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Women and Medicine on the Gold Coast, 1880-1945

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A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in History

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ABSTRACT

Prior to colonial rule and the imposition of western medicine and practices, several countries in Sub-Saharan Africa relied on traditional medicine to treat tropical diseases that ravaged the populace. Specialists in traditional medicine, both men and women, restored and preserved their patients' health through herbarium and spiritism. Like their male counterparts, female traditional medicine practitioners on the Gold Coast were highly respected by people for their knowledge and competence as their communities' primary healers and caregivers. This study, drawing on various primary and secondary sources, including oral traditions, colonial reports, medical journals, and historical accounts, argues that women played a substantial role in traditional medicine on the Gold Coast. However, the disruption of traditional medicine practises caused by the imposition of colonial rule and Western medicine in the late nineteenth century led to the exploitation, marginalisation, and exclusion of women in some fields of the newly imposed colonial medical system on the Gold Coast. This study explores native women's roles in medicine on the Gold Coast during the pre-colonial period and how Western medicine and practices altered their role and place in the field during colonial times.

Keywords: Gender, Colonialism, Motherhood and Imperialism, Health, Medical Beliefs, Traditional Medicine, Western Medicine, Priestess Healers, Herbalists, Traditional Birth Attendants, Sanitary Labourers and Inspectors, Mosquito Brigades, Dispensers, Medical Doctors, Nurses and Midwives.

SUMMARY FOR LAY AUDIENCE

This thesis examines the contributions, place and roles of Indigenous Gold Coast women in traditional medicine during the pre-colonial times and how they were exploited, excluded, and marginalized in medicine by the British colonial governments after the imposition of colonial rule and Western medicine from the late nineteenth century to mid-twentieth century. The women of the Gold Coast, who had been integral members of the healthcare provision in all traditional medical systems prior to colonial policies favouring the training and employment of male healthcare practitioners, were marginalised. Women were only allowed into subservient roles as nurses and midwives, enforcing and imposing European mothercraft concepts on their fellow African or indigenous mothers and paving the way for their male counterparts who cooperated with colonial authorities to occupy and dominate higher medical fields.

DEDICATION

This thesis is dedicated to the loving memories of my late mother, Maame Afia Afrakoma (a.k.a. Linda Osei).

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LIST OF ABBREVIATIONS

TBA(S)	Traditional Birth Attendant(s)
NA	Native Authority
SSO	Senior Sanitary Officer
SSI	Senior Sanitary Inspector
DMS	Director of Medical Services
DMSS	Director of Medical and Sanitation Services
JMO	Junior Medical Officer
RMP	Registered Medical Practitioner
WAMS	West Africa Medical Services
CC	Chief Commissioner
ACC	Assistant Chief Commissioner

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

The study of women and medicine on the Gold Coast during pre-colonial and colonial times is a crucial aspect of understanding the intersection of gender, health, and colonialism in Africa. The Gold Coast, now known as Ghana, was a vibrant and diverse region long before the arrival of European colonizers.

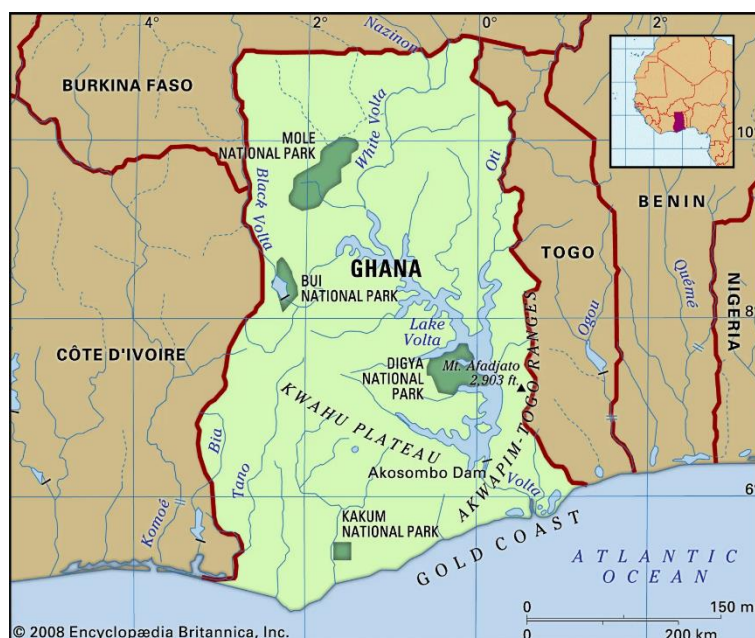


Figure 1.1 Map of the Gold Coast¹ (Source: Encyclopaedia Britannica, Inc. <https://www.britannica.com/place/Ghana/images-videos>)

¹ The Gold Coast comprised of five major ethnic groups, namely; the Akans, Ewes, Ga-Adangbe, Mole-Dagbani, and the Guans. While historical sources indicate that the Guans are the original inhabitants of the region currently known as Ghana, the Akans form the largest ethnic group spread out in neighbouring country Ivory Coast and other Caribbean countries like Trinidad and Tobago, Haiti, and Jamaica. From the colonial histories, the incorporation of the entire region under the control of the British Crown occurred under different circumstances. The coastal areas of the Gold Coast came under British colonial control immediately after signing the Bond of 1844 with Commander Hill to get British protection against the Ashanti empire – a tribe of the Akan ethnic group. The most formidable and ruthless indigenous military force (the Ashanti empire) was gradually incorporated under the British colonial rule after their defeat in the Anglo-Ashanti war popularly known as the Sagrenti War of 1874. The Northern Territories were also declared a British protectorate in 1902. The Trans Volta-Togoland under British Mandate was added to the region after the plebiscite of 1956.

