review in this chapter has been organized thematically to identify aspects of their research that needs attention, particularly regarding the influenza epidemic of 1918 and other infectious diseases in the Gold Coast and Ashanti during the colonial period. Relevant areas that have been explored include the nature, outbreak, and spread of influenza in the Gold Coast from 1918 to 1919, European conceptualization of diseases and medicine, Indigenous conception of diseases, and colonial medical policy in British colonies in West Africa from 1870 to the early 1900s.

Nature, Outbreak and Spread of Influenza in the Gold Coast from 1918 to 1919

According to Tomkins, the earliest appearance of influenza in Africa was in Sierra Leone in August 1918, from England through a Royal Navy warship and later spread rapidly to other territories of British West Africa.⁶² To allow naval operations to continue uninterrupted, the

⁶² Tomkins, Sandra M. "Colonial Administration in British Africa during the Influenza Epidemic of 1918–19." *Canadian Journal of African Studies/La Revue Canadienne des Études Africaines* 28, no. 1 (1994):64.

colonial authorities made no serious attempt to place restrictions on the movement of passengers.⁶³ Consequently, by the time information concerning the epidemic reached the Gold Coast, it was late as almost every ship that came from Sierra Leone had been infected. Patterson acknowledges that a call was made from the Governor in Sierra Leone to his counterpart in Accra to inform him of identified traces.⁶⁴ Yet, this was to no avail. The colonial administration's passive response to influenza in the African colonies shows that they underestimated the disease in the first place. Similarly, in England and other countries in Europe, scholarship on the influenza of 1918 has shown that officials ignored the signs of the epidemic.

In the Gold Coast, Akyeampong and Patterson contend that influenza was not unknown to the country before 1918; that of 1891 had earlier on led to several deaths in parts of the country.⁶⁵ However, the colonial officials like their counterparts in Europe and other parts of the world had little or no information on how to treat the disease.⁶⁶ Essentially, the occurrence of the influenza of 1918 and its economic and social impact on the Gold Coast cannot be compared to any other destructive epidemic in the country's health history. Patterson argues that the disease affected all the villages in the Gold Coast and neither the local authorities nor the colonial officials could prevent it.⁶⁷ Scholars have recorded that several measures were initiated by the government, yet the extent to which the disease spread shows that those interventions failed.

According to Patterson influenza spread faster and unexpectedly from the coastal regions toward the interior. He mentions that the first case among the coastal towns was recorded in

⁶³ Phillips, Howard, *Influenza Pandemic (Africa)* (Encyclopaedia of the First World War. Berlin: Freie Universität Berlin. <https://encyclopedia.1914.de/>).

⁶⁴ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983):206

⁶⁵ Akyeampong, Emmanuel Kwaku (Ed.), *Themes in West Africa's history*, 200; Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 206.

⁶⁶ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 206

⁶⁷ Patterson, K. David *The influenza epidemic of 1918–19 in the Gold Coast*, 205.

Saltpond on 21st September and later got to its height by the first week of October.⁶⁸ However, he fails to acknowledge the movement of people as a major contributing factor to the spread of the disease. He limits the causes of the unusual spread of influenza to factors including negligence by the colonial officials, the unserious attempt to maintain a quarantine in the Gold Coast, financial constraints in the medical department, and the lack of qualified medical personnel. The movement of people from places that were hit harder by the epidemic (the north) to the south cannot be overlooked. In the Gold Coast, Akyeampong asserts that influenza reached Ashanti through the movement of people which contributed to the spread of the disease in the region. Historical records from the fifteenth century have emphasized that the Akan (consisting of several matrilineal clans including Ashanti), during the era of the slave trade imported many slaves due to the overconcentration of slaves in slums. Hence, the rapid movements led to the presence of a hostile disease environment in Ashanti and its environs.⁶⁹ Akyeampong argues that the movement of people in the pre-colonial era helped them to escape many of the parasites and disease organisms that their predecessors were accustomed to.⁷⁰ Thus, aside from seeking better living conditions in other areas, people migrated or moved to other places to improve their health and wellbeing. It is essential to note that Akyeampong did not focus on the influenza epidemic of 1918 to 1919 in the Gold Coast or Ashanti. Yet, his argument helps to establish that the movement of people during the early 1900s complicated disease patterns. The argument that population movement contributes to the transfer and spread of diseases from one place to another has been acknowledged by several writers including Patterson, Mark Pawson, and Randall Packard. For instance, Patterson asserts that the movement of humans facilitated the transfer of diseases from one place to the other in

⁶⁸ Patterson, K. David *The influenza epidemic of 1918–19 in the Gold Coast*, 141.

⁶⁹ Akyeampong, Emmanuel Kwaku (Ed.), *Themes in West Africa's history*, 191.

⁷⁰ Akyeampong, Emmanuel Kwaku (Ed.), *Themes in West Africa's history*, 186.

Africa. Similarly, Pawson and Packard have observed that the spread of smallpox in Kenya and tuberculosis in South Africa respectively were aided by population movements.⁷¹ Although none of these scholars focused on the mode in which diseases spread in Ashanti, their arguments help to highlight movement as a determining factor in transporting diseases among people.

Aside from people spreading the disease from one place to another, some scholars have acknowledged the role of colonial infrastructure in facilitating the spread of the disease in the British colonies. In Nigeria, Akyeampong posits that the disease was introduced from either Sierra Leone or the Gold Coast and penetrated the interior through railway networks, boats, and roads.⁷² Killingray asserts that in Namibia, railway workers and their families were among the first to be infected and die of the disease.⁷³ In the Gold Coast, the development of transport services in the early 1900s facilitated the spread of influenza. Ntewusu has hinted that by the beginning of the 1900s there was a rapid development of transportation systems in the sense that, colonial policies were modified to expand the various transport networks further north.⁷⁴ The attempt to connect road networks from the south to the north meant that the development of colonial policies regarding transport services contributed to the spread of the disease in Ashanti.

Kwarteng and Osei-Owusu have noted that within four months after influenza had entered the Gold Coast, the disease spread quickly to the northern and southern colonies.⁷⁵ The spread and pattern of the disease show that influenza moved quickly to other regions within a week. As pointed out, the area of entry of the disease to the Gold Coast was at Cape Coast from 31st August,

⁷¹ S. Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992), 40

⁷² Akyeampong, Emmanuel Kwaku (Ed.), *Themes in West Africa's history*, 200

⁷³ Killingray, David. "A new 'imperial disease': The influenza pandemic of 1918–9 and its impact on the British Empire." *Caribbean Quarterly* 49, no. 4 (2003):36

⁷⁴ Ntewusu, S. A., *Serendipity: conducting research on social history in Ghana's Archives* (History in Africa, 41 2012), 419.

⁷⁵ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in "Africa and the First World War: Remembrance, Memories and Representations After 100 Years, 148.

the influenza reached Sekondi on 5th September when a boat arrived at the port of the region. The pattern followed as the Accra region became infected within a week and in the middle of September. Kwarteng and Osei-Owusu continue that the next town to record a case was Koforidua on 19th September, followed by Kumasi on 23rd September. Areas such as Axim and Winneba had their fair share of the epidemic within two days after the Ashanti territory had been infected. In the Ashanti territories, Patterson explains that Obuasi recorded its first case on 1st October, followed by Wenchi, Kintampo, and Sunyani by the 26th of the same month.⁷⁶

Patterson argues that in the Gold Coast, the epidemic reached its peak in early October.⁷⁷ As the disease spread rapidly in the southern colonies and penetrated extensively in the interior, the northern territories were not left out. Addae postulates that the disease entered the Northern Territories through two main entry points: a northerly spread from the South (mostly the Ashanti territories) and the French Territories (mainly from the Upper Volta).⁷⁸ Although Addae fails to point out particular areas the disease spread from Ashanti, reports on the pattern of distribution of the disease suggest that the northern province of Ashanti was hit the most. Adu-Gyamfi suggests that perhaps this was due to how villages were situated close to each other in the northern province of Ashanti which may have led to the fast spread of the disease.⁷⁹ This could be the case for the spread of the disease in other parts of Africa as some places recorded high cases of infection than others. In the northern territories of the Gold Coast, Patterson, Kwarteng, and Osei-Owusu agree that Yeji was the first town in the northern region to record some cases of infection in early

⁷⁶ Patterson, K. David, *The influenza epidemic of 1918–19 in the Gold Coast* (The Journal of African History 24, no. 4 1983), 208

⁷⁷ Patterson, K. David, *The influenza epidemic of 1918–19 in the Gold Coast*, 207

⁷⁸ Addae, Stephen, *The evolution of modern medicine in a developing country: Ghana 1880-1960* (Durham Academic Press 1996), 351

⁷⁹ Adu-Gyamfi, Samuel. "The influenza pandemic in colonial Asante: Lesson drawing for the fight against COVID-19 in the twenty-first century." *Revista de Etnologie și Culturologie* 30 (2021): 13

October.⁸⁰ Bole followed in late October with Tamale and Salaga recording cases in early November. Lawra, Wa, and other towns in the North recorded some cases in the same month.⁸¹

It is worth emphasizing that Patterson, Adu-Gyamfi and Kwarteng, and Osei-Owusu agree on the distribution pattern of the disease in the Gold Coast. However, the authors fail to highlight activities (policies or measures) of the colonial authorities that contributed to the spread of the disease in some parts of the Gold Coast. It may be right to say that the initial distribution pattern of the disease was beyond the control of the colonial administration. The measures that were adopted by the colonial administration were to mitigate the awful spread of the disease rather than control the distribution pattern of the disease. Yet, as I argue, some of the colonial measures made the situation worse and consequently led to the spread of the disease in parts of Ashanti that hitherto could have been prevented.

As observed, Patterson centers his arguments on the widespread nature of the influenza epidemic in the Gold Coast and colonial interventions that were introduced to control the disease. In the same light, Kwarteng and Osei-Owusu have emphasized the factors that facilitated the spread of influenza and the roles played by the colonial authorities to control it. Lastly, Adu-Gyamfi's research is a build-up on Kwarteng and Osei-Owusu's work since he focuses on comparing the strategies deployed during the influenza epidemic of 1918 and the measures adopted to fight the COVID-19 pandemic in 2020. In looking at the impact of the influenza epidemic of 1918 to 1919, the works of Kwarteng and Osei-Owusu, and Adu-Gyamfi remain the closest that can be found on Ashanti. Yet, the same research leaves a significant historical gap. None of these

⁸⁰ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919 in Africa and the First World War: Remembrance, Memories and Representations After 100 Years*, 149; Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 208

⁸¹ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919*, 208

historians have made arguments towards the possibilities of varying philosophies of the colonial administration and the Natives on medicine contributing to the adoption of colonial health policies.

Indigenous Conception of Disease

In a study that looks at Indigenous understanding of diseases, it is necessary to explore Indigenous knowledge. Konadu defines Indigenous knowledge as “the collective body of knowledge of the ways in which people respond to reality.”⁸² Thus the experiences, reasoning or imagination, and the occurrence of particular events affects people’s thinking and way of life. In the same manner, Dahlberg defines it as “the unique, traditional, local knowledge existing within and developed around the specific conditions of women and men Indigenous to a particular area.”⁸³ These definitions recognize the fact that culture plays a major role in influencing people’s understanding of particular events including diseases. Dahlberg further explains that knowledge systems among Indigenous societies are subjected to continuity and change, thus they are “dynamic and represent generations of experiences and experiments, where new knowledge is continually added and irrelevant knowledge is lost.”⁸⁴ However, it should be emphasized that any changes or adaptation of external knowledge in Indigenous medical practices are usually within the scope of the people’s local culture or accepted practices.

Oral traditions have shown that in most African societies, the health of an individual transcends the physical world. According to Twumasi, a relationship exists between the physical and supernatural world.⁸⁵ The traditional philosophy of disease is founded on the premise that

⁸² Konadu, Kwasi B, *Indigenous medicine and knowledge in African society*, 2007.

⁸³ Dahlberg, Annika C., and Sophie B. Trygger, *Indigenous medicine and primary health care: The importance of lay knowledge and use of medicinal plants in rural South Africa*, *Human Ecology* 37, no. 1 (2009): 80

⁸⁴ Dahlberg, Annika C., and Sophie B. Trygger. *Indigenous medicine and primary health care: The importance of lay knowledge and use of medicinal plants in rural South Africa*, 2009, 80

⁸⁵ Twumasi A. Patrick, *Medical Systems in Ghana, A Study of Medical Sociology* (Accra: Ghana Publishing Corporation 1975), 10

human beings are “tripartite beings consisting of mind (soul), body and spirit.”⁸⁶ Thus, the enjoyment of good health, therefore, means the presence of a peaceful harmony among the body, mind (soul), and spirit.⁸⁷ This social orientation defines the link between the supernatural or spiritual and physical world. In this regard, diseases or sicknesses in African traditional societies are the consequences of failing to observe the laws of nature. If individuals fail to conform to societal norms, it is believed that the spirits visit them and inflict diseases or sickness on them, sometimes their families.

Despite the spiritual inference of diseases, Twumasi has argued that some diseases are believed to be caused by microbes in the environment.⁸⁸ Thus, healing strategies in traditional societies are geared towards the utilization of both natural (physical) and supernatural (spiritual) remedies. Table 1.0 below shows some varied categories of diseases present in Ashanti and corresponding explanations or causes attributed to each disease.

Disease Category	Cause	Cure
1. <i>bayie yareε</i> (“witchcraft” diseases, also referred to as <i>sunsum bayie</i>)	This is typical as a result of “bad” medicine in one’s food, jealousy, the work of <i>abayifoε</i> , and <i>bayie</i> that is either inborn or acquired.	Usually, an <i>amulet</i> is hung around the neck of the sick person and the Indigenous healer invokes the spirits to intercede. An <i>amulet</i> is defined as small figure of gods, goddesses, and sacred symbols cut from stones or molded from clay baked and glazed. From the 1900s Amulets were recognized as a charm of protection against various spirits.
2. <i>sunsum yareε</i> (a disease born of or through spiritual means or disease at the spiritual level)	This is among other causative factors, resulting from cursing someone through the use of an <i>εbosom</i> .	

(Table Continues)

⁸⁶ Asante, Emmanuel, *Scientific medical practitioners and traditional medicine in contemporary Ghana: A study of attitudes and perceptions* (PhD diss., University of Cape Coast, 2010), 55

⁸⁷ Asante, Emmanuel, *Scientific medical practitioners and traditional medicine in contemporary Ghana: A study of attitudes and perceptions*, 55.

⁸⁸ Twumasi, Patrick A, *Medical systems in Ghana: A study in medical sociology* (Ghana Publishing Corporation, 2005), 8

3. <i>nka no kwa yaree</i>	This is when a person is inflicted with sickness without any obvious or perceivable cause, but with the understanding that <i>ayaree nka no kwa</i> (disease or sickness does not touch or affect him or her for no reason).	Efforts are usually made to probe this type of sickness or disease more thoroughly.
4. <i>aduto</i> (“negative type of [roasted] medicine”)	This is usually transacted between two people, which may be the response to having sex with someone else’s wife, and where the disease is contracted through harmful or “roasted” medicine on which the victim steps or comes into contact.	
5. <i>abɔdeɛ yaree</i> (nature disease)	This is caused by <i>efi</i> (concept of “dirt” that includes all bodily wastes), polluted water, insects (e.g., flies), an unclean environment, polluted air, or the wind (e.g., airborne diseases), and contaminated river water.	
6. <i>aduane yaree</i> (food disease)	This was derived from bad food, drinking alcohol, consuming tabooed foods, spoiled leftovers, and uncovered foods	
7. <i>mmoaa yaree</i> (germs, bacteria, microorganisms)	These are associated with sexually transmitted disease and gutters, eating where garbage is close by, wearing unwashed clothing (for several days), eating without brushing one’s teeth, germ-filled living conditions, not covering a small child very well when it is windy, and lack of proper hygiene.	
8. <i>duabɔ yaree</i> (cursing)	Refers to a disease caused by cursing someone.	
9. <i>honhom yaree</i> (breath of life)	This refers to diseases borne by an unidentified “kind of spirit”	

(Table Continues)

10. <i>ɔman yareɛ</i> (social disease)	This is used to refer to those diseases which derive from negative social acts, such as stealing or offending one's parents, which can result in psychological illnesses.	Here, the medicine may consist of confessing, apologizing, or both in addition to returning the stolen items, in the case of theft.
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Table 1.0. Local explanations of some diseases in Ashanti.⁸⁹

It should be noted that regardless of the nature of the disease, the people of Ashanti believe that every disease or suffering had meaning. Thus, diseases or sicknesses do not affect people for no reason. Actuated by this principle, conscious efforts were made at every stage to probe and explain all events to order to find remedies for them. This form of understanding held collectively by the people made the roles of Native physicians relevant in the Ashanti society. As Bosman puts it, Native physicians were believed to have acquired unquestionable knowledge about Indigenous medical therapies.⁹⁰ Usually, when families visited their Native physicians, they looked for answers to questions like “Why did it happen?” but “Why did it happen to us?” and possibly “Who caused it?” and “What should we do about it?”⁹¹ As Janzen and Green note,

“Usually, consultation with a diviner is not undertaken until there is sufficient reason in the kin group of the sufferer to suspect causes other than natural ones. Such a precipitating factor may be the worsening turn of a sick person, a sudden and mysterious death, the coincidence of sickness with a conflict in the close social environment of the sufferer, or the paradoxical occurrence of a disease on only one side of a family. In such cases the clients are looking for answers to questions not only of “Why did it happen?” but

⁸⁹ Konadu, Kwasi B, *Indigenous medicine and knowledge in African society*, 86.

⁹⁰ Bosman, William, *A new and accurate description of the coast of Guinea: divided into the Gold, the Slave, and the Ivory coasts*, (Cass, 1967), 223. Bosman was a Dutch merchant who sailed to the Gold Coast and gave a detailed account of the activities of the Native population including how they maintained their health.

⁹¹ Janzen, John M., and Edward C. Green, *Medicine in Africa*, (Encyclopedia of the History of Science, Technology, and Medicine in Non-Western Cultures, 3rd edition, Dordrecht: Springer Netherlands 2016), 4

“Why did it happen to us?” and possibly “Who caused it?” and “What should we do about it?”⁹²

These types of enquires show that Native physicians were believed to be able to cure all manner of diseases regardless of their nature. Again, it establishes a clear distinction between the European doctor who employs Western science in his practice and the Native physician who adheres to divination. For instance, the European doctor may answer all the questions above but not “Why did it happen to us?”. This is because scientific explanations of diseases are not directed to any one person. While the European doctor may attribute the cause of a disease to an individual’s physiology and the environment, the Native physician due to his belief in the combination of naturalistic and supernatural causal factors may attribute the disease to either human cause or God-cause. Thus, this type of inquiry requires an answer from a Native physician who is an expert in that regard.

The various ways through which one could become a Native physician in Ashanti as outlined by some scholars include spirit possession, association with dwarfs, revelations, close relatives, and well-known practitioners. According to Twumasi and Ashanti, there is no fixed approach to becoming an Indigenous healer.⁹³ Yet, there are the “don’ts” that are considered taboos in all the training processes. For example, Emmanuel Asante points out that a person who receives training through spiritual possession is not allowed to use a comb, dress his or her hair, or shave any part of the body for the period of his or her training (three years).⁹⁴ Also, Indigenous healers who claimed they received their knowledge of herbs through dreams or revelations could identify

⁹² Janzen and Green, *Medicine in Africa*, 5

⁹³ Asante, Emmanuel, *Scientific medical practitioners and traditional medicine in contemporary Ghana: A study of attitudes and perceptions*, (PhD diss., University of Cape Coast, 2010), 59; Twumasi, Patrick A, *History of pluralistic medical systems: a sociological analysis of the Ghanaian case*, African Issues 9, no. 3 (1979)

⁹⁴ Asante, Emmanuel, *Scientific medical practitioners and traditional medicine in contemporary Ghana: A study of attitudes and perceptions*, 59

the color, size, and shape of a plant and then link it to the illness to be cured. For example, seeds shaped like fingers could suggest a cure for the festered thumb and a nut that looks like the heart could also manage cardiac illnesses.⁹⁵ The above observations suggest that the medicinal knowledge of Indigenous healers was unquestionable and could not be subjected to any form of scientific or laboratory explanation. Bosman argues that the efficacy of the medicine administered by the Indigenous healers is testified by their clients. The Indigenous healer is never accused of falsehood in case a person dies in the process of administering therapy to him or her. Also, if his predictions came to pass, he was rewarded very well.⁹⁶ Significantly, the belief in the ministrations of the Indigenous healer and his medicine helped curb certain behaviors and lifestyles that were abhorred in society. Some of these behaviors could attract repercussions on the physical and psychological health of the deviant.⁹⁷ The implication is that not only did the belief in the supernatural help in protecting the health of the people but also helped to correct behaviors in society.

European Conceptualization of Disease and Medicine

The term Western medicine has gained a place as an area of discussion because of its role in advancing science and producing effective therapies. The accounts of the history, understanding, and approaches of Western medicine have been examined by several scholars including Patrick Twumasi and Opoku-Mensah. Twumasi contends that Western medicine (also known as scientific medicine) functions in a particular social organization that operates largely on the germ theory of

⁹⁵ Asante, Emmanuel, *Scientific medical practitioners, and traditional medicine in contemporary Ghana: A study of attitudes and perceptions*, 59

⁹⁶ Bosman, William, *A new and accurate description of the coast of Guinea: divided into the Gold, the Slave, and the Ivory coasts*, 222.

⁹⁷ Adu-Gyamfi, Samuel, *A Historical Study of The Impact of Colonial Rule on Indigenous Medical Practices in Ashanti: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumasi, 1902-1957*, (Published PhD. dissertation 2010).

disease.⁹⁸ Relatedly, Opoku-Mensah defines it as “any medical system that is based on sound biomedical research and is considered foreign to African culture.”⁹⁹ What these definitions or explanations have in common is the fact that Western medicine favors the scientific explanation of diseases. Western medicine is associated with diseases that affect the physical body only and its administration is based on the provision of healthcare in hospitals clinics etc. According to Emmanuel Asante, advocates of Western medicine believe in the notion that the human body is just like a machine that could be analyzed in terms of its parts. Diseases could be detected when the machine broke down. Thus, Western medicine played its role rationally by probing into the cause and effect and consequently, a solution is found on that premise.¹⁰⁰ Adu-Gyamfi notes that the clinical advances of Western medicine in promoting good health practices make it useful in society. During the colonial era, the introduction and application of Western medicine by the British colonial administration in most of their colonies in Africa was due to the nature of colonial activities in the area. Kojo Sena has argued that the history and development of Western medicine in the Gold Coast can be explained by considering the nature of the political and economic relationship that prevailed between the Gold Coast and Britain.¹⁰¹ Essentially, the application and understanding of the germ theory of diseases helped colonial health officials to emphasize the importance of some health practices such as hand washing and covering the mouth and nose to prevent the transmission of influenza and other communicable diseases.¹⁰²

⁹⁸ Twumasi, Patrick A, *History of pluralistic medical systems: a sociological analysis of the Ghanaian case*, African Issues 9, no. 3 (1979):32.

⁹⁹ Opoku-Mensah, Foster Abrampa, *Integrating traditional and orthodox medicines in healthcare delivery in Ghana: a study of Wenchi municipality*, (PhD diss., University of Ghana), 2015, 10.

¹⁰⁰ Asante, Emmanuel, *Scientific medical practitioners, and traditional medicine in contemporary Ghana: A study of attitudes and perceptions*, 32.

¹⁰¹ Senah, Kojo. "In sickness and in health: Globalization and health care delivery in Ghana." *Institute of African Studies Research Review* 17, no. 1 (2001): 83

¹⁰² Beach, Brian, Karen Clay, and Martin H. Saavedra, *The 1918 influenza pandemic and its lessons for COVID-19*, 14.

David Arnold has emphasized that the nineteenth and twentieth centuries brought significant changes in the history of Western medicine.¹⁰³ He stated that scholarly works between the nineteenth and twentieth centuries focused on:

“... identifying diseases and medicine as a site of contact, conflict and possible eventual convergence between western rulers and indigenous peoples, by illustrating the contradictions and rivalries within the imperial order itself, by identifying the importance of medicine and disease to the ideological and political framework of empire, and by drawing attention to the role of medical agencies and practices in shaping the impact and identity of colonial regimes....”¹⁰⁴

According to Arnold, an understanding of medicine and disease within the nineteenth and twentieth centuries describes the relationship of power and authority between rulers and ruled and between colonialism's constituents.¹⁰⁵ Arnold's argument suggests that colonial influences, as well as changes within European territories, led to a shift in the understanding and roles of medicine and disease. Many people began to utilize or incorporate Western medical therapies into their healing process. The argument that diverse understandings of medicine and disease impacted the political framework of the colonial administration is supported by Gale and Adu-Gyamfi. Gale believes that medical policy was linked to the changing political goals of Britain during the colonial era.¹⁰⁶ Similarly, Adu-Gyamfi postulates that the colonial administration showed commitment toward improving the lives of Indigenous people partly because of their self-

¹⁰³ Arnold, David (Ed.), *Imperial medicine and indigenous societies*, (Manchester: Manchester University Press, 1988), 2.

¹⁰⁴ Arnold, David (Ed.), *Imperial medicine and indigenous societies*, 2.

¹⁰⁵ Arnold, David, (Ed.) *Imperial medicine and indigenous societies*, 2.

¹⁰⁶ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 1972.

interest.¹⁰⁷ In the case of the outbreak of influenza, the strategies and sometimes directions of colonial policies were tailored towards benefitting colonial goals.

Several scholars have put forward arguments that support the closely linked relationship between colonial medical policies and the political goals of the colonial administration. Perhaps this could be attributed to the colonial administration's desire to claim hegemony in the area of health. The notion of Western medical dominance exhibited by the colonial administration could be traced to an earlier period of Greece and Roman civilization. These eras led to developments such as the political invention of citizenship, arts, medicine, and improvement in agriculture among others.¹⁰⁸ These developments altered the social organization of society in various stages including the practice of medicine. Arnold argues that Africa, Asia, and the Americas were all seen by European colonizers as having hostile and unfavorable environmental conditions as a result of the presence of disease vectors, and only through the superior knowledge and skill of European medicine was it possible to tame them under effective control.¹⁰⁹ Relatedly, Loudon reports that imperialists transferred medicine to their colonial territories as a 'tool of empire' to protect their dominance.¹¹⁰ Therefore, the colonial administration perceived Western medicine to be an antidote to all manner of ailments including local diseases in West Africa.

It is worth considering that the spread of Western medicine was accompanied by the spread of diseases in European settlements. Loudon reveals that European settlers in the Americas, Australasia, and southern Africa introduced diseases such as smallpox and measles to their African

¹⁰⁷ Adu-Gyamfi, Samuel, Razak Mohammed Gyasi, Dennis Baffour Awuah, Richard Oware, and Samuel Kwame Ampadu. "Western Medicine in a Community in Ghana: A Social Change Review." *Social Change Review* 17, no. 1 (2019): 64.

¹⁰⁸ Goldstone, Jack A. "The origins of Western superiority: a comment on modes of meta-History and Duchesne's Indo-Europeans Article." *Cliodynamics* 4, no. 1 (2013). 54

¹⁰⁹ Arnold, David, (Ed.), *Imperial medicine and indigenous societies*, 3

¹¹⁰ Loudon, Irvine, (Ed.), *Western medicine: an illustrated history* (Oxford University Press, 2001), 253.

territories to which the Indigenous peoples had no immunity.¹¹¹ He explains that as a result of these exposures, Indigenous populations became decimated leading to the massive destruction of their societies. Akyeampong buttresses Loudon's argument that most of the diseases in West Africa have been introduced through external contacts, particularly the Atlantic trade.¹¹²

According to Vaughan, the colonial authorities used claims of scientific neutrality of Western medicine to create a bad image for several of the Indigenous medical practices in Africa.¹¹³ She believes that cultural differences had an impact on the understanding, and the way medicine was practiced by both Europeans and traditional societies in Africa. Significantly, Vaughan highlights two schools of thought who have centered their arguments around this view. First, we have those who believed that the "primitiveness" of African societies was a contributing factor to the presence of certain diseases.¹¹⁴ This created a challenge among some Indigenous societies which hitherto utilized Indigenous medicine since it discouraged the colonial administration to accept Indigenous medical practices. The proponents of this notion were largely Christian missionaries. The second school of thought elaborates on a tradition of 'deculturization' which suggests that Africans had forgone their way of life and ventured across boundaries of difference; they had accepted the use of Western medicine.¹¹⁵ The proponents of this view believed in a tradition of social change where human interactions and relationships transformed the cultural and social institutions of Africans. This corroborates Tomkins's assertion that the presence of Western medicine and science in West Africa advanced notions of inadequacy and backwardness in Indigenous societies.¹¹⁶ This explains why the colonial administration made efforts to promote Western medicine at the expense of

¹¹¹ Loudon, Irvine, (Ed), *Western medicine: an illustrated history*, 2001, 251

¹¹² Akyeampong, Emmanuel Kwaku (Ed.), *Themes in West Africa's history*, 187

¹¹³ Vaughan, Megan, *Curing their ills: Colonial power and African illness* (Stanford University Press, 1991), 201

¹¹⁴ Vaughan, Megan, *Curing their ills: Colonial power and African illness*, 201.

¹¹⁵ Vaughan, Megan, *Curing their ills: Colonial power and African illness*, 203.

¹¹⁶ Tomkins, Sandra M. "Colonial Administration in British Africa during the Influenza Epidemic of 1918–19." *Canadian Journal of African Studies/La Revue Canadienne des Études Africaines* 28, no. 1 (1994):62

Indigenous medicine. Vaughan's argument helps to appreciate that cultural interactions are significant in influencing the understanding and practice of medicine of a people in a society. This does not omit the colonial administration's quest to disregard Indigenous medical practices as barbaric, charlatanry, and superstitious. Vaughan's views about the connection between cultural beliefs and diseases are quite similar to some of the views shared by Carothers.