Culture, spirituality, and the natural world significantly contributed to the development of the Indigenous peoples' medical and health-related expertise. For generations, many countries in sub-Saharan Africa relied on traditional medicine as their sole method of providing medical care.² On the Gold Coast and several other African countries, "access to traditional medicine was generally through traditional healers, who were community members trained in the use of traditional medicine."³ Their medical practices were based on herbalism and spiritism, where spiritual entities were consulted for knowledge about medicinal plants in the environment. As a result, the Indigenous Gold Coasters had diverse notions of spiritual entities, which varied depending on the specific ethnic group and community. In general, however, their belief centred around a Supreme Being associated with power, justice, and wisdom. This being, worshipped as the universe's maker and sustainer, was believed to have made knowledge easily accessible to anyone seeking it. The Gold Coasters held that the Supreme Being created various deities and entrusted them with varying degrees of responsibility in the lives of humans, with many of these deities being associated with aspects of nature such as rivers, forests, and animals. This implies that the deities were generally not considered equivalent to the Supreme Being in the Indigenous people's pantheon. The Indigenous people on the Gold Coast did not view the Supreme Being as gendered. Thus, the concept of gender did not apply to their understanding of divinity, and their deities were often depicted as either gender-neutral or capable of changing genders.⁴

² Sara, Lowes, and Eduardo Montero. "Traditional Medicine in Central Africa." *AEA Papers and Proceedings* 109 (2019): p.516.

³ *Ibid.*, p.516

⁴ This system of belief by the Gold Coasters is in contrast to some European colonial perspectives, which often associated the divine with masculinity and used gendered language to describe the Supreme Being. Admittedly, the impact of colonialism and Christianity is that some cultures in Ghana now attribute masculine characteristics to their Supreme Being, who was once a genderless being.

Oral histories confirm that both men and women were knowledgeable traditional healers on the Gold Coast. This is because there were no barriers to learning based on gender. Women on the Gold Coast played an essential role in providing care and treatment within the community-based healthcare system during the pre-colonial period. As Priestess Healers, Herbalists, and Traditional Birth Attendants (TBAs), Indigenous Gold Coast women wielded considerable authority and influence in the realm of traditional medicine. However, with the entry of European colonial powers and the subsequent establishment of colonial control on the Gold Coast in the late nineteenth century, the health and medical landscape of the Gold Coast underwent a significant shift.

While firmly entrenched on the Gold Coast, the British imported Western medicine and imposed new modes of health delivery during the colonial period, dramatically altering both the treatment of illness and the role of native women in providing medical services. Women's experiences in medicine during this time were affected by a variety of factors, including but not limited to western gender biases, colonial regulations, and advances in medical knowledge and practice. When colonial policy favoured the training and employment of male healthcare providers, the women of the Gold Coast, who had previously been active participants in healthcare provision in all facets of the traditional medical systems, were pushed to the fringes. Later, to reinforce European gender norms associated with motherhood, nursing and midwifery became professions open to women, albeit with strict gender roles and limitations. These were subordinate positions of patient care and caregiving. This is a significant facet of the experiences of Ghanaian and African women under colonial authority, which reshaped their roles and standings in institutions in which they had been participating for generations prior to colonial rule. There is a need to enquire about

these meaningful historical experiences of Gold Coast and African women's encounters with colonial rule. Therefore, this study examines the Indigenous Gold Coast women's place, roles and experiences in the pre-colonial traditional medical system, their exclusion from higher colonial medical fields and restrictions from becoming Sanitary Officers and Inspectors, Dispensers, and Medical Doctors, and their sudden concentration in subservient roles of nursing and midwifery to enforce European gender ideals of mothercraft.

Consequently, a research methodology that combines historical and qualitative approaches was required to analyse all these significant aspects of Gold Coast and African women's history which have been sidelined. The study used a strategy of collecting data from a wide range of primary and secondary sources, such as primary documents from archives, interviews with participants, and articles from medical publications. To better understand the intricacies of the women of the Gold Coast's experiences with colonial rule and Western medicine, the primary sources were analysed to unearth their medical experiences. Archival materials, colonial records, including annual government reports, correspondence, and other official documents related to health and medicine on the Gold Coast, were thoroughly examined. These materials produced valuable insights into the policies and practices of colonial authorities regarding health and medicine, as well as their impact on native women on the Gold Coast.

In order to learn about women's role as traditional medical practitioners in pre-colonial Gold Coast society, oral histories were an important source of knowledge available. Therefore, a semi-structured interview was used as a data collection strategy following clearance from The University of Western Ontario's non-medical Ethical

Board and the voluntary recruitment of participants by a credible member of the community at the study site. Four individuals from the Ashanti region of Ghana (all of whom have been given pseudonyms in this study) were interviewed in their homes between September and October 2022. Participants Maame Adwoa Ampafo Brakatu, Maame Yaa Mansa, Maame Abena Yiadom, and Maame Ama Benewaa were chosen because they had either worked as female traditional medical practitioners or had knowledge of the oral history of the activities of pre-colonial Gold Coast female medical practitioners that had been passed down through the generations. Both Maame Adwoa Ampafo Brakatu and Maame Yaa Mansa, who are well recognised in their communities as leading experts in traditional herbal medicine and birthing practises, learned their craft from their mothers. At an early age, Maame Abena Yiadom encountered a divinity that wished to possess her and allow her to join the practice as a priestess healer. However, her family performed rituals to beg the deity to leave her, and eventually, it did. According to the participant, her parents opposed the idea of her becoming a priestess healer due to personal reasons that cannot be disclosed. Even yet, she continues to see visions of spirits leading her to various medicinal plants for healing. Maame Ama Benewaa, on the other hand, learned her traditional medical skills and knowledge from her family. While all of the participants are currently based in the Ashanti region, their shared experiences cut across ethnic boundaries because three of the participants were raised in homes with members of different ethnicities who practised traditional medicine.