Carothers believes that African culture trapped individuals in a world of illusion that was symbolized by the importance of magic, *juju*, and witchcraft and the lack of objectivity.¹¹⁷ As Frantz Fanon puts it "For the native, objectivity is always directed against him."¹¹⁸ In the state of wrongful conduct, African societies attributed diseases and sicknesses to the roguery of individuals whose actions angered the gods and deities. According to Carothers, these norms or explanations for diseases made it difficult for Africans to mature psychologically. He believed that the belief in witchcraft and other supernatural elements prevented Africans from developing logic and curiosity in their daily lives. It is rather unfortunate that Carothers's representation of Indigenous cultural beliefs and understanding lends itself to increasing misrepresentation and misinterpretation. Carothers did not conduct any fieldwork but turned to publications on the impact of environmental factors on the psychological traits of individuals to draw such connections.¹¹⁹ This draws attention to the fact that the dynamics of contemporary history should be focused on the direct participation of the researcher in knowing the past or things that happen elsewhere. Rather than relying on second-hand information to understand Indigenous culture, ideas, history, power, and politics researchers should endeavor to have a direct engagement with their object of research.

¹¹⁷ Carothers, John Colin, and World Health Organization, *The African mind in health and disease: A study in ethnopsychiatry*, (World Health Organization 1953), 107

¹¹⁸ Quote from and Frantz Fanon in Jonathan Sadowsky's *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria*, (Berkeley: University of Berkeley Press, 1999), 97

¹¹⁹ Carothers, *The African Mind in Health and Diseases*, 115-118.

It should be noted that Carothers's view about cultural beliefs in traditional societies was similar to the perceptions held by the colonial administration, and this led to the formulation and inclusion of certain strategies that were set out in the colonial medical policy in West Africa.

Although the policies set out by the colonial administration were generally geared towards preventing epidemics of different kinds in Africa, there were those policies that were directly implemented to stop the spread of influenza in 1918 and 1919.

Colonial Medical Policy in British colonies in West Africa from 1870 to the early 1900s

The British Colonial Administration led by the Colonial Secretary was based in England, where major colonial policies for the entire British Empire were formulated and executed. Numerous colonial officers manned different departments in the colonies and ensured that colonial policies were enforced. In West Africa, the colonial administration's medical policy recognized the significance of preventive medical care. From the late 1870s, the colonial administration had recognized the need to provide the sanitary needs of their West African colonies as they endeavored to pursue their political goals. In the Gold Coast, Arhinful contends that the British administration introduced an effective medical policy in 1890 for two reasons. These include "consolidation of British power and influence and concern for European health with the principal aim of reducing the abnormally high mortality of Europeans resident in colonial tropical climates, principally due to malaria."¹²⁰ Between 1872 and 1874 onwards British influence began to spread beyond the coast following the defeat of Ashanti in the Sagrenti War. This led to a rapid expansion of administrative activities and the increase of Europeans in the colony. Arhinful estimates that the European population in the Gold Coast by the late 1890s had shot up to six times compared to

¹²⁰ Arhinful, Daniel Kojo, *The solidarity of self-interest: Social and cultural feasibility of rural health insurance in Ghana* (African Studies Centre, Leiden, 2003), 31

what it was in previous years.¹²¹ The population increase, however, created a public health concern as different diseases were introduced into the colony leading to higher deaths among Europeans.

The emergence of the influenza epidemic of 1918 and 19 created a major economic shock that became unbearable since authorities including the colonial administration and Native heads were unprepared for it. Tomkins referencing a quote by MacLeod and Lewis writes,

“When they threatened the status quo, epidemics also created conditions favorable to the consolidation of imperial or government rule. . . . Empires which based their claims of occupation and settlement in part on the moral superiority of European civilization and saw an obligation to secure the safety of their subjects, found their credibility as purveyors of European culture and rational government intricately tied to their power to control the spread of disease.”¹²²

In the case of the influenza epidemic, the colonial administration later acknowledged that the disease was a threat to colonial imperialism and thus, they made efforts to protect colonial interests. According to the Gold Coast medical and sanitary report for 1918, the British government passed a new ordinance cited as the Disease of Animals Ordinance No.27 of 1918.¹²³ This ordinance was passed to give the colonial administration absolute powers to deal with various outbreaks of diseases among Cattle that had devastated the colonies. Again, the colonial administration within the same period made amendments to previous Ordinances to make provisions that could curb infectious diseases that may occur in their territories. For instance, the Order-in-Council No. 32 of 1917 was created to revoke No. 31 of 1917 and declared Axim free from infection. Again, Rule No. 3 of 1918 was created to declare Anthrax as an infectious disease

¹²¹ Arhinful, Daniel Kojo, *The solidarity of self-interest: Social and cultural feasibility of rural health insurance in Ghana*, 31.

¹²² Tomkins, Sandra M. "Colonial Administration in British Africa during the Influenza Epidemic of 1918–19." *Canadian Journal of African Studies/La Revue Canadienne des Études Africaines* 28, no. 1 (1994): 62

¹²³ Gold Coast Medical Department, *Medical and Sanitary Report for the year 1918*, 27.

and make regulations for the notification of anthrax and smallpox. Also, No. 1 of 1918 was created to give full regulation powers to the colonial administration to regulate towns and villages. Lastly, notification by gazette No. 63 of 1918 dated 26/9/18 of the outbreak of influenza at Sierra Leon.¹²⁴ As mentioned, the efforts by the colonial administration to control infectious diseases were not intended to protect the lives of the Indigenous peoples but rather defend colonial motives since these diseases pose a threat to imperialism.

In explaining the motives that shaped colonial medical policy, Gale argues that the only time the colonial government recognized the need to introduce and implement public health measures in their West African colonies was from the 1870s.¹²⁵ The colonial administration acknowledged the responsibility to protect the health needs of their colonial settlements to reduce the loss of European lives. This made the medical policy of the colonial administration increasingly controversial. Gale postulates that British medical policy during the early 1900s placed emphasis on protecting and safeguarding the lives of Europeans and neglected the growing sanitary problems of the African towns.¹²⁶ Similarly, Loudon posits that medical work in European settlements centered on protecting and maintaining the health of European administrators. He attributed this to the small number of medical practitioners who practiced within restricted European territories.¹²⁷ In the Gold Coast, Twumasi notes that British medical officers were responsible for the health needs of the senior administrative officials of the colonial government.¹²⁸ He argues that efforts such as developing separate housing for colonial officials, building bungalows for top government officials, merchants, and officials of mining companies, constructing modern water

¹²⁴ Gold Coast Medical Department, *Medical and Sanitary Report for the year 1918*, 27.

¹²⁵ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 48.

¹²⁶ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 3.

¹²⁷ Loudon, Irvine (Ed.), *Western medicine: an illustrated history* (Oxford University Press, 2001), 253

¹²⁸ Twumasi, Patrick A, *History of pluralistic medical systems: a sociological analysis of the Ghanaian case*, African Issues 9, no. 3 (1979):32.

supply and sanitary disposal of sewerage at concentrated and strategic places, and giving special medical coverage to supporting domestic, clerical and medical staff were all geared towards protecting the health of expatriates.¹²⁹ To some extent, the colonial administration restricted the prevention of diseases among Europeans due to the limited resources available. Significantly, it was only in 1919 that Col. Amery, Under-Secretary of State for the Colonies suggested to the House of Commons that efforts had been made to extend medical services to the Native population in West Africa.¹³⁰ This was following the precarious loss of European lives as a result of the First World War and the outbreak of the influenza epidemic. As Gale suggests, Col. Amery's decision came about because of the desire to construct medical facilities to solve the healthcare needs of colonial officials and to some extent the Native population in their West African colonies.¹³¹ The period 1919, suggests that Col. Amery's decision was influenced by the annihilation of a major populace of the Gold Coast colony including Europeans by influenza in the previous year. Despite his efforts to extend healthcare coverage to the Indigenous people, the health facilities did not exist to fulfill their intended purposes. In terms of providing effective therapy for diseases including local diseases, Gale argues that colonial health facilities through the use of Western medicine could not provide effective remedies for local diseases. Again, the preconceived notions of most Africans towards Western medicine and therapies hindered the effective use of the newly built colonial health facilities.¹³² For instance, he cites an example of one surgeon who was confronted with the challenges of treating patients who did not know why drugs, bandages, or splints were prescribed to treat certain ailments.¹³³

¹²⁹ Twumasi, Patrick A. "Colonialism and international health: A study in social change in Ghana." *Social Science & Medicine. Part B: Medical Anthropology* 15, no. 2 (1981): 147

¹³⁰ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 351

¹³¹ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 115.

¹³² Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 116.

¹³³ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 122.

According to Kwarteng and Osei-Owusu, the state of healthcare facilities and healthcare existed on an ad hoc basis; to serve a specific purpose.¹³⁴ This was following years of neglect of the medical needs of the majority of Africans. For instance, between 1878 and 1915 Europeans had a greater chance of being admitted to a hospital bed than Africans. In 1916, only 2.74 percent of the Natives could benefit from colonial medical treatment.¹³⁵ The deliberate neglect of the medical needs of Africans remained the same with little improvement even in the post-epidemic years up to the mid-1900s.¹³⁶ Medical treatment between Europeans and Africans continued to be imbalanced although there had been an increase in medical facilities during the 1870 and early 1900 periods.¹³⁷

Contrary to Kwarteng and Osei-Owusu's argument, Patterson blamed the poor state of medical infrastructure in the Gold Coast on underfinancing in the medical department and the war.¹³⁸ Although Patterson does not disregard the fact that the colonial administration did little to attend to the health needs of Africans, he failed to acknowledge that the issue of healthcare had never been part of the political goals of the colonial administration. The Eurocentric views by some Europeans towards the medical topography of the African continent which they believed Africans had immunity to, influenced the colonial administration's decision not to extend healthcare to most Africans. For instance, Gale hints at the term "The White Man's Grave" which was a widely known reputation of the African continent and by some Western scholars who tend to label the continent as a threat to human life. Again, Twumasi argues that the colonial administration believed that expatriates needed to benefit from the new medical strategies since they were possible carriers of

¹³⁴ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in *"Africa and the First World War: Remembrance, Memories and Representations After 100 Years*, 122

¹³⁵ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 366

¹³⁶ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919*, 122

¹³⁷ Gale, T. S. *"Official medical policy in British West Africa 1870-1930*, 131

¹³⁸ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 212.

infection.¹³⁹ Thus, it is fair to say that the war had little or no interference with the provision of medical care in the Gold Coast and other British West African colonies.

Another aspect of the colonial medical policy that became controversial was the framers' inability to make provisions for the recruitment of adequate medical officials in their West African colonies. One major challenge that the colonial administration faced was the problem of limited colonial personnel despite their desire to maintain hegemony in the area of medicine. This became a major setback at the time that influenza broke out in the British colonies in West Africa. It should be noted that although the disease broke out at the later stages of the First World War, some scholars believe that activities during the war had a tremendous impact on the continent. According to Kwarteng and Osei-Owusu, circumstances during the war required assistance from medical personnel on the battlefield to take care of several wounded soldiers.¹⁴⁰ As a result, a lot of medical personnel from most countries were called upon to the battlefield. In the Gold Coast, the authors have argued that medical officers who were all Europeans were sent to support the Royal Medical Corps who served in the then German Togo, Cameroons, and East Africa. Thus, the movement or transport of medical officers to the battlefield dented several efforts to control the epidemic since it led to a shortage of medical personnel.¹⁴¹

In contrast, Twumasi contends that although the colonial administration set out to implement health measures that sought to protect the lives of Europeans, as epidemic diseases occurred, they recognized the need to recruit local people for the provision of medical services.¹⁴² For instance,

¹³⁹ Twumasi, Patrick A. "Colonialism and international health: A study in social change in Ghana." *Social Science & Medicine. Part B: Medical Anthropology* 15, no. 2 (1981): 147

¹⁴⁰ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in "Africa and the First World War: Remembrance, Memories and Representations After 100 Years, 153

¹⁴¹ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in "Africa and the First World War: Remembrance, Memories and Representations After 100 Years, 153

¹⁴² Twumasi, Patrick A. "Colonialism and international health: A study in social change in Ghana." *Social Science & Medicine. Part B: Medical Anthropology* 15, no. 2 (1981): 147.

he argues that measures such as building separate housing to protect the health of expatriates were eventually halted after the colonial administration found out that cultural isolation proved ineffective in preventing epidemic diseases. Rather, epidemic diseases could be eradicated if the causative organism was located and neutralized.¹⁴³ He recounts that in 1878, the colonial administration started recruiting local people in nursing, dispensary, and laboratory to bathe and feed the sick, dress wounds, and administer drugs to local populations under European medical supervision.¹⁴⁴

Significantly, the arguments of Kwarteng and Osei-Owusu and Twumasi as contrasting as they might be point to the fact that the colonial administration faced a problem of inadequate medical personnel. However, the authors of both arguments have left significant gaps that need to be filled in this study. In their arguments, Kwarteng and Osei-Owusu failed to establish whether the medical personnel who were sent to the battlefield during the war participated in the war aside from taking care of the soldiers. Again, it is unclear whether the medical personnel died or never returned to their original countries after the war had ended. It is important to note that this information is relevant especially when highlighting the role of medical personnel in Ashanti and the Gold Coast during the influenza epidemic of 1918. On the other hand, it should be emphasized that Twumasi does not focus on the influenza epidemic nor the period 1918 to 1919, yet he treats Europe's efforts at combating and preventing epidemic diseases from the 1870s in the Gold Coast. This makes his contribution relevant to this study because the influenza epidemic of 1918 to 1919 had a huge impact on the Gold Coast and has become part of its history.

¹⁴³ Twumasi, Patrick A, *Colonialism, and international health: A study in social change in Ghana*, 147.

¹⁴⁴ Twumasi, Patrick A, *Colonialism, and international health: A study in social change in Ghana*, 147.

CHAPTER III: COLONIAL POLICIES AND STRATEGIES TO COMBAT THE INFLUENZA EPIDEMIC OF 1918 TO 1919 IN ASHANTI

In 1918 when influenza made its way to Ashanti, neither the colonial administration nor the Native population was prepared for combating the outbreak of the influenza epidemic. Reports indicate that measures that were necessary for the control of the disease were directly controlled by the colonial administration. To a large extent, these methods or policies were unsuccessful to control the influenza epidemic in Ashanti. In the ensuing discussion, emphasis is placed on the preventive measures which were introduced by the colonial administration and why some were not successful.

As influenza spread and continued to invade several villages in Ashanti it became imperative for collaborated efforts to be made between the Colonial Administrators and the Native Heads or chiefs. Several factors accounted for this, and this could be placed within the context of the Indirect Rule system. That is, ruling vast geographical areas in Africa with limited colonial personnel and resources. Thus, collaboration with Native Authorities like chiefs and headmen with the cooperation of the Indigenous population was a colonial medical strategy to combat the influenza epidemic of 1918.