Secondary sources such as historical works, medical histories, and anthropological studies were consulted to provide a broader historical and cultural context for women's medical experiences on the Gold Coast. Thus, these sources were used to contextualise the findings from the primary sources.

Despite the importance of this topic, there is a dearth of research on African women's agency in medicine and how colonial rule impeded their ability to practice in this field. When writing about women's experiences, several anthropologists and historians misconstrued women in the broader colonial discourse until the first half of the twenty-first century. This was especially true for African women. African women's history has been marginalised, and this trend inspired effort to recover their historical experiences. More research on this aspect of African women's agency (medicine) is needed to understand how women's roles in African communities were diminished by colonial dominance. Because most academics, historians, and anthropologists view medicine as a male-dominated field unsuited to female participation, the duties and responsibilities of women in such a field and the deliberate segregation of women into submissive positions are rarely discussed. Then, there is the issue of locating the historical records comprehensively covering all facets of African women's lives because scholarship on the experience of African women under colonial authority and its effects on their status and power has ignored the medical area but has significantly explored economic and political aspects. There is an underlying supposition that African women had more of a central role in the functioning of African societal institutions than is documented in the existing literature on African women's history.

Through their works, Nwando Achebe and Ifi Amadiume contribute to our understanding of African women's power and how colonial rule altered their place in institutions. In her book *Male Daughters, Female Husbands: Gender and Sex in an African Society*,⁵ Amadiume argued that Igbo gender construction was flexible and was separated from biological sex, which enabled women to have some sphere of influence

⁵ Ifi, Amadiume. *Male Daughters, Female Husbands. Gender and Sex in an African Society*. (London and New Jersey: Zed Books, 1989)

and authority in all the aspects of the Igbo society, be it religion, political, social, or economic. Her study indicates that women were guaranteed and achieved power in pre-colonial Igbo society, but the colonial imposition undermined the existing social institutions in which women exhibited their place and power. Likewise, Achebe, in her book *Farmers, Traders, Warriors, and Kings: Female Power and Authority in Northern Igbo land, 1900-1960*,⁶ represents women of south-eastern Nigeria in history by examining their political and economic power and authority as farmers, traders, warriors, and kings. Similar works broadly looking at these areas of African women's history have been undertaken by Theodora Akachi Ezeigbo, Judith Van Allen, Farrar Tarikhu, Gloria Chuku, and Agnes Aidoo.⁷ Although each of these works adds to our understanding of African women's history, the study conducted on them belongs to the category of extensively researched issues in African women's past that overlooks other crucial areas, such as women's experiences in medicine. Consequently, these publications are part of the overly-explored scholarship on the experience of colonial control on the lives of African women in the political, social and economic spheres. These works, however, cannot be disregarded in their entirety since they give the framework and viewpoints necessary to place African women's historical experiences in context.

Women's experiences in medicine, both traditional and Western, are underrepresented or mentioned just in passing in the vast literature on medicine in the

⁶ Nwando, Achebe. *Farmers, Traders, Warriors, and Kings: Female Power and Authority in Northern Igbo land, 1900-1960*. Portsmouth, NH: Heineman, 2005.

⁷ See, Theodora, Ezeigbo Akachi. "Traditional Women's Institutions in Igbo Society: Implications for the Igbo Female Writer." *African Languages and Cultures* 3 (2): (1990) see, Agnes, Akosua. Aidoo. "Asante Queen Mothers in Government and Politics in the Nineteenth Century." *Journal of the Historical Society of Nigeria*, 9 (1): (1977), see. Gloria, Chuku. "Igbo Women and Political Participation in Nigeria, 1800s-2005." *The International Journal of African Historical Studies* 42, no. 1 (2009) see, Tarikhu, Farrar. "The Queen mother, Matriarchy, and the Question of Female Political Authority in Precolonial West African Monarchy." *Journal of Black Studies* 27 (5): (1997).

Gold Coast and Africa. Regarding the Indigenous people of the Gold Coast and other African countries, anthropological studies, medical journals, and articles all share a common pattern: they examine the medical exchanges between the Indigenous people and the European sojourners and colonists while also presuming that medicine was the domain of men. Such stereotypes are due to a lack of in-depth understanding of Indigenous African institutions, especially the traditional medical system's operations. Interestingly, George M. Foster and Barbara G. Anderson's book *Medical Anthropology*⁸ provides the scope and framework for understanding different medical systems through their examination of the historical development of medical anthropology. The book emphasizes the importance of the relationship between culture and health in every medical system. In their view, medical systems interact with and are influenced by cultural systems and how they shape cultural beliefs and practices related to health and illness. Thus, the authors argue that health and illness are not simply biological phenomena but are also culturally constructed and shaped by the beliefs and values of a particular society. Such a framework fit perfectly into this study's analysis of the Indigenous Gold Coast's traditional medical notions and ideologies of the development of diseases, healing, caring, protection, and medical knowledge acquisition which revolved around their socio-cultural beliefs, which have been misinterpreted. Based on this framework of the importance of culture and the medical system's relationship, Nancy Romero-Dadza, in her article "Traditional Medicine in Africa,"⁹ tries to emphasize the importance of traditional medicine in its healthcare provision. The author argues that traditional medicine has been an integral

⁸ George M. Foster and Barbara G. Anderson. *Medical Anthropology*. Wiley and Sons, New York: Knopf. 1978

⁹ Nancy, Romero-Dadza. "Traditional Medicine in Africa." *The Annals of the American Academy of Political and Social Science* 583 (2002): p.173

part of African healthcare systems for centuries and continues to be an essential source of healthcare for many African communities, particularly in rural areas where access to modern medical facilities is limited. Despite this contribution to the body of knowledge of traditional medicine, her article focuses primarily on the policies that various African governments have taken to recognize and regulate traditional medicine as part of official health care systems. The article is silent on the traditional medical practitioners and their activities in this healthcare delivery system. This is where this study fills the gap by exploring the female traditional medical practitioners who comprised a significant number of the specialized traditional medical practitioners on the Gold Coast.