First, the political structure introduced by the colonial government did not only help the administration of the colony in terms of development but also assisted in the control of influenza in Ashanti. Stephen Hymer argues that the fundamental goal of the Europeans was to maintain certain political structures with limited resources rather than economic growth.¹⁴⁵ This does not neglect the fact that economic growth was not on the agenda of the colonial government. Rather they understood that to take advantage of the economic situation in Africa, they had to maintain strong political structures. Administratively, Ashanti was divided into four main provinces

¹⁴⁵ Hymer, Stephen, *The political economy of the Gold Coast and Ghana*, Discussion paper: Yale University 1969) 2

(Northern province, Western province, and Southern province) with five districts, each represented by Provincial Commissioners (P. Cs) and District Commissioners (D. Cs) respectively. The establishment of the five districts by F.C. Fuller, chief commissioner of Ashanti in 1906 was to solve the administrative problem in Ashanti. There were concerns from officers who were put in charge of the previously demarcated districts outlying that the districts were too large to be managed by a single officer.¹⁴⁶ As pointed out, commissioners were largely confined to headquarters for the collection of caravan tolls, and they could rarely visit some areas in their jurisdictions. Thus, the establishment of the five districts with their headquarters as depicted in Fig. 3.0. was to facilitate easy access to respective areas. The colonial administration on the other hand maintained its headquarters headed by the Chief Commissioner in Kumasi.

¹⁴⁶ Bening, R. Bagulo. "The Location of Administrative Capitals in Ashanti, Ghana, 1896-1911." *The International Journal of African Historical Studies* 12, no. 2 (1979):226

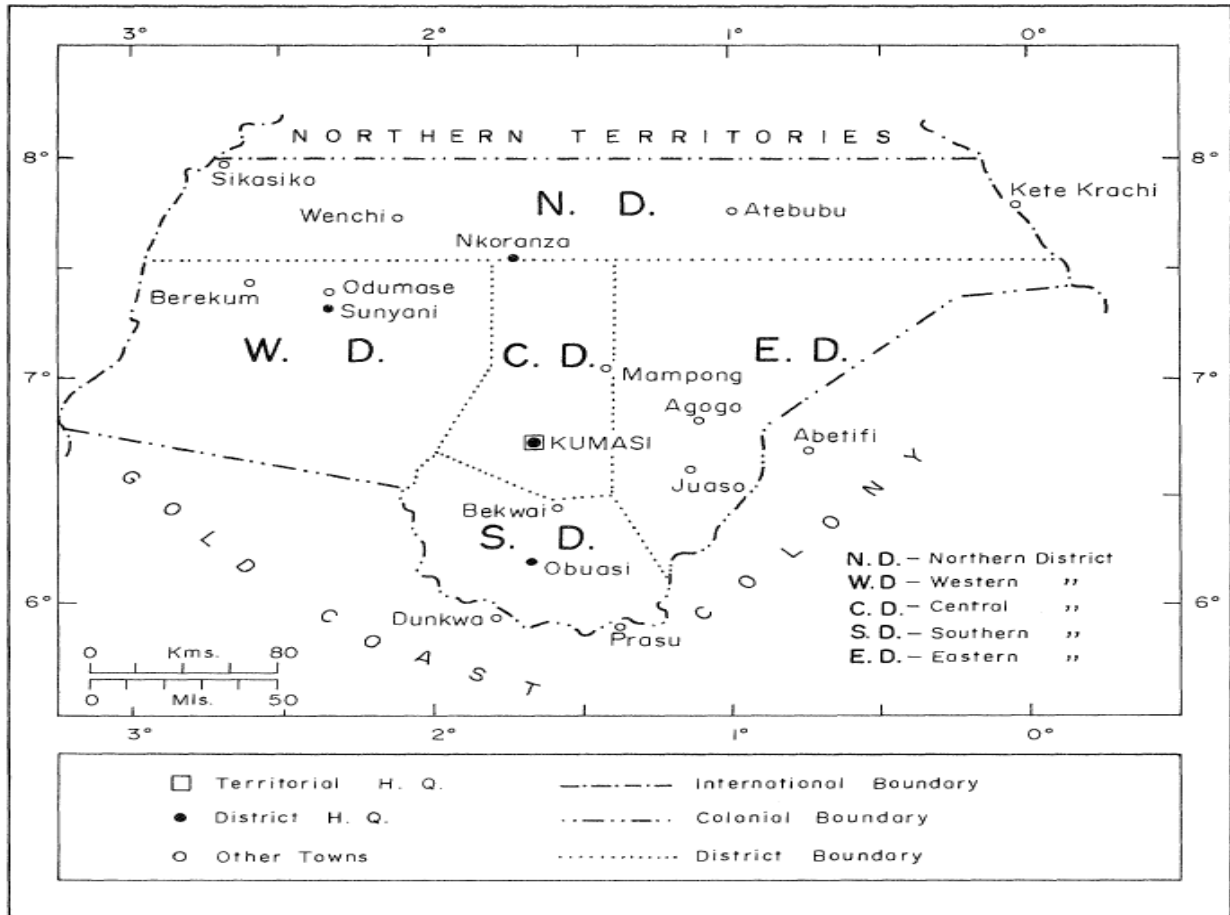


Fig. 3.0. The demarcations of Ashanti into districts by the British colonial administration.¹⁴⁷

In each of the five districts, two assistant district commissioners were posted to each administrative capital to help with the collection of revenues from the collecting stations in Kumasi. This means that each district commissioner in the five districts was supported by two assistant district commissioners. Consequently, the district capitals were transformed into superior administrative headquarters known as provinces while the other minor divisions were maintained as districts as shown in Fig. 4.0. This led to the titles of the district commissioner and assistant

¹⁴⁷ Bening, R. Bagulo, *The Location of Administrative Capitals in Ashanti, Ghana, 1896-1911* (The International Journal of African Historical Studies) 12, no. 2 (1979): 226

district commissioner being changed to the provincial commissioner and district commissioner respectively.

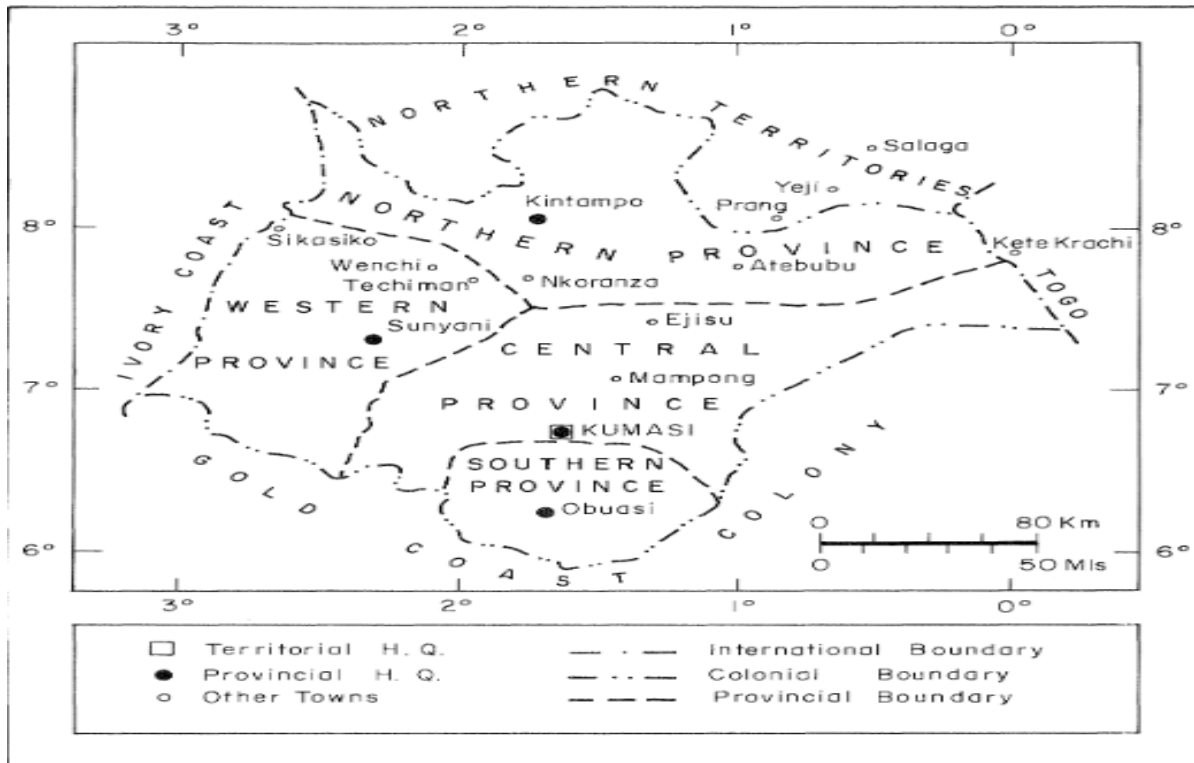


Fig.4.0. The demarcations of Ashanti into provinces by the British colonial administration.¹⁴⁸

The administrative design of Ashanti had a great influence on the hierarchical structure of the colonial administration in 1918 and 1919. The colonial government recognized the role that the Native Heads played in their communities and involved them in the administrative process during the epidemic. The Native Heads were tasked with reporting the conditions of the disease in their various towns and villages to the district commissioners, who later reported to the provincial commissioners, and eventually to the Chief Commissioner of Ashanti. As a directive, the colonial

¹⁴⁸The new territorial map of Ashanti had a great impact on the administration of Ashanti by the Colonial Administration. It helped the colonial administration to record the cases of influenza in the various parts of Ashanti and also share responsibilities among the various colonial officials in Ashanti. Bening, R. Bagulo, *The Location of Administrative Capitals in Ashanti, Ghana, 1896-1911*, (The International Journal of African Historical Studies) 12, no. 2 (1979): 230

administration through its Chief Commissioner in Ashanti ordered all provincial commissioners and district commissioners to collect daily reports (every Thursday) from the *Amanhin*¹⁴⁹ or the Native Heads on the number of deaths occurring in their various divisions.¹⁵⁰ The idea was to know whether the epidemic was spreading or not. The district commissioners were charged with reporting cases of deaths, ages (children, adults, or old people), sex of the deceased, and the Head Chiefs in those divisions.¹⁵¹

It should be pointed out that Native Heads were instrumental in the decision-making processes of their jurisdictions, yet their position in the administrative structure created a dent in Ashanti Indigenous culture. Indigenous traditional societies according to Nukunya were “characterized by the type of domination based on the belief in the legitimacy of an authority that has always existed.”¹⁵² In Ashanti, local authorities including Native Heads were and continue to be highly respected by their people due to their inherited status. The Native population is subjected to their commands because they conform to Native customs. This shows that the involvement of Native Heads in combating influenza was necessary. Yet, the establishment of the district commissioner’s office meant an interference in the affairs of the Native Heads. This was because although Native Heads represented the Native population in various divisions, the district commissioners on the other hand were representatives of the colonial government and other officials in the same divisions as the heads of the Natives. The creation of the office of the district

¹⁴⁹ In pre-colonial Asante, *Amanhins* were seen as heads of their respective metropolitan Ashanti states. They exerted legislative, judicial, and executive powers and served as a medium between their people and the gods.

¹⁵⁰Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between the Chief Commissioner of Asante and the Provincial and District Commissioners in Asante on Influenza-Epidemic, 12th October 1918.

¹⁵¹ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between an unknown District Commissioner in Kumasi and the Provincial Commissioner on Influenza-Epidemic, 4th February 1919.

¹⁵² Nukunya, Godwin Kwaku, *Tradition and change in Ghana: An introduction to sociology* (Ghana Universities Press, 2003), 5

commissioner was the idea of Governor F.M. Hodgson in March 1900, after he had visited Kumasi to deal with problems of administration in the region. As it was considered, district commissioners were appointed based on their knowledge of military responsibilities and experience in the handling of Africans.¹⁵³ Their duties in Ashanti were both civil and judicial and targeted at the Native population. In one of his recommendations to the governor, the Chief Commissioner proposed an improvement in administrative efficiency in Ashanti:

“What is really required in Ashanti, however, is a more widely extended system of civil administration, under which there will be a sufficient number of Commissioners and Assistant Commissioners to travel frequently through their respective Districts, and to make themselves personally acquainted not merely with every chief, but with every village Headman.”¹⁵⁴

The purpose of the improvement of the administrative make-over by the colonial administration was to utilize Ashanti’s natural resources through the construction of roads and the expansion of agriculture. Yet, how it was carried out compromised the authority of the Native Heads. Some members of the local council expressed concerns about the loss of control in their territories as a result of the administrative structure of the colonial administration. In 1903, Princess Efua Dappa of the Nkoranza local authority made a complaint to the colonial administration about the loss of authority in that part of her territory included in the Northern Territories.¹⁵⁵ This indicates that before the emergence of the epidemic in 1918, there were raging concerns from the local authorities on the administrative design that had been established by the colonial administration. During the epidemic, these tensions persisted between the district commissioners and Native Heads on several occasions.

¹⁵³ Bening, R. Bagulo, *The Location of Administrative Capitals in Ashanti, Ghana, 1896-1911*, 216.

¹⁵⁴ Bening, R. Bagulo, *The Location of Administrative Capitals in Ashanti, Ghana, 1896-1911*, 224

¹⁵⁵ Bening, R. Bagulo, *The Location of Administrative Capitals in Ashanti, Ghana, 1896-1911*, 222

One of the significant mandates of the commissioners in 1900 was to regulate all concessions from confiscated lands that were subjected to the control of the colonial government in Ashanti.¹⁵⁶ The demarcations of Ashanti into districts and provinces for colonial rule brought about several land disputes among chiefs since some boundaries were unevenly distributed. The presence of some powerful chiefs who showed discontent towards the colonial government posed a threat to the governor and as such gave directives to commissioners to deal with rebellious chiefs. Thus, the commissioners served as mediators to settle boundaries and other disputes between chiefs in Ashanti. Interestingly, in the absence of district commissioners, some political officers were appointed to deal with such matters. On 19th November 1909, the colonial administration appointed Major Leslie who was supervising the construction of the Kumasi-Tamale road within Ashanti as a traveling commissioner to decide on petty civil and criminal cases when no local commissioner was available.¹⁵⁷ This shows that local commissioners did not only settle disputes among chiefs but also decided on matters that involved Natives. The colonial administration held chiefs accountable and sometimes imposed sanctions on them for their actions.

The ideological underpinnings of the indirect rule system which was used in Africa and elsewhere by the British established that Africans had to be ruled through their institutions. This means Native authorities including chiefs were allowed to exercise traditional powers over their subjects. In Ashanti, the practical application of the Indirect Rule system rather limited the traditional authority of Native Heads and made them subjects to the colonial administration. For example, in 1907, E.C Fuller the Chief Commissioner of Ashanti dealt with and fined some chiefs for wrongfully accusing one Cudjoe, an Indigenous Priest Healer.¹⁵⁸ As it were, the Chief

¹⁵⁶ Bening, R. Bagulo, *The Location of Administrative Capitals in Ashanti, Ghana, 1896-1911*, 234

¹⁵⁷ G. C. Conf. of 19 November 1909, CO 96/487

¹⁵⁸ PRAAD, Accra, ADM 11/1/10, Correspondence between the Chief Commissioner of Ashanti and Acting Colonial Secretary, 1907

Commissioner ensured that the chiefs involved refunded all proceeds obtained from the Indigenous Healer including compensation paid to him. There were internal agitations among some association members in Kumasi due to the disregard or disrespect shown to some Native Heads by the colonial administration.