Emmanuel Evans-Anfom's book *Traditional Medicine in Ghana: Practice, Problems, and Prospects*,¹⁰ published in 1986, is one of the earliest works on traditional medical practices in Ghana. The author analyses traditional medicine in Ghana and its important role in the Ghanaian healthcare system. According to the author, traditional medicine is the most easily accessible healthcare available to many people living in the rural communities of Ghana; hence, the need to integrate it into the modern healthcare system. He highlighted the relevance of supernatural elements in traditional medicine and how the healers incorporated them into their pharmacopoeia. The author calls for the recognition of traditional medical practitioners, the integration of traditional medical practices into the broader healthcare system, and the provision of support and resources to help traditional medicine practitioners to develop their skills and improve their practices. A gap in this important work is that it portrays the traditional medical field as the realm of men. Readers of this work will assume that the traditional healers

¹⁰ Emmanuel, Evans-Anfom. *Traditional Medicine in Ghana: Practice, Problems, and Prospects*, Academy of Arts and Sciences, Accra, 1986.

were only men who could use their expertise to heal people suffering from various illnesses. Thus, this work seems to glorify male healers and ignores the healing practices of traditional female healers as if they never existed. Also, despite the author indicating the relevance of supernatural elements in traditional medicine in Ghana, he fails to do an in-depth analysis of the people's conception of diseases and the principles guiding the dissemination of medical knowledge amongst the ethnic groups in Ghana. Like Evans-Anfom, Patrick A. Twumasi's article "Ashanti Traditional Medicine"¹¹ portrays a vital part of the traditional medical system—the fetish priesthood—as the domain of men. The article provides an interesting analysis of how the Ashanti priests received medical training as apprentices under the watch of a fully-fledged traditional medical practitioner. Twumasi emphasized that it is crucial for the men who had contact with deities to receive professional training to acquaint themselves with that particular deity's medical powers. According to the author, the Ashanti priests' healing activities were influenced by spiritual entities who tasked them to alleviate the illness and suffering of the members of his immediate community. Although his article contributes significantly to the body of knowledge in this field of study, it is limited in scope because it creates the assumption that the Ashanti traditional medical institution comprised only the fetish priesthood. The author writes absolutely nothing about the Ashanti herbal healers and traditional birth attendants who contributed to the development of the Ashanti traditional medical practices. It is clear that both authors, Evans-Anfom and Twumasi, portray the traditional medical field as an exclusively male domain and thus fail to recognize the presence of women and their medical practices in the traditional medical fields they explored. Therefore, this study fills these gaps by

¹¹ Patrick, A. Twumasi. "Ashanti Traditional Medicine." *Transition*, no. 41 (1972): <https://doi.org/10.2307/2935116>

representing Gold Coast women's experiences and medical practices in a field in which they have been denied recognition and acknowledgement as active practitioners.

Primary accounts by some European sojourners give information about the pre-colonial Gold Coast's traditional medical system. Regarding European anthropologists' and observers' accounts of the Gold Coast's traditional medical practices, the texts available also represent medicine as a male domain. David Birmingham is one of the numerous European writers who have written on the medical practices of the Indigenous people and the medical interactions between the European sojourners and the native Gold Coasters. In his article "The Regimento Da Mina,"¹² he examines how the Portuguese governed their African territories, particularly the castle at Elmina, and the challenges they faced and the methods they used to overcome them. According to Birmingham, the Portuguese sought to establish a "fortress culture" based on control, order and discipline. This culture was reflected in the regimento da mina, a set of rules and regulations governing the behaviour of the Portuguese soldiers stationed at Elmina. In Birmingham's view, the Portuguese government faced some challenges in governing the Indigenous people on the Gold Coast. The author notes that apart from dealing with the hostility of the local population, who resented the presence of Europeans and their cultural values, the Portuguese government still had to deal with the problem of diseases, which were rampant in the tropical climate and often incapacitated their soldiers. Although his article does not give an in-depth analysis of the medical interactions, it provides brief information on how the potency of local herbs and the successes of the healing activities of the Indigenous healers influenced the Portuguese

¹² David, Birmingham. "The Regimento Da Mina." *Transactions of the Historical Society of Ghana* 11 (1970)

sojourner's decision to incorporate the local herbs and some methods of healing into their pharmacopoeia. Thus, the brief portion of his article that looked at the medical activities on the Gold Coast provides evidence that native healers had expertise in the traditional medical fields and that the herbs used for healing ailments were potent. However, this article does not explicitly examine the Indigenous healers and their distinct medical practices on the Gold Coast.

Willem Bosman also provides fascinating insights into the Dutch activities in West Africa during the late seventeenth and early eighteenth centuries. Bosman's book, *A New and Accurate Description of the Coast of Guinea*,¹³ details the varied facets of Dutch participation in the region. This primary source document from the past is crucial for elucidating the local healthcare system. The book delves into the folk medicines, treatments, and beliefs of the individuals he met. An aspect relevant to this study are his accounts of the traditional medical practices of the Indigenous people on the Gold Coast. Bosman notes that the people he encountered on the Gold Coast believed in a variety of supernatural elements of illnesses which demons, witches and ancestors usually influenced. According to Bosman, the means of dealing with illnesses amongst the natives were through traditional medical practices, including herbal remedies, amulets, charms, and scarification. He opines that these medical practices were deeply rooted in local traditions and beliefs. While Bosman's account provides valuable insights into the medical practices of the time, it is important to note that the text is limited by his Eurocentric lens. He tends to present the practices he observed as primitive and barbaric. For instance, when recounting the medical methods of the

¹³ Willem, Bosman. *A New and Accurate Description of the Coast of Guinea*. (1705). London: By Ballantyne and Co. Limited, at the Ballantyn Press. p.221. See. Maier, D. "Nineteenth-Century Asante Medical Practices." *Comparative Studies in Society and History* 21, no. 1 (1979): <http://www.jstor.org/stable/178452>.

traditional healers he encountered, he asserted that “as for their manner of curing diseases, it is so wretchedly barbarous, and altogether superstitious, that it is incredible to relate it.”¹⁴ As a European observer, he had a limited understanding of the cultural and social context in which medical practices occurred. Obviously, his observation may have been influenced by the biases and beliefs of his cultural background. Additionally, he portrays the traditional medical fields as the domain of men.