Reports from the Provincial Commissioner to the Chief Commissioner indicated that some Native Heads had failed to adhere to directives from the district commissioners since they had to report directly to the latter regarding the state of their people's health. On 15th October 1918, the Provincial Commissioner of Obuasi wrote to the Chief Commissioner that "the chiefs were not complying with the instructions given by the colonial government to report deaths in their various divisions every Thursday".¹⁵⁹ Again, on 26th November 1918, the Provincial Commissioner of Sunyani reported that he was unable to give accurate figures of deaths from influenza owing to Chiefs not reporting the number of deaths in their jurisdictions.¹⁶⁰ It could be argued from the above perspectives that the bureaucratic structure introduced by the colonial administration to oversee and control the disease could have contributed to the spread of the disease rather than mitigate it. By 1918 when influenza had eroded most villages in Ashanti, it might have appeared to some Native Heads that district commissioners only served as messengers to the Chief Commissioner. Yet, taking some directives directly from the district commissioners perhaps might have contributed to why the chiefs or Native Heads did not comply fully with the instructions. In addition, the organization and manner in which reports on the epidemic were collected from the various towns have contributed to the inaccuracies in reporting the exact figures on the epidemic

¹⁵⁹ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between the Chief Commissioner of Asante and the Provincial Commissioners in Obuasi, 12th October 1918

¹⁶⁰ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between the Chief Commissioner of Asante and the Provincial Commissioners of Sunyani on Influenza-Epidemic, 26th November 1918.

of influenza in Ashanti. For instance, the directive from the Chief Commissioner required that reports on the epidemic were to be compiled only when the various representatives noticed the epidemic was coming to an end in their respective jurisdictions.¹⁶¹ This shows that the strategy that was adopted to monitor and trace infected persons during the epidemic was disorganized from the onset, thus leading to the escalation of the diseases in Ashanti.

Another method that was employed by the colonial administration was to prevent civilians from entering the lines from the roads but allow the main roads to operate. To emphasize, this approach was needless and influenced by colonial self-interest. On 25th September 1918, the Commanding Officer of the troops in Kumasi wrote to the Chief Commissioner of Ashanti requesting that the main roads through Cantonments be closed to the public, however, a passage was to be granted for Native civilians who had important activities to undertake in Cantonments such as Public Works Department, and laborers working in the new hospital buildings, etc.¹⁶² This recommendation from the Commanding Officer was strongly objected to by the Chief Commissioner who rather ordered that the roads be opened to full operation while the lines from the road be blocked from entry. Perhaps the directive from the Chief Commissioner was informed by the revenues derived from trading activities from 1918 to 1919 in the Gold Coast. Evidence from the expenditure in the Gold Coast including Kumasi indicates that there was a revenue increase from £7,729,124 in 1918 to £18,761,156 in 1919.¹⁶³ These revenues were needed to fund the first world war expenditure incurred by Britain. Hence, activities like closing down trading

¹⁶¹ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Letter from the Chief Commissioner of Asante to all provincial commissioners and district commissioners at various outstations in Asante, 2nd December 1918.

¹⁶² Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between the Chief Commissioner of Asante and the Commanding Officer of the Troops in Kumasi, and 25th September 1918.

¹⁶³ Sederberg, Peter C. "The Gold Coast under colonial rule: an expenditure analysis." *African studies review* 14, no. 2 (1971): 183.

patterns as indicated by the Commanding Officer of the troops were bound to be objected to. This clearly shows that the colonial interest in increasing revenue for British expenditures was prioritized over measures that could help curb the spread of influenza in Ashanti. Considering the ways through which the disease spread inland in most territories in Africa, this approach by the colonial administration proved ineffective in controlling the spread of the disease.

Below is Fig. 5.0. showing the various lines from the main roads which were blocked by the colonial administration in Kumasi.

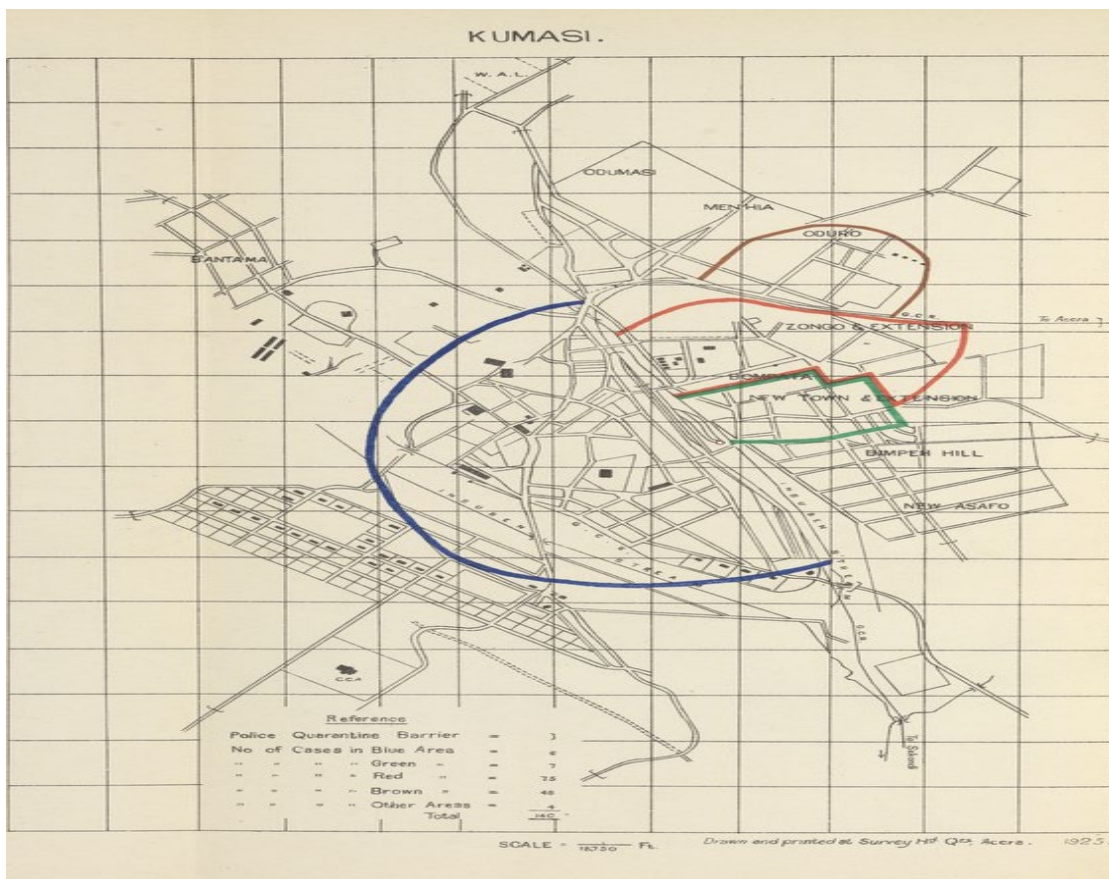


Fig. 5.0. A Pictorial View of the transportation measures adopted by the colonial administration.¹⁶⁴

¹⁶⁴ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Pictorial view of the road measures adopted by the Commanding Officer of the Troops in Kumasi, 22nd September 1925

The geographical location of Kumasi was a major factor that led to the spread of the disease in Ashanti. As shown in the diagram above, there were direct roads that connected from regions that had initial contact with the disease to Kumasi. For example, there were routes from Sekondi linking directly to the center of Kumasi, particularly in the Menhia and Newtown Extensions. Again, the number of cases that were recorded in areas that had been blocked shows that the blocking of the lanes rather proved ineffective in controlling the spread of the disease. As depicted in the diagram, places like New Asafo Bimpeh Hill, New Town & Extension, Bompata, and Zongo & Extension which are represented by red and green, recorded 85 new cases which was the highest number of cases recorded as compared to the other towns. These figures do not necessarily represent the exact number of infected persons as some deaths were not reported to the authorities. In areas like Oduro, Menhia, and Odumasi, there were 45 cases of influenza recorded. It should be noted that these towns were connected to Accra through Cantonments. Patterson hints that the disease reached Accra on 3rd September 1918 and spread rapidly to other areas where the infection could not be controlled.¹⁶⁵ Thus, the closing of the main roads from Accra to Kumasi as suggested by the Commanding Officer could have reduced the spread of the disease in those areas in Kumasi.

The statistics from the weekly reports showed that operations on the main roads contributed to the spread of the disease in some villages. The report from one of the villages in the Eastern District to the Provincial Commissioner stated that “the epidemic appeared to spread Northwards from the main Accra roads, and most of the deaths occurred in the early part of November.”¹⁶⁶ The

¹⁶⁵ Patterson, K. David, *The influenza epidemic of 1918-1919 in the Gold Coast*, (Transactions of the Historical Society of Ghana) Vol. 16, no. 2 (1995): 206.

¹⁶⁶ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between the District Commissioner of Juaso to the Provincial Commissioner on Influenza-Epidemic, 22nd January 1919.

report further shows that 60 to 70 percent of the inhabitants were infected.¹⁶⁷ The chief of Ejisu, Nana Kwaku Duko, reported that influenza attacked the majority of the people to the point that there was no strong person left to hew down trees on the Ejisu-Odasu new road.¹⁶⁸ Several correspondences point to the fact that the figures recorded in the report were not a true representation of infected persons since not all persons were reported by the Native Heads. In his report, the district commissioner of Akim wrote that “these figures were only approximated as many of the villages were so affected that they were unable to send message to the *Amanhin*.¹⁶⁹ Also, the provincial commissioner of the Western province in one of his letters wrote that “during my recent tour I personally made every endeavor, to collect details of sex and age but with no success.”¹⁷⁰ It could be argued from the above evidence that considering the timing between the opening of the main roads and deaths in some of the villages, it is clear that the Chief Commissioner’s decision contributed to the many deaths that occurred in most of the villages. The table below shows a compiled list of some towns that suffered from the infection in the Southern Province of Ashanti and the mortality rate by December 1918.

Name of town	Mortality Rate for October, November, and December
Wam (Dormaa Ahenkro)	142
Tekiman (Techiman)	210
Drobo	83

¹⁶⁷ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1/14/2/6 Correspondence between the District Commissioner of Juaso to the Provincial Commissioner on Influenza-Epidemic, 22nd January 1919.

¹⁶⁸ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1/14/2/6 Correspondence between the Ejisu Ahenfie and the District Commissioner of Kumasi, 15th October 1918.

¹⁶⁹ Public Records and Archives Administration (PRAAD), Kumase, ARG1/14/2/6. Letter from the District Commissioner of Akim to the Provincial Commissioner, 9th December 1918

¹⁷⁰ Public Records and Archives Administration (PRAAD), Kumase, ARG1/14/2/6. Correspondence between the Provincial Commissioner of Sunyani and the Chief Commissioner of Ashanti, 5th April 1919.

Nkwanta	71
Wenchi Town and Zongo	144
Noberko and villages	100
Sunyani	43
Berekum	45
Odomase	53
Jemo	30

Table 2.0. Kumasi Regional Archives, Manhyia Palace, Kumasi, Ashanti Region¹⁷¹

One of the most important duties of the Chief Commissioner of Ashanti after the British administration had occupied the area in 1896 was to encourage trade and to keep all roads, especially the ones leading to its capital, Kumasi open. The colonial administration led a campaign to clear all roads leading to the north to allow free access to the other parts of the country and beyond the forest.¹⁷² Thus, the opening of the main roads during the epidemic meant trade and transportation of commodities from the North to the South continued uninterrupted. Records have shown that colonial infrastructure played a pivotal role in transporting the disease in most African countries. Patterson hints that in Kumasi, the disease was believed to have been introduced by road.¹⁷³ In the Gold Coast, and around the early 1900s, the colonial administration had initiated an extensive and strategic expansion of the various transport networks to connect from the south to the north to allow for easy transportation of goods.¹⁷⁴ Reports suggest that railway workers and

¹⁷¹ Public Records and Archives Administration (PRAAD), Kumase, ARG1/14/2/6. Report on Epidemic Influenza in the Southern Province of Ashanti during the months of October, November and December 1918.

¹⁷² Bening, R. Bagulo, *The Location of Administrative Capitals in Ashanti, Ghana, 1896-1911*, 212.

¹⁷³ Patterson, K. David. "The influenza epidemic of 1918-19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 210

¹⁷⁴ Ntewusu, S. A., *Serendipity: conducting research on social history in Ghana's Archives*, (History in Africa, 41 2012), 419.

their families were also infected and died of the disease in Ashanti. The Weekly Epidemiological report gives evidence of one European official and Senior Inspector of Mines, Mr. Holmes, and his wife who were among the first to be infected in Obuasi and were taken to Kumasi Hospital.¹⁷⁵ In a letter dated 23rd October 1918, the provincial commissioner of the Southern province reported the deaths of some Europeans in the Ashanti Goldfields Corporation Limited including Thomas Blight (Miner), John Speakman (Miner), James Thomas Warne (Mine Forman), and Arthur Walter Emms (Boilermaker).¹⁷⁶

In the North, the first cases of influenza infection were reported on the main north-south route. The disease hit the Northern Territories so hard that about 80 percent of the population had become infected.¹⁷⁷ Akyeampong argues that the export and import of goods merge epidemiological zones as isolated peoples come into contact with uninfected persons.¹⁷⁸ Thus, trading activities during this period were a significant cause of the spread of infectious diseases in Ashanti. There is little or no information to show that the colonial administration placed restrictions on trade and travel on the main south-north route. Even if so, trade and travel restrictions alone are not effective measures to curb the spread of influenza. No serious attempt was made to identify or trace infected persons even at the time that the disease had reached its peak in Kumasi and its environs. The Gold Coast medical and sanitary report of 1918 shows that public health measures were introduced to sanitize the environment and prevent some diseases.¹⁷⁹ Yet, little attempt was made towards combating the spread of the influenza epidemic according to

¹⁷⁵ Public Records and Archives Administration (PRAAD), Kumase, ARG1/14/2/6. Report on Epidemic Influenza in the Southern Province of Ashanti during the months of October, November and December 1918.

¹⁷⁶ Public Records and Archives Administration (PRAAD), Kumase, ARG1/14/2/6. Report on Epidemic Influenza in the Southern Province of Ashanti during the months of October, November and December 1918.

¹⁷⁷ Patterson, K. David. "The Influenza Epidemic of 1918–19 in the Gold Coast 1." *The Journal of African History* 24, no. 4 (1983): 209

¹⁷⁸ Akyeampong, Emmanuel Kwaku (Ed.), *Themes in West Africa's history*, 191

¹⁷⁹ Gold Coast Medical Department, *Medical and Sanitary Report for the year 1918*, 24

the report. Rather the focus of those measures was geared towards the prevention of mosquito and insert-borne diseases, malaria, yellow fever, filariasis, dengue, and tuberculosis. Another important observation that could be made from the report is that serious attention was not paid to infectious and epidemic diseases within this period. For instance, little was done to check diseases like chickenpox, dysentery, enteric, and smallpox.¹⁸⁰ Perhaps this could be attributed to the fact that the few cases that were recorded were among Native populations. It can be deduced from the above information that such diseases were only recognized as a threat to human lives after they had reached their peak and affected a large number of people including Europeans. This shows that influenza became a public health concern only after it had spread and killed several people.

Another measure that the colonial Medical Department proposed in Ashanti was social distancing (quarantine). It is worth considering that the mitigating circumstances that could have helped lessen the spread of the disease rather proved ineffective due to the measures introduced by the Medical Department. It looks like the Medical Department had too much power which they could not use wisely to solve the situation. This was evident in 1913, five years prior to the occurrence of the epidemic after governor H. Clifford had arrived in the Gold Coast. He continuously resisted and defied some of the health measures introduced proposed by the Medical Department calling them “impractical” and of no essence in the African colonies.¹⁸¹ During the epidemic, the Provincial Medical Officer needlessly proposed a quarantine after the disease had spread in many of the towns in Ashanti. The colonial administration believed that the disease only spread through personal contact. i.e., by the breathing of germs sprayed out from the throat and

¹⁸⁰ Gold Coast Medical Department, *Medical and Sanitary Report for the year 1918*, 24

¹⁸¹ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, (PhD diss., School of Oriental and African Studies: University of London 1972), 266

mouth by coughing and by the vomits.¹⁸² Laws were made to check the unnecessary movement of civilians in all places although there were exceptions to such legislation. Some civilians and other European officials who were engaged in activities that favored the colonial administration were allowed to work and go about their activities with minimal interference. For instance, health officials and people who worked in the mining sector were protected and allowed passage since they provided services largely to the European community. Several factors including interferences from the Chief Commissioner of Ashanti made quarantine impractical. This is not to say that the European officials including the Chief Commissioner did not make efforts to ensure that quarantine measures were enforced. Admittedly, the detrimental effect of the disease on trade and commercial activities prompted the colonial administration to enforce restrictions on unnecessary movements in Ashanti. The Medical Department dispensed medical advice through the chiefs to ensure that people stay indoors to minimize contact with outsiders. Yet, these measures could not hold the disruptive nature of the epidemic. The colonial officials themselves had no hopes in the quarantine measures due to its failure in Lome although strenuous measures were taken to ensure its success.¹⁸³

Besides the failure of some higher European officials to adhere to quarantine measures thwarted the hopes of making such social distancing measures effective. On 24th September 1918, the leadership of the Gold Coast Railways Commission wrote to the Chief Commissioner of Ashanti to reject his proposal to stop railway passenger traffic to Kumasi and inspect all third-class passengers.¹⁸⁴ The economic downturn that occurred in the Gold Coast as a result of the outbreak

¹⁸² Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between the Provincial Medical Officer and the Chief Commissioner of Asante, 1918

¹⁸³ Patterson, K. David. "The Influenza Epidemic of 1918–19 in the Gold Coast 1." *The Journal of African History* 24, no. 4 (1983): 209

¹⁸⁴ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6. Letter from the General Manager of the Gold Coast Railways to the Chief Commissioner of Asante, 24th September 1918.

led to the unwillingness of some colonial officials to enforce quarantine measures. Osei Kwarteng and Osei-Owusu assert that the exportation of cocoa suffered greatly as its shipment was delayed and ships bypassed the port of the Gold Coast.¹⁸⁵ The impact on trade and commercial activities threatened the feasibility of such a policy. Admittedly, some higher European officials were quite willing to enforce quarantine measures, however, they believed it was too strict to enforce at once.

Significantly, measures like quarantine disrupted the social structure of the Indigenous population in terms of family cohesion. Thus, despite the widespread nature of the disease, Natives who experienced cough could walk about their activities unperturbed. In Ejisu, Nana Kwaku Doku reported that while two-thirds of the people in his town were laid in bed, one-third were moving about with a cough.¹⁸⁶ Perhaps the regulations introduced to ensure quarantine measures were enforced were seen as harsh, thus the failure to adhere to them. For example, in addition to ensuring that people stayed in their homes, the administration erected fences around infected towns, placed markets outside their borders, and directed traffic to alternative trade routes.¹⁸⁷ In Ashanti, the communal way of the people allowed the society particularly family to be closely connected. The family structure was communally organized through the extended family system. The members of the family consisted of a residential group of people who accepted extensive mutual responsibilities, obligations, and duties. Thus, each member of the family believed that they had to perform duties to relations outside the immediate (nuclear) family. According to Amoah-Mensah, in African societies, it is believed that each individual possesses unique capabilities such as ideas, talents, skills, leadership, human energy, and financial and material resources. For these

¹⁸⁵ Osei Kwarteng K., and Osei-Owusu S, *The influenza pandemic in the Gold Coast and Asante 1918-1919* in *Africa and the First World War: Remembrance, Memories and Representations After 100 Years*, 2018

¹⁸⁶Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6 Correspondence between the Ejisu Ahenfie and the District Commissioner of Kumase, 15th October 1918.

¹⁸⁷ Sambala, Evanson Zondani. "Lessons of pandemic influenza from sub-Saharan Africa: experiences of 1918." *Journal of Public Health Management and Practice* 17, no. 1 (2011): 74

capabilities to be fully utilized, individuals took it upon themselves to come together so that they can appreciate their capabilities and encourage local initiatives.¹⁸⁸ This idea was manifested in every aspect of Ashanti social and economic arrangement. For example, community work such as constructing latrines, schools, and roads and cleaning the environment was done by everyone. The notion of community participation manifested in activities such as festivals, funerals, marriages, rites of passage, and naming ceremonies for the people.

Economically, a sense of community participation was present among the people of Ashanti. The primary economic activity present in Ashanti was agriculture. According to Nukunya “the primacy of agriculture in traditional economic life makes land the most important asset in these societies.”¹⁸⁹ In Ashanti's traditional society, land was considered communal property. People organized themselves in working groups and shared responsibilities among themselves to complete tasks. This was called the *nnoboa* system. Under this system, if a person needed assistance on his farm, he could request the help of other members of the community who would render such services in return for a promise that the individual whose work is being done would reciprocate the same in the future. As they came together to work on their farms, each individual made sure they worked hard to accomplish the group goal. As Amoah-Mensah puts it “This spirit of self-help is voluntary but compulsory.”¹⁹⁰ This shows that among the people of the Ashanti community participation formed the foundation of development in the society. Thus, any attempt to isolate the community including social distancing measures that placed restrictions on such activities would be considered an impediment to societal norms and values.

¹⁸⁸ Amoah-Mensah, Aborampah. "Nnoboa and Rotated Susu as Agents of Savings Mobilization: Developing a Theoretical Model Using Grounded Theory." *Qualitative Report* 26, no. 1 (2021). 141-142

¹⁸⁹ Nukunya, Godwin Kwaku, *Tradition and change in Ghana: An introduction to sociology*, (Ghana Universities Press, 2003)

¹⁹⁰ Amoah-Mensah, Aborampah. "Nnoboa and Rotated Susu as Agents of Savings Mobilization: Developing a Theoretical Model Using Grounded Theory." *Qualitative Report* 26, no. 1 (2021). 142

Besides, the Indigenous understanding of the supernatural concept of the world contributed to the nonconformity of such measures. In Ashanti's traditional society, customs strictly demand that individuals adhere to traditional norms and taboos. The failure to act according to such laws called for the presence of disease demons who shall inflict diseases on those individuals. Thus, most diseases were attributed to either act of God or deities and spiritual or mystical demons. In describing the customs of the Native population on the occasion of sickness, William Bosman writes that:

“In sickness (in which they all agree with the rest of the World) they first have recourse to Remedies: However, not thinking them sufficient alone to preserve life and restore Health, they apply their faith and Superstitious Religious Worship as more effectual to those Ends.....and what contributes to the promotion of this Custom is that the individual cannot be recovered without some Offerings made to the False God in order to appease him.”¹⁹¹

In the context of Ashanti cosmology, Twumasi argues that there was, and still, no conceptual separation between the natural or physical world on one hand and the supernatural world on the other.¹⁹² Indigenous health practitioners in Ashanti did not limit the treatment of diseases to the application of herbs and plants, they also used magico-religious means which required consultation of the gods and other spirits. This underlines the fact that some mysterious events happen in the world which transcend natural law thus such events could be understood in relation to the supernatural. In the case of the influenza epidemic, the supernatural causation of disease became clear; the Native population believed that influenza was an obscure happening when known

¹⁹¹ Bosman, William *A new and accurate description of the coast of Guinea: divided into the Gold, the Slave, and the Ivory coasts*, 222

¹⁹² Twumasi, Patrick A, *Medical systems in Ghana: A study in medical sociology*, (Ghana Publishing Corporation, 2005), 8.

measures, as well as efficacious medicaments, failed. They believed the epidemic was a punishment from the gods on mankind thus no “ordinary” human could possess control or power to preside over it. This, as it were, explains why the Indigenous people would only understand measures like quarantine as a colonial mechanism to restrict the personal liberties of Africans or disregard their Native customs.

Another measure that was adopted by the colonial government to combat the influenza epidemic in Ashanti was the indefinite banning of public and some private activities. The colonial administration through the recommendations of the Provincial Medical Officer suspended any form of public activity in Ashanti. On 7th October 1918, the Chief Commissioner sent a communique to all managers including heads of departments, missionaries, and firms to postpone the Kumasi Red Cross week celebration.¹⁹³ In Ashanti, the colonial administration ensured that people did not come together, especially during celebrations and markets days. During occasions where individuals interact with frequent handshakes and hugs, especially at funerals and marriage ceremonies, people are exposed to infections with serious health implications. Hence, such events were highly discouraged by the colonial administration.

The Chief Commissioner directed that all schools in Kumasi both under the Native mallams and those for European instructions be closed indefinitely. Instructions were given to businesses whose duties necessitated the presence of people not to entertain visitors in their offices. For example, various courts were held in the open air and members of the public were not admitted. Although this policy seemed practical, there were still some colonial administrators who failed to adhere to the directives. The Officer in charge of the Education Department in Kumasi violated the Provincial Medical Officer’s instructions and rather reported that “schools be closed for a

¹⁹³ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1/14/2/6. Letter from the Chief Commissioner of Asante to all Heads of various organizations in the Gold Coast, 7th October 1918.

period of one month.”¹⁹⁴ Other officials wanted to see signs and symptoms of influenza in their territories before they could carry out instructions given by the Chief Commissioner. In Juaso, the District Commissioner reluctantly wrote back to the Chief Commissioner stating that “I do not think it is necessary to close down schools yet, but I have sent instructions to the teacher and police that they must inform me immediately if there are symptoms of influenza observed.”¹⁹⁵ The attitude of some colonial administrators including District Commissioners depicts that there were administrative issues within the colonial administration that created tensions between the colonial officials. These problems led to the escalation of the disease among the Native population in Ashanti. In Juaso and its surrounding towns, reported cases as of 2nd November 1918 showed an increase in the number of infected persons and death cases in the district.

Town	Death cases	Infected persons
Juaso	36	Many cases continued to be recorded during this time
Obogu	0	20
Bompata	1	2/3 of the people attacked
Kumawu	9	Cases continued to be reported

Table 3.0. Summary of recorded cases of influenza in Juaso District.¹⁹⁶

¹⁹⁴ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6. Letter from the Officer in charge, Education Department Kumasi, to the Chief Commissioner of Asante, 23rd September 1918.

¹⁹⁵ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6. Letter from the District Commissioner of Juaso to the Chief Commissioner of Ashanti, 26th September 1918

¹⁹⁶ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6. Letter from the District Commissioner of Juaso to the Chief Commissioner of Ashanti, 2nd November 1918

The figures above show that the disease spread profusely after the district commissioner had failed to comply with the measures and waited almost unconcerned. In the early stages of the occupation of Ashanti, the duties of the district commissioner centered on political or economic rather than social. However, during the epidemic, district commissioners were not trained to understand the nature or methods of protecting the people against spreading influenza. This was a serious problem that contributed to the spread of the disease.

Some of the directives from the Chief Commissioner seemed vague and some district commissioners had to employ their directives at some point. Perhaps this gave district commissioners some form of authority to carry out their mandate while turning deaf ears to some directives from the Chief Commissioner. Another administrative flaw that gave district commissioners absolute authority was to allow them to establish personal and direct acquaintance with the Native population. On 24th September 1918, the Chief Commissioner wrote to the district commissioner of Ejura stating that:

“...it has been found necessary to close down all schools and to discourage as much as possible public and private reunions and assemblies which might prove strong factors in the spread of the disease.”¹⁹⁷

Though the directive gave specific instructions to close schools and other known public or private events, it gives room for the district commissioner to determine at his discretion what reunions or assemblies were to be allowed or canceled. Another example that supports the argument that correspondence from the Chief Commissioner lacked detailed content about how to effectively control influenza is shown in one Sub-Assistant treasurer's response. In his letter dated 25th September 1918, he wrote that “...I should be grateful if the Medical Officer of Health would kindly advise us what drugs, etc. should be taken internally for preventive purposes and how

¹⁹⁷ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1/14/2/6. Letter from the Chief Commissioner of Ashanti to the District Commissioner of Ashanti, 24th September 1918.

often.”¹⁹⁸ This gives evidence to the fact that most of the colonial administrators were themselves naïve about the disease. The colonial medical team should have made efforts to educate colonial administrators on the disease rather than merely reporting figures in their territories. Again, the failure to control the spread of the disease in some districts to some extent defeats Governor F.M. Hodgson's argument that district commissioners were experienced in handling Africans.

There were specific instructions given to the police magistrate to halt Native functions while missionaries were urged to *temporarily* close their churches or *hold services in the open air*. In his letter to the Chief Commissioner, the Provincial Medical Officer wrote that “the various open-air meetings, rejoicings held by the Natives in the moonlight with tomtoms, bands, etc be strongly discouraged and if possible, stopped.”¹⁹⁹ In Ashanti, social life and activities were built on the premise of a communal lifestyle that was deeply entrenched in the Indigenous belief system of the people. Social activities such as funerals, marriage ceremonies, naming, and festivals bound people together due to their association with the supernatural. For instance, the *Adae Afahye* was a significant customary practice that was observed annually to glorify and celebrate the achievement of statehood of the people of Ashanti. During its celebration, the head priest and the chief invoked spirits to ask for their protection and blessings to start the new year.²⁰⁰ Also, the ban on funeral celebrations was seen as a denial of Ashanti traditional rituals performed for the dead. Marleen de Witte asserts that “Funerals are at the heart of Ashanti culture and social life.”²⁰¹ Funeral celebrations in Ashanti centered around the extended family, beliefs, death, and ancestorship. Among the people of Ashanti and other traditional societies, it is believed that when a person dies,

¹⁹⁸ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6. Letter from the Sub-Assistant Treasurer to the Chief Commissioner of Ashanti, 25th September 1918.