Like Bosman, Henry Meredith, a soldier who was stationed on the Gold Coast, provides a first-hand account of medical practices he witnessed during his time in the region. His account in his book *An Account of the Gold Coast of Africa*¹⁵ highlights the importance of traditional medicine on the Gold Coast. The author notes that the Indigenous people relied heavily on traditional medicine and that it was common for them to visit herbalists to seek treatment for various ailments. Meredith also confirms Bosman’s account of the Indigenous people’s belief in the meta-physical causes of diseases. He intimated that the natives believed that various factors, including supernatural forces, caused illnesses and that traditional medicine was the best way to treat these illnesses. Meredith provides snapshots of medical activities some few women undertook and specialized in. However, like many other European anthropologists and observers, Meredith did not understand the socio-cultural underpinnings of the medical practices he witnessed. The author failed to identify and adequately interpret the reasons behind the medical practices, so he regarded them as primitive, barbaric and unscientific. Despite providing information on some native women’s dexterity in surgical practices, he did not cover all the fields of traditional

¹⁴ Ibid., p.24

¹⁵ Henry, Meredith. *An Account of the Gold Coast of Africa*. London: Printed for Longman, Hurst, Rees, Orme, and Brown. (1812).

<https://archive.org/details/anaccountgoldco01meregoog/page/n4/mode/2up>

medicine in which women participated. As a result, the author's work equally portrays the traditional medical fields as the domain of men. Therefore, while the historical accounts of David Birmingham, Willem Bosman, and Henry Meredith sideline native women and represent medicine as a male domain, parts of my study represent female medical practitioners and present their traditional medical activities on the Gold Coast like their male counterparts. It also seeks to clarify the misconceptions and misrepresentations of the motives behind the various medical practices undertaken by Indigenous female medical practitioners.

Unlike Evans-Anfom, Twumasi, Birmingham, Bosman, and Meredith's work which sidelines women's experiences in the traditional medical fields, Susan J. Rasmussen establishes Niger women's place in traditional medicine. In the Tuareg region of Niger in West Africa, Rasmussen examines the role of herbal medicine women among the Tuareg people of Niger. In her article, "Only Women Know Trees: Medicine Women and the Role of Herbal Healing in Tuareg Culture," she asserts that the people believe that knowledge of traditional medicine is "transmitted to, belongs to, and is practised and managed by women, like property."¹⁶ Rasmussen points out that although men are not excluded from the field of healing, "herbalism is primarily identified with women."¹⁷ Finding themselves in a society that embraced Islamic religion and patriarchy, these herbal medicine women mediated their way and performed their healing duties for the people who required their services. This article strongly informs my research because part of this study demonstrates how Gold Coast

¹⁶Susan, J. Rasmussen. "Only Women Know Trees: Medicine Women and the Role of Herbal Healing in Tuareg Culture." *Journal of Anthropological Research* 54, no. 2 (1998). p.148

¹⁷ Ibid., p.149

women, like the Tuaregs, mediated power to wield traditional medical knowledge and perform healing and caring practices.

Research that argues for women's place and power in medicine and their subjugation by male powers and authorities has been undertaken by scholars and feminists such as Barbara Ehrenreich and Deirdre English, Ann Douglas Wood, and Jean Donnison. These authors examined male dominance and European women's suppression in medicine. In their article, "Witches, Midwives, and Nurses: A History of Women Healers,"¹⁸ Ehrenreich and English used oral and written sources to present important phases of the assumed male takeover of healthcare through the suppression of witches in medieval Europe and the rise of the male medical profession in nineteenth-century America. They believed that women in medieval Europe lost their place in medicine as part of the gender struggle between the sexes, where men continued to subjugate women. They argued that the church and state intentionally planned the takeover of the medical field and male dominance in them as women were excluded from seeking medical knowledge in schools. Like Ehrenreich and English, Wood's article, "The Fashionable Diseases: Women's Complaints and Their Treatment in Nineteenth-Century America,"¹⁹ is a point of reference for women's history and the history of medicine. She examined the medical and scientific theories regarding femininity, how they impacted women's lives, and the theories used to justify women's confinement to the domestic sphere. According to Wood, medicine in the nineteenth century was structured as a punitive and corrective medicine for the female body. From

¹⁸ Barbara, Ehrenreich, and Deirdre English. *Witches, Midwives, and Nurses: A History of Women Healers*. Project Muse. New York: The Feminist Press. 1973. See. Barbara, Ehrenreich, and Deirdre English. "Witches, Midwives, and Nurses: a History of Women Healers." <http://feministes-radicales.org/wp-content/uploads/2012/06/Barbara-Ehrenreich-and-Deirdre-English-Witches-Midwives-and-Nurses-A-History-of-Women-Healers.-Introduction..pdf>

¹⁹ Ann, Douglas Wood. "'The Fashionable Diseases': Women's Complaints and Their Treatment in Nineteenth-Century America." *Journal of Interdisciplinary History* 4 (1): 1973.