¹⁹⁹ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6. Correspondence between the Provincial Medical Officer of Asante and the Chief Commissioner of Ashanti, 23rd September 1918

²⁰⁰ Nukunya, Godwin Kwaku, *Tradition and change in Ghana: An introduction to sociology* (Ghana Universities Press, 2003), 74.

²⁰¹ De Witte, Marleen. "Money and death: Funeral business in Asante, Ghana." *Africa* 73, no. 4 (2003): 531-559.

his soul goes to the land of the spirit to join other departed souls. Significantly, most families in Ashanti honor individuals who lived exemplary lives while on earth. It is believed that when they die, they become ancestors or spirits who watch and protect their families living on earth and punish deviants who violate acceptable norms in society.

Significantly, the social ritual of educating the community particularly the youth on societal norms was also compromised by the colonial administration's directive. In Ashanti, storytelling or folktales was a means of bringing together people of all ages. According to Koithan and Farrell stories and legends are used to teach positive behaviors as well as the consequences of failing to observe the laws of nature.²⁰² The elderly in the society were considered narrators of folktales since they were looked at as wise and more knowledgeable about societal norms. Usually, people gathered around the narrator in a circle and listened attentively as he or she speak. Activities that were performed during the function are clapping, dancing, and singing. This clearly shows that any attempt to deny the people of celebrations such as the pouring of libation in public, funerals, festivals, gathering to share folktales among other customary practices was considered as a disregard for Native customs and was bound to be objected to.

On 23rd September 1918, the Chief Commissioner wrote to the Head of Missionaries stating that "I strongly urge the discontinuation of Church Meetings and Public or Private reunions indoors and recommend that all services and necessary assemblies be held as much as possible in the open air."²⁰³ The attempt to allow aspects of missionary activities to continue uninterrupted while banning all Native functions justifies the colonial goal of converting the Native population amid the raging epidemic. Since they possessed cures for most diseases, Christian missions and

²⁰² Koithan, Mary, and Cynthia Farrell. "Indigenous native American healing traditions." *The journal for nurse practitioners: JNP* 6, no. 6 (2010): 477.

²⁰³ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6. Correspondence between the Chief Commissioner of Ashanti and the Head of Missionaries in Ashanti, 23rd September 1918

their hospitals contributed to the conversions of many Africans.²⁰⁴ Some Christian converts met and organized an open-air meeting to pray to God to intervene.²⁰⁵ The following hymn was composed and circulated by a Native,

1. *In grief and dear, to thee, O Lord,
We now for succor fly,
Thine awful judgment are abroad,
O shield us, lest we die.*
2. *The fell disease on every side
Walks forth with tainted breath.
And pestilence, with rapid stride,
Bestrews the land with death.*
3. *O look with pity on the scene,
Of sadness and of dread,
And let thine angel stand between
The living and the dead.*
4. *With contrite hearts to thee, our King,
We turn, who oft have stayed.
Accept the sacrifice we bring.*²⁰⁶

The resilience of Natives who later became adherents of the Christian faith and those who believed in the power of deities show that majority of the Natives even when converted believed in the existence of a spiritual force. However, efforts by Christian missionaries to undermine the Native religious beliefs continued. Reports on missionary encounters in Ashanti from the 1890s show that colonial missionaries discredited the basis of Indigenous knowledge as the overall approach to ritual healing. Kwame Arhin records those missionaries reported that they were stricken by Ashanti customary practices including rituals and punishment, blasphemy of the Ashanti who

²⁰⁴ Janzen, John M., and Edward C. Green, *Medicine in Africa*, 3.

²⁰⁵ Patterson, K. David. "The influenza epidemic of 1918-1919 in the Gold Coast." *Transactions of the Historical Society of Ghana* 1 (Vol. 16, no. 2 (1995): 207

²⁰⁶ Gold Coast Medical Department, *Medical and Sanitary Report for the year 1918*, 15

declared the *Asantehene*, King of Ashanti as God and among other practices. This led to a campaign led by F.A. Ramseyer who served as a spy to the colonial administration in Ashanti to report Ashanti customary practices as “misdeeds” that went against the precepts of Christianity.²⁰⁷ Thus, the only way Ashanti could be saved was within the colonial framework. Janzen and Green note that the African worldview that social dynamics such as individual actions and behaviors could cause misfortune or suffering on them were dismissed by Christian missionaries who referred to such assumptions as barbaric and superstitious.²⁰⁸ Thus, it can be argued from the above perspectives that the presence of the influenza epidemic of 1918 to 1919 in Ashanti presented an opportunity for the colonial government to oust Ashanti customary practices.

The state of medical readiness as well as the prevailing challenges in the colonial medical system worsened the situation when the epidemic broke out in Ashanti. Significantly, the collective notion to challenge the colonial government on matters of state policy cannot be overemphasized. Subsequently, there were coordinated efforts by the Native population through their institutions and enterprise to control the spread of the disease. Such efforts were sometimes disregarded by the colonial administration as they did not have confidence in Native practices. The next chapter looks at the responses from the Native population towards colonial policies and what they did to protect themselves from the disease.

²⁰⁷ Arhin, Kwame, *The missionary role on the Gold Coast and in Ashanti: Reverend FA Ramseyer and the British take-over of Ashanti 1869-1894* (Institute of Development Studies, 1968), 4

²⁰⁸ Janzen, John M., and Edward C. Green, *Medicine in Africa*, 3.

CHAPTER IV: RESPONSES FROM THE NATIVE POPULATION OF ASHANTI TOWARDS THE OUTBREAK OF THE INFLUENZA EPIDEMIC

The outbreak of the influenza epidemic distorted traditional or cultural activities in Ashanti. In their quest to combat the spread of influenza, the people of Ashanti resorted to the utilization of Indigenous medical therapies. Several factors accounted for this among which include the general perception of European medical practices. Also, the trust the people had in Indigenous healers. Lastly, the existing challenges that were faced in the colonial healthcare system such as limited medical personnel and poor state of medical infrastructure. The discussions below focus on the responses of the Native population during the outbreak of influenza. I consider the general resistance from the Natives towards colonial health policies as part of the responses by the Native population of Ashanti.

The people of Ashanti known for their cultural integration and consciousness showed resilience in combating influenza by entrusting their health issues to traditional healers known as *nnusifo*). As an expert in handling the health of the Natives, the activities of Indigenous healers revolved around the belief system of the Ashanti traditional society. They did not limit the interpretation of diseases to religious viewpoints, they also accounted for natural causation factors as contributing to ailments. They utilized the bark of trees among other traditional methods to treat in addition to perceiving diseases as coming about because of the misdemeanor of an individual. The concept of the supernatural among the people of Ashanti was manifested in the beliefs and practices of the people. These beliefs and practices existed in various forms and levels. They included the people's belief in *The High God, small gods, ancestors*, and practices like *witchcraft, magic, and sorcery*, which were all associated with the supernatural.²⁰⁹ The concept of the High God also known as the Supreme Being was common in Ashanti before the introduction of

²⁰⁹ Nukunya, Godwin Kwaku, *Tradition and change in Ghana: An introduction to sociology*, 64.

Christianity.²¹⁰ According to Godwin Nukunya, the Supreme Being was believed to be the source of the power of everything in this world.²¹¹ This meant small gods who usually existed in shrines derived their powers from the Supreme Being. It was within these shrines that Indigenous healers or Native physicians sat to operate and intervene in matters regarding the community. In his report to the colonial administration, William Bosman wrote that:

“They do not depend on Medicinal Remedies alone but make Offerings to their Gods on account of the sick. What these consist of. Their Gratitude to Physicians, which they frequently change, and renew their Offerings.”²¹²

Bosman’s observation points to the fact that Native physicians served as messengers and representatives of the spirit world on earth. In Ashanti, Twumasi has noted that Indigenous healers refer to various healers including *nnunsinfo* or herbalists, *akomfoo* or fetish priests and priestesses also known as Indigenous Priest Healers (IPHs), Traditional Birth Attendants (TBAs), Circumcision surgeons, and psychic healers.²¹³ These healers were acquainted with traditional authority and defined traditional medicine. They were believed to have possessed knowledge of Indigenous medical therapies and were very protective of their herbal knowledge and traditions. The art of healing as practiced by Indigenous healers was through the invocation of spirits or deities, incantations, spells, and the preparation of concoctions. Fig 6.0. below shows an Indigenous healer exhibiting divination to probe into the cause of an illness. Indigenous healers

²¹⁰ Nukunya, Godwin Kwaku, *Tradition and change in Ghana: An introduction to sociology*, 64.

²¹¹ Nukunya, Godwin Kwaku, *Tradition and change in Ghana: An introduction to sociology*, 64.

²¹² Bosman, William. *A new and accurate description of the coast of Guinea: divided into the Gold, the Slave, and the Ivory coasts*, 224.

²¹³ Twumasi, Patrick A. "History of pluralistic medical systems: a sociological analysis of the Ghanaian case." *African Issues* 9, no. 3 (1979): 30.

have their unique ways or methods of communicating to their clients through spiritual consultation with deities or ancestors.



Fig. 6.0. An Indigenous healer is being consulted to investigate the cause of an event.²¹⁴

By throwing animal bones, shells, stones, dies, and different kinds of rocks with wires wrapped around them on the mat, Indigenous healers can tell through the directions of the gods what herbs should be used to heal a particular disease. Sometimes, by casting these objects on the mat, the healer can tell things that are yet to happen in someone's life. Essentially, all these objects

²¹⁴ Janzen, John M., and Edward C. Green, *Medicine in Africa*, 7.

represent ideas that are peculiar to the Indigenous healer. Perhaps this explains why they were perceived to have possessed unquestionable knowledge about traditional healing.

By the outbreak of influenza in 1918, the activities of traditional healers particularly herbalists and fetish priests became important as a result of the trust the people had in Native remedies. They believed that Native remedies were effective in curing all manner of diseases. The Chief Medical Officer of Gold Coast, John Farrell Easmon had earlier revealed that the Natives including some African medical officers who had been trained by the colonial administration “used Native drugs because they found them effective.”²¹⁵ During the epidemic, some reports from the colonial officials suggested that the local people had resorted to the services of traditional healers. In a letter dated 17th December 1918, the District Commissioner of Juaso wrote to the Chief Commissioner stating that “The number has increased in most villages because of the activities of unknown Native physicians.”²¹⁶ Essentially Patterson has observed that the Principal Medical Officer realizing the challenge the medical department faced with understaffed colonial officials, attempted to recruit “Native practitioners” for temporal appointments during the era of the fight against the influenza epidemic.²¹⁷ Yet, it looks as if the activities of Native physicians were not fully recognized by the colonial administration. The District Commissioner’s letter to the Chief Commissioner shows that tensions might have erupted between some political officers and Indigenous healers. There was a reliance on the use of concoctions and decoctions made of stems, roots, and leaves of trees, sometimes prepared by the victims of the infection, or recommended by the traditional healers.

²¹⁵ Report of Commission of Inquiry into Dr. Easmon, CO 96/296.

²¹⁶ Public Records and Archives Administration Department (PRAAD), Kumasi, ARG1 /14/2/6. Letter from the District Commissioner in Juaso and the Chief Commissioner of Ashanti, 23rd September 1918

²¹⁷ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 208

During the epidemic, Native practitioners used the opportunity to popularize themselves as they provided alternatives to stop the spread of influenza.²¹⁸ The power to connect with supernatural elements helped Indigenous healers to explain the causes of diseases. According to Emmanuel Asante, the Indigenous religious belief system recognizes two forms of supernatural agents who cause diseases or sickness. These include the good supernatural agents and the evil supernatural agents.²¹⁹ It is believed that each of these agents visits individuals based on the circumstance and the extent of the crime committed. The good supernatural agents which include, God, ancestors, and deities may inflict diseases on people or make them experience a severe shortage of food if they fail to adhere to societal norms.²²⁰ On the other hand, evil supernatural agents like witches, sorcerers, and demons may inflict diseases on people out of jealousy, envy, or greed. The diseases may include leprosy, mental illness, bareness, and infertility among others.²²¹ From this perspective, diseases that are believed to be caused by evil supernatural agents are more directed towards individuals than the entire community. This shows that diseases of epidemic extent like influenza that affected the whole nation are likely to be considered a punishment from God, ancestors, or deities (good supernatural agents). Therefore, the only means to avert such a misfortune was to offer sacrifices and prayers to the spirits to seek favor. Concerning the roles that the Indigenous healer played, Bosman wrote

.....and they being strongly bent to Superstition, and immediately ready to follow the Priest's advice, accordingly define him to enquire of their God what he would please to have.²²²

²¹⁸Patterson, David. "The influenza epidemic of 1918–19 in the Gold Coast." 211

²¹⁹ Asante, Emmanuel, *Scientific medical practitioners, and traditional medicine in contemporary Ghana: A study of attitudes and perceptions*, 58.

²²⁰ Asante, Emmanuel, *Scientific medical practitioners, and traditional medicine in contemporary Ghana: A study of attitudes and perceptions*, 58.

²²¹ Asante, Emmanuel. "Scientific medical practitioners and traditional medicine in contemporary Ghana: A study of attitudes and perceptions." 58

²²² Bosman, William. *A new and accurate description of the coast of Guinea: divided into the Gold, the Slave, and the Ivory coasts*, 224.

The description given by Bosman shows that Indigenous healers served as watchdogs against evil spirits. Significantly, during influenza in 1918, there were several medical approaches from all sorts of healers including colonial medical doctors, traditional healers, and even quack practitioners who used the situation to exploit people.²²³ Scholars have alluded that from the 1920s to the 1930s there was an increase in the number of adherents of Indigenous medicine in Ashanti.²²⁴ Inferring from the two perspectives, it could be argued that most people were consulting Indigenous healers at the time that the influenza was lingering in Ashanti. Also, the activities of traditional healers might have increased because the occurrence of the epidemic heightened the trust the people had in their deities since all attempts including European interventions had failed.