the author's point of view, the purported female illness of menstrual disorders and maladies of the reproductive organs were the justifications for the constraints on women's intellectual and professional ambitions and their persistent exclusion from the medical field. Thus, the confinement of women to the domestic spheres was meant to control them and objectify their bodies by male medical practitioners. In the same vein, Donnison's book *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*²⁰ analysed the history of medicine as a history of oppression. This book is part of the pioneering works on the history of childbirth and midwives. The author analyzes the activities and experiences of women, obstetrics, and physicians in England since the seventeenth century. Donnison shares the same view with Ehrenreich and English that women and men continuously engaged in a relationship of struggle and oppression in the medical field. In Donnison's view, the suppression of women resulted from male physicians' control of knowledge through the development of instruments and surgical techniques. Also, the author did not discard the imperative role of religion in the subjection of women in medicine. He stressed that while religion persecuted female practitioners, medical knowledge also condemned them as ignorant in the medical sphere. These studies focused on women's medical experiences in Europe and the United States pave the way for comparative studies to be conducted on women's medical experiences in Africa and elsewhere.

Similar narratives of the integration of state and religion to suppress and sideline women in the field of medicine were explored by Temilola Alanamu, whose article contributes knowledge to our understanding of the interactions between Indigenous medical practitioners and imperial Christian missionaries that supported colonial

²⁰ Jean, Donnison. *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*. New York: Schocken; London: Heinemann. 1977.

policies. Using the nineteenth-century journals of the Church Missionary Society, Alanamu explores the complexities of nineteenth-century local beliefs about health and healing in Yorubaland of Nigeria. Her article, "Indigenous Medical Practices and the Advent of CMS Medical Evangelism in Nineteenth-Century Yorubaland," elucidates why Christian missionaries decided to practice "medical evangelism" rather than focusing on their protestant evangelism activities in the Yorubaland. The author argues that missionaries' disdain and disregard for traditional healers were evident in their activities and resonated throughout their journals.²¹ According to Alanamu, missionaries such as Henry Townsend convinced their converts to despise and reject Indigenous medicine by persistently criticizing and condemning traditional healers.²² The traditional healers of the Gold Coast were no exception to the frequent condemnations by the missionaries, and female healers of the Gold Coast became the target group of both the colonial authorities and missionaries. In complementing Alanamu's work, this study focuses on how the British colonial government initially deployed policies to exclude Gold Coast women from higher medical fields and later concentrated them in a subservient role as nurses and midwives to enforce European gender ideals.

Sara Lowe and Eduardo Montero's brief article, which focuses on traditional medicine in Central Africa, presents information about how colonial governments in some Central African countries endeavoured to impose western medicine in their colonies. According to the author, "anecdotal evidence suggests that colonial governments and missionaries targeted traditional medicine in Central Africa."²³ The

²¹ Temilola, Alanamu. "Indigenous Medical Practices and the Advent of CMS Medical Evangelism in Nineteenth-Century Yorubaland." *Church History and Religious Culture* 93, no. 1 (2013): p.7

²² *Ibid.*, p.7

²³ Sara, Lowes, and Eduardo Montero. "Traditional Medicine in Central Africa." *AEA Papers and Proceedings* 109 (2019): p.517.

same arguments can be made for traditional healers of the Gold Coast, specifically women who became the targets of colonial medical exclusionist policies that relegated them to the domestic sphere and only accepted their expertise in a subservient role as nurses and midwives. The authors' article does not necessarily examine the role of female healers. Although this article lacks in-depth information and analysis about the experiences and activities of traditional healers in the pre-colonial and colonial periods, it is relevant to my study.

The scholarship reviewed above confirms that research on African women's activities in medicine and how the imposition of colonial rule altered their position in the medical fields is limited. Despite oral histories and European travelogues affirming the participation of native women in the traditional medical fields, women only appear as footnotes in the medical histories of the Gold Coast and Africa at large. Therefore, this research will contribute important knowledge to the discourse and encourage further investigations and discussions in this field.

CHAPTER 2

WOMEN'S PLACE AND POWER IN PRE-COLONIAL TRADITIONAL MEDICINE ON THE GOLD COAST

2.1 INTRODUCTION

This chapter uses information gathered from four Indigenous women who are experts in traditional medicine to examine how Indigenous peoples in the pre-colonial era conceptualized disease and the principles of knowledge acquisition. Women's responsibilities as traditional Priestess Healers, Herbalists, and Traditional Birth Attendants on the Gold Coast are also highlighted in this chapter. Therefore, this chapter illustrates the concept that indigenous women on the Gold Coast were fully engaged in the caring and healing parts of traditional medical practices and the health system prior to the imposition of Western medicine.

2.2 THE CONCEPT OF DISEASES AND THE PRINCIPLES OF KNOWLEDGE ACQUISITION ON THE GOLD COAST

As described by Nancy Romero-Daza, traditional medical practises are community-based and founded on a long history of shared beliefs about the nature of health and healing.²⁴ In addition, George Maccllelland Forster and Barbara Gallatin Anderson opine that Indigenous medicine/traditional medicine is the "beliefs and practices relating to diseases which are products of Indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine."²⁵

²⁴ Nancy, Romero-Daza. "Traditional Medicine in Africa." *The Annals of the American Academy of Political and Social Science* 583 (2002): p.173.

²⁵ George M. Foster and Barbara G. Anderson. *Medical Anthropology*. Wiley and Sons, New York: Knopf. 1978. p.

This idea and belief supported the growth of medical knowledge on the Gold Coast prior to colonisation. A means of survival was obviously crucial to the pre-colonial Gold Coast's Indigenous peoples' existence, given the region's reputation among European travellers, explorers, traders, and missionaries as a hotbed of deadly tropical diseases. The presence of diseases meant that the natives used Indigenous medicinal knowledge to combat the prevailing diseases. According to the pre-colonial cosmologies of the Gold Coast's major ethnic groups, a human consisted of a body and a soul, and the two had to be in harmony for an individual to be healthy.²⁶ In other words, a person gets ill if his/her physical body or spiritual soul sustains an injury or disease. Every person's two aspects (body and soul) worked harmoniously to keep the body and mind in check. Thus, a person's physical and spiritual well-being were inextricably linked, and one needed to strike a balance between the two to thrive. In this sense, every person's physical form and spiritual essence were inseparable.

In the Indigenous peoples' perspectives on health, illness and sickness were seen as more than merely pathological alterations in a person's anatomy because they believed that these conditions were possibly instigated and perpetuated by supernatural entities.²⁷ It was widely thought that spiritual beings, including deities, dwarfs, woodland monsters, witches, and wizards, had a hand in spreading sicknesses, especially among disobedient humans and communities. Spiritual beings, such as deities and dead ancestors, were viewed as agents of the Supreme Being by the Indigenous people of the Gold Coast.²⁸ These agents (deities and other spiritual forces)

²⁶ Interview with Maame Yaa Mansa, at her residence, Kumasi, 30th September, 2022

²⁷ Ibid

²⁸ Although the major Gold Coast ethnic groups did not always use the same name for their Supreme Being, their conceptions of that being's role in the cosmos were consistent. Ewes, Ga-Adangbe, Akans and Mole-Dagbanis called their Supreme Being Mawu, Nyogmo, Nyame/Onyankopon, and Naawuni respectively.

were tasked with guiding and inspecting the course of life in each community, identifying and rewarding good people, and punishing wrongdoers for their evil deeds.²⁹ As a return for their good deeds, the spiritual entities bestowed upon the faithful divine protection, while those who committed evil met with bizarre illnesses or an early grave. The phrase affirms the socio-religious idea that good activities may attract blessings and good health. However, there was also a common belief that charitable individuals were just as susceptible to the ill effects of demonic spirits as were the wicked.³⁰ This belief in the meta-physical causes of diseases did not escape the accounts of Europeans who observed the socio-religious lives of the people on the Gold Coast. For instance, a piece of knowledge relayed to Thos C. Rice (Senior Sanitary Officer, Accra) by a local of Accra, detailing the widespread cultural idea among Accra's Indigenous people that the smallpox virus was connected to magic and religion encapsulates the natives' belief in the metaphysical causes of diseases. From Rice's account:

The natives of Accra and the surrounding districts believe that the infection of Small-Pox is generally brought about as a result of some disobedience of, or annoyance caused to some Fetish or Ju-Ju. At Labadi (about some five miles away), there is a Fetish called 'Akotia,' who is said, amongst other attributes, to be able to bring about Small-Pox. The deity does not entirely exist for bringing Small-Pox to towns, but has other powers to use when the occasion arises. The natives of Labadi when pronouncing a curse, often say 'I will send Akotia into your house to visit you,' implying thereby that 'I will send Small-Pox into your house to visit you.'³¹

It appears from this account that if a disease was physical and spiritual, a cure had to be as well. The Indigenous people were of the view that any illness could be cured with the help of the material and spiritual aspects included in the medicines created by

²⁹ Interview with Maame Yaa Mansa, at her residence, Kumasi, 30th September, 2022

³⁰ Ibid

³¹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1912*. London: Waterlow and Sons Limited, Printers, London Wall. pp.93-94

traditional medical practitioners under the guidance of spirits.³² The Indigenous Gold Coasters' belief in this concept reflected their more comprehensive view of the physical and metaphysical components at play in disease development. Understanding these concepts and etiologies of diseases was crucial to maintaining and safeguarding good health in every society on the Gold Coast. It was then a collective responsibility of the traditional healers (men and women), who were members of the community/village, to heal and protect the people and communities suffering from all kinds of diseases. It is important to note that in order to heal and safeguard their communities, healers needed either knowledge of the local pharmacopoeia or strong contacts with spiritual forces.

Living in harmony with their natural and spiritual surroundings, the Indigenous inhabitants of the Gold Coast discovered how to preserve their health and safeguard their lives through herbariums and spiritism. A fascinating feature of the traditional health system was that it was community-based, and women were not denied access to the knowledge and secrets needed to treat the virulent diseases common to the Gold Coast. There was a widespread notion among many people that the Supreme Being, as the ultimate force and source of all knowledge, had infused the entire cosmos with brilliance (knowledge) and made it accessible to anyone who sought it.³³ The Indigenous people maintained that all people should have equal access to knowledge and influence. In this way, the widely known Akan proverb lends credence to the Indigenous Gold Coast people's view that all individuals should have equal access to knowledge and power. As the old adage goes:

Like the ever-expanding baobab tree, knowledge, wisdom, and the truth are impossibly massive. In light of the baobab tree's ginormous proportions, no

³² Interview with Maame Yaa Mansa, at her residence, Kumasi, 30th September, 2022

³³ Ibid

human arm can hold it by itself. A full embrace of the baobab tree is impossible unless many people's arms reach out at once.³⁴

The critical examination of the proverb and its relation to the ideological notions of the Gold Coast's traditional health systems leads to the hypothesis that the cure and prevention of several diseases required a collective effort by the community's traditional medical practitioners, devoid of any gender restrictions and marginalisation. From this adage, knowledge and truth are universal and accessible to everyone regardless of their background or physiological makeup. Thus, the cultural foundations and ideas about learning in pre-colonial Gold Coast support the view that there was no gender delineation in terms of access to or control over knowledge. A large number of people from different ethnic groups on the Gold Coast firmly adhered to such long-held Indigenous cultural values.