Also, the fear that Indigenous healers may dominate the Ashanti medical system resulted in the colonial administration trying to control the spiritual and traditional customs of the people. The attitude of the colonial administration towards the Indigenous system was borne out of their disregard for Indigenous medical practices. As Gevitz points out, Indigenous medical practices are “are not accepted as correct, proper, or appropriate or are not in conformity with the belief or standards of the dominant group of medical practitioners in a society.”²²⁵ This was the attitude of the colonial administration towards Indigenous medical practices in Ashanti. In the case of Ashanti, Indigenous medicine was the dominant health system practiced by the majority of the people before the coming of the Europeans. The presence of the colonial administration in Ashanti, however, imposed certain practices on the Native population which later became dominant

²²³ Patterson, K. David, *The influenza epidemic of 1918–19 in the Gold Coast (The Journal of African History* 24, no. 4 1983), 211

²²⁴ Adu-Gyamfi, Samuel, *A Historical Study of The Impact of Colonial Rule on Indigenous Medical Practices in Ashanti: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumasi, 1902-1957*, 68

²²⁵ Gevitz, Norman, *Other healers* (The Johns Hopkins University Press, Baltimore, MD, 1988), 1

although they had limited colonial personnel and resources. Despite the introduction of the Indirect rule system in Ashanti, the intention of the colonial administration was partly to dominate all the social and cultural institutions in Ashanti including the area of health. Yet, the presence of Indigenous healers in dealing with the health needs of the people posed a threat to colonial objectives. Thus, the only way for the administration to gain dominance in the area of health was to make Indigenous healers unpopular and Indigenous medical therapies unattractive. As Stephen notes,

... they lacked the strength to handle the tensions of economic growth, they feared the development of local bases of power and acted often as a brake rather than an accelerator in an attempt to slow down the growth of specialization, exchange, and accumulation of capital ²²⁶

The colonial administration believed that by condemning certain practices, the people would lose their trust in Indigenous healers and start utilizing Western medicine. Before 1902, Ashanti resistance towards Britain posed a threat to the colonial authority even after they had occupied the colony in 1896. Thus, after occupying Ashanti, the colonial government made several efforts to topple Ashanti power including compromising the agency of the Native authorities. Significantly, the administration devised strategies to suppress local initiatives. This was due to the fear that such initiatives may empower the local people which in theory distorts the purpose of colonization. Before the outbreak of influenza and around the 1870s, the colonial administration had started a campaign to promote Western medicine in the Gold Coast. In 1878, the Native Customs Regulation Ordinance was introduced in the Gold Coast to ban any form of traditional healing and practices which contradicted Western science.²²⁷ This was a period following the introduction of

²²⁶ Hymer, Stephen, *The political economy of the Gold Coast and Ghana*, 2

²²⁷ Senah, Kojo, *In sickness and in health: Globalization and health care delivery in Ghana*, 84.

Western medicine that the colonial administration had to promote. Other attempts were made to ensure the ban of all activities that had direct involvement of Native physicians in Ashanti. For instance, only colonial medical officers could issue certified disability notes to African public servants. Also, there were serious implications for Christian converts who sought the services of traditional healers.²²⁸ Essentially, these attempts could not yield many results. These harsh measures may have created challenges since adherents of Indigenous medicine could not work in a peaceful environment. However, since the health dispensation of the Natives was tied to their customary practices there is a possibility that the Natives consulted Indigenous healers in secrecy.

The African understanding of medical treatments led to a cultural clash between the colonial administration and the people of Ashanti. The contrasting philosophies of diseases between the Europeans and the Africans led to the failure of some colonial interventions in Ashanti during the outbreak of the epidemic influenza. The colonial administration's understanding of the germ theory of diseases prompted the administration to adopt imported practices to control the disease in Ashanti. This contrasted the social causative theory of diseases known to Africans including the people of Ashanti, thus making colonial interventions unpopular during the outbreak of the disease. Hymer has argued that the colonial administration since the inception of colonization objected to the Native system, referring to Indigenous practices as inferior to European ones.²²⁹ Significantly, in the colonial medical department, these assumptions led to discrimination against African medical officers. In his report to the colonial secretary, the Provincial Medical Officer, Henderson in the late 1800s wrote,

"I regret to say that the majority of the Medical Officers sent out during the last twelve months were what I can only describe as the dregs of the profession; men who cannot get anything to do in England and take

²²⁸ Senah, Kojo, *In sickness and in health: Globalization and health care delivery in Ghana*, 84.

²²⁹ Hymer, Stephen, *The political economy of the Gold Coast and Ghana*, 12

whatever offers; this is borne out by the fact that, for various and discreditable causes, so many have had to be sent home after at most a few weeks in the Colony. Sending out such men puts the Colony to great expense and brings discredit on the Department."²³⁰

The colonial administration frowned on Indigenous forms of healing power due to their inability to explain the science behind them. For example, Adu-Gyamfi argues that most of the Indigenous medical therapies including medicine in Ashanti came about as a result of trial and error. However, these practices eventually became accepted due to their effectiveness in curing some diseases more than others. Thus, "magic was the motive, but medicine was the result."²³¹ Therefore, explanations to most Indigenous forms of healing were believed to be spiritual and could only be understood by a person who was believed to be spiritually endowed to do so.

The assumption that Native practices were inferior was evident not only in health, but in mining, agriculture, and transportation. Usually, in taking initiatives the colonial government did not research local problems but instead preferred to enforce imported techniques that were unpopular among the Native population. In the case of the influenza epidemic, most of the colonial measures failed because the colonial administration did not incorporate the traditional philosophy of spiritual inference of diseases in their policies. This was a result of the lack of confidence in the Native health system. Perhaps if they had involved the Indigenous healers in their health decision-making processes, they would have understood Native practices and incorporated them into their policies. Accordingly, the people would have had confidence in those policies and thus conformed to them.

²³⁰ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 281.

²³¹ Adu-Gyamfi, Samuel, *A Historical Study of The Impact of Colonial Rule on Indigenous Medical Practices in Ashanti: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumasi, 1902-1957*, 66

Also, the Natives failed to utilize the existing colonial health facilities. As mentioned, one of the most controversial parts of British medical policy in the Gold Coast in the late 1800s was its emphasis on protecting the health of Europeans. However, beginning from the 1900s most Africans began to realize the colonial government had no interest in protecting the health of the Indigenous population.²³² Reports on the influenza epidemic of 1918 in the Gold Coast suggest that there was a decline in the number of Natives who used colonial health facilities. The distrust of Africans towards European medical therapies was evident in the attacks on the colonial government in the lay press by educated Africans.²³³ Criticisms leveled against the colonial government were their failure to train more African doctors, the prejudice in the medical department, and the deliberate attempt to neglect the health needs of the Native population among others. Significantly, aside from the few medical doctors that were available to care for victims of influenza, African doctors in the medical service felt reluctant to help when they were called upon to do so.²³⁴ Patterson believes they did so due to the prejudice against African doctors in the medical service.²³⁵ In addition, there is a possibility that they wanted to expose the failure of the colonial administration to claim hegemony in the area of medicine with their limited colonial personnel and resources. Significantly, discrimination against African doctors provoked other Natives who felt reluctant to receive treatment from European doctors.²³⁶ In his explanation of why some Africans rejected Western medical therapies, Gale asserts that

“The African looked upon the white doctor as a 'queer, incomprehensible creature'. He was seen as a 'quack', or someone to be consulted only when the situation was

²³² Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 323.

²³³ Gold Coast Medical Department, *Medical and Sanitary Report for the year 1918*, 15

²³⁴ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast." *The Journal of African History* 24, no. 4 (1983): 211

²³⁵ Patterson, K. David. "The influenza epidemic of 1918–19 in the Gold Coast," 1983, 211

²³⁶ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 328

otherwise hopeless or when a specific treatment such as an injection was desired. Otherwise, Africans wanted to have little to do with a foreigner who is obviously neither intelligent nor respectable.”²³⁷

Gale’s assertion suggests that African distrust in colonial medical therapies was a result of its non-conformity with the customary practices of Indigenous societies. He argues that the colonial officials could neither speak the Native language nor understand the true health situation of the Indigenous people.²³⁸ One possible explanation for African discontent towards colonial medical facilities could be that seeking the services of European doctors was a betrayal of their gods or deities. Again, as observed, that most epidemic diseases got introduced to Africa due to contact with the outside world, it would be sufficient to say that Natives believed colonial medical facilities were a haven for diseases. The behavior of Africans towards Western medical practices bore similarities to how the colonial administration perceived Indigenous medicine. Perhaps, one way the colonial administration could have gotten Africans to adapt to the new ideas was to appreciate the decision of Natives on what they wanted to become. As Beisser points out, as societies evolve “man finds himself in a position where rather than needing to adapt himself to an existing order, he must be able to adapt himself to a series of changing orders.”²³⁹ Therefore by accepting and allowing Indigenous medical practices to operate, the Natives would have decided on whether to accept the new social order or not.

²³⁷ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 415

²³⁸ Gale, T. S., *Official medical policy in British West Africa 1870-1930*, 415

²³⁹ Beisser, Arnold, *The paradoxical theory of change* (Gestalt therapy now) 1, no. 1 (1970): 142

CHAPTER V: SUMMARY OF FINDINGS AND CONCLUSION

This chapter makes a summary of the findings of this thesis. It analyses how Indigenous archives of Ashanti cultural knowledge conceptualized and interpreted diseases, medicine, and healing. It highlights the policies and strategies that were adopted by the colonial administration to combat the influenza epidemic of 1918 to 1919 in Ashanti and why some of the policies were unsuccessful. In addition, the findings present responses of the Native population of Ashanti toward the outbreak of influenza in 1918 in Ashanti.

Summary Of Findings

The study found out that the earliest cases of influenza in Ashanti occurred in Kumasi, the capital, on September 23rd, 1918, and later spread to other towns and villages in the area. The study revealed that there were 9,000 deaths in Ashanti, out of a total population of 450,000 in 1918. Although these figures are estimated, scholarly records have shown that the official records on the mortality rate of influenza in most countries are generally incomplete, miscalculated, or unknown.²⁴⁰ In Ashanti, the organization and manner in which reports on the epidemic were collected from the various towns contributed to the inaccuracies in reporting the number of deaths during the outbreak of the disease in the region.

The study revealed that as a result of the colonial administration's claim to dominance in the area of medicine, health interventions were introduced to control the spread of influenza in Ashanti. Measures like collaboration with Native Authorities such as chiefs and headmen, road and rail closure, quarantine and isolation, and banning of public and some private activities were adopted by the colonial administration in Ashanti. However, these interventions failed because

²⁴⁰ Patterson, K. David, and Gerald F. Pyle, *The geography and mortality of the 1918 influenza pandemic*, (Bulletin of the History of Medicine 65, no. 1 1991),13.

they were unpopular among the Natives of Ashanti. Essentially, the study acknowledges that some of these measures worked in other parts of Africa including Lome. However, those interventions became effective for a period of time although strenuous measures were taken to ensure their implementation.

Again, the study looked at the role of the medical department and how they utilized their power to manage the disease in Ashanti. I argue that most of the challenges in controlling and managing the health problems in Ashanti during the outbreak of influenza were ineffective due to the ignorance of the medical staff regarding the true health situation among Africans. The medical staff did not know the customary practices of the people of Ashanti. Even if they did, the assumption that Indigenous practices were not in conformity with accepted practices made them ignore the African belief system and how it was tied to the people's health. The study suggests that the situation could have improved if the medical officials were reoriented to understand what sickness or diseases meant to the Ashanti Natives. Essentially, this would have assisted the colonial administration to provide better care for Natives either by modifying certain Indigenous medical practices or incorporating the African philosophy of diseases in their policies.

Also, the study postulates that the failure of the colonial administration to admit their inability to cope and manage the crisis effectively with a Western social orientation led to the spread of influenza in Ashanti. The belief that Western medicine, which was based on the premise of science, is capable of eliminating all manner of diseases led to the continuous spread of the disease. As shown in the research most of the health policies that were implemented during the outbreak of influenza in Ashanti, were imported norms or practices that favored the environment in the Western world. It has been pointed out that social and political structures among the people of Ashanti were shaped by the customary practices of the people. Customary practices such as

funerals, marriage ceremonies, naming, and festivals bound people together due to their association with the supernatural. Hence, any form of intervention that was introduced by the colonial administration should have been within the scope and context of the people's culture. For instance, the introduction of measures like quarantine and isolation in a communal society like Ashanti were bound to be objected to due to the restrictions it placed on individual personal liberties, disregard towards Native customs, and sense of control. Thus, I argue from the above perspective that the failure of the colonial administration to prioritize societal standards that correspond to the demands of the people led to the spread of influenza in Ashanti.

It should be noted that regardless of the nature of a disease, the people of Ashanti subscribed meaning to every disease or suffering. The African belief in the ability of the gods and deities to inflict diseases on individuals for their actions contributed to the Indigenous explanations that were attributed to the occurrence of influenza at the time. As pointed out in the research, the majority of Natives who believed in the supernatural causation of disease became convinced that influenza was an obscure happening when known measures, as well as efficacious medicaments, failed. Some Natives who became infected with influenza at some point failed to report to the authorities and rather sought assistance from Indigenous healers. In the years following the occurrence of the influenza epidemic in Ashanti, scholarly evidence shows that adherents of Indigenous medicine increased.²⁴¹ Therefore, it could be argued that the influenza of 1918 deepened the reliance of most Natives on the roles of Indigenous healers in effecting treatment amongst the Native population in Ashanti.

In addition, the thesis has looked at the attempt by the colonial administration to sideline Ashanti Indigenous healers due to the fear that they may dominate the Ashanti medical system.

²⁴¹ Adu-Gyamfi, Samuel, *A Historical Study of The Impact of Colonial Rule on Indigenous Medical Practices in Ashanti: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumasi, 1902-1957*, 68

The study found out that the trust the Natives had in the effectiveness of Indigenous medical therapies coupled with the presence of Indigenous healers in dealing with the health needs of the people, posed a threat to the colonial administration. From the early twentieth century, Indigenous healers in the Gold Coast became influential and powerful due to their healing abilities. In 1878, the colonial administration passed the Native Customs Regulation Ordinance in the Gold Coast to ban any form of traditional healing or practices, which were not in conformity with Western science.²⁴² By implementing such policies, the colonial government aimed at toppling Ashanti power by compromising the agency of the Native Authorities and making Indigenous medical therapies unattractive.

Essentially, the thesis has argued that it takes collective efforts to influence change in every society. The varying philosophies of disease between the colonial administration and the Native population could not allow health interventions that were common to both groups to exist. The Native population of Ashanti rejected colonial health measures because they were not in conformity with Ashanti social and cultural norms. As Beisser puts it, by rejecting the role of a change agent, “people are able to make meaningful and orderly change possible to be fully invested in their current positions.”²⁴³ Hence, the study suggests that effective and efficient policy considerations to control a disease of an epidemic extent like influenza should look at the environment, the people, and their belief system. Once the medical authorities had realized the true health situation and how the people understood health, their attitude towards formulating policies would have changed.

²⁴² Senah, Kojo, *In sickness and in health: Globalization and health care delivery in Ghana* (Institute of African Studies Research Review 17, no. 1 2001), 84.

²⁴³ Beisser, Arnold, *The paradoxical theory of change*, 79

Finally, several factors including the improvement of transportation, communication, and contact with the outside world led to the increase of epidemics in most African countries. The years following the outbreak of the disease saw a growing awareness among individuals and groups about diseases and the need for preparedness. Importantly, one of the lessons learned is that the preservation of one's life does not mean the absence of disease or sickness. Rather, a collective effort to protect the lives of all people leads to a safe environment. Presently, the improvement of technology although has brought about progress in our global community, has also led to the proliferation of diseases among populations. Today, policymakers overlook the cultural significance underlying diseases, their causes, treatment, and their spread in Ghana. As Sir Winston Churchill puts it "Those who fail to learn from history are doomed to repeat it." Hence, governments and policymakers must pay attention to the past to help solve current public health concerns.

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