It is not surprising that medical knowledge and healing practices on the Gold Coast during the pre-colonial period were diverse, and "many different members of society participated in enacting rituals of healing."³⁵ Therefore, it was a common practice in many pre-colonial African communities, including that of the Gold Coast, for both men and women to have access to the knowledge of herbs and the healing powers of spirits bestowed upon them by the Supreme Being who controlled the world. With the help of spirits and herbal knowledge, men and women probably worked together to create therapeutic procedures that kept the population healthy. Because of the Indigenous community-based health care system and the value placed on open access to knowledge, many Indigenous community members held varying degrees of Indigenous medical expertise. As part of the Akan medical system, Kofi Konadu

³⁴ Ibid

³⁵ Jonathan, Roberts. "Medical Exchange on the Gold Coast during the Seventeenth and Eighteenth Centuries." *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines* 45, no. 3 (2011): p.484.

divided medical knowledge into "basic knowledge, peripheral knowledge, and specialised and in-depth knowledge."³⁶ Importantly, these areas of Indigenous medical knowledge were not unique to the Akan people; other ethnic groups, like the Ga-Adangbe, Ewe, Guans, and Mole-Dagbani, possessed similar specialisations. Thus, medical knowledge was diverse, and widely disseminated and understood among the ethnic communities of the Gold Coast, as evidenced by oral histories.

It was common knowledge among people of different cultural backgrounds that certain herbariums, medicinal plant applications, and curative properties existed. It should be emphasised that the vast majority of Indigenous households had at least some familiarity with traditional medicine, which they might use to their advantage in a medical emergency.³⁷ Thus, every family (comprising men and women) had at least a rudimentary understanding of the healing properties of various plants. By extension, Indigenous women of the Gold Coast, along with their male counterparts who possessed primary plant medicinal knowledge, served as the first line of defence in sustaining individual lives prior to being passed on to specialists like priestess healers and herbalists for more in-depth traditional medical treatment and healing. Given this understanding and philosophy of traditional medicine, it is not unexpected that Indigenous women on the Gold Coast had access to medical knowledge and were able to treat sick members of their own families. It is clear from oral sources that women played a major part in the pre-colonial Gold Coast's and many other African countries' Indigenous community-based health systems by serving their families' medical requirements. Women could freely administer medication that could heal sick people

³⁶ Kofi, Konadu. "Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and Medical encounters with (Medical) Anthropology," *African Studies Quarterly*, volume 10, Issues 2 and 3, 2008. p.3

³⁷ Interview with Maame Yaa Mansa, at her residence, Kumasi, 30th September, 2022

even with only minimal knowledge of plant medicinals, which they had gained over the course of several years from experienced relatives and community members.³⁸

As opposed to the primary sphere of traditional medical knowledge, which was confined to the household or family level, those who belonged to the specialised sphere (herbalists, priests and priestesses, and traditional birth attendants) practised on a larger scale with the help of spiritual beings who persistently revealed in-depth secrets of several herbaria and healing practises. Specialised Indigenous healers were the ones who learned the ins and outs of traditional medicine and used their expertise to ensure the health and safety of their communities. In addition, they knew how to treat a wide range of deadly tropical diseases that had been plaguing the population. Many communities viewed these individuals as the "keepers of the keys to life and death."³⁹ Interestingly, women accounted for a significant portion of the medical practitioners on the Gold Coast who possessed the specialised domain of traditional medical knowledge. These women deeply understood the physical and metaphysical causes of the illnesses that plagued the Indigenous population of the Gold Coast. They (women) knew what signs to look for in their patients. Without any restrictions, it can be stated that traditional medical knowledge was equally easily distributed among men and women in pre-colonial Gold Coast, which is reflected in the common Akan adage "adwene ne nyansa nni baakofo tirim" (an individual cannot monopolise knowledge and wisdom).⁴⁰ Basically, this aphorism suggests that knowledge is accessible to every person, and an individual cannot claim absolute ownership of knowledge.

³⁸ Ibid

³⁹ Ibid

⁴⁰ Ibid

Indeed, it may be emphasised that both sexes were included in the realms of learning traditional medical knowledge because they each had important duties to play in the Indigenous community's health system. One may make the case that pre-colonial women were free to exert their authority without hindrance or limits, provided they learned the tricks of the trade for acquiring knowledge on par with males. Women's status, experience, and power in the Indigenous medical field or health systems on the Gold Coast are portrayed by the concept of unfettered healing and medicinal knowledge acquisition inherent in the medical cosmology of these people. These women contributed to the preventative and curative facets of conventional medicine. Given that women were not excluded from pursuing knowledge in the precolonial period, it is reasonable to inquire about the extent to which they participated in the traditional medical institution on the Gold Coast before the imposition of colonial rule and western medicine.

2.3 THE GOLD COAST TRADITIONAL PRIESTESS HEALER (S): MEDICAL RESPONSIBILITIES AND TRAINING DURING THE PRE- COLONIAL PERIOD

Before colonial domination and the introduction of Western medicine and techniques, Indigenous peoples in many African countries, including the Gold Coast, managed their own medical and health requirements. As already indicated, traditional African medicine and healing practices have existed for centuries in many parts of African societies. Emmanuel Evans-Anfom described traditional medicine as "a collection of individually evolved practices developed in different families over generations and transferred to a limited number of people by apprenticeship"⁴¹ From Evans-Anfom's

⁴¹ Emmanuel, Evans-Anfom. *Traditional Medicine in Ghana: Practice, Problems, and Prospects*, Academy of Arts and Sciences, Accra, 1986. p.26

definition, we can infer that traditional healers with specialised knowledge were among the small group of people who could learn about medicinal practices through apprenticeship. Priestesses, female herbalists, and traditional birth attendants all had important roles in this group. Traditional healers (specialists) were likely the most readily available medical professionals to local populations by virtue of their expertise in using medicinal plants for treatment.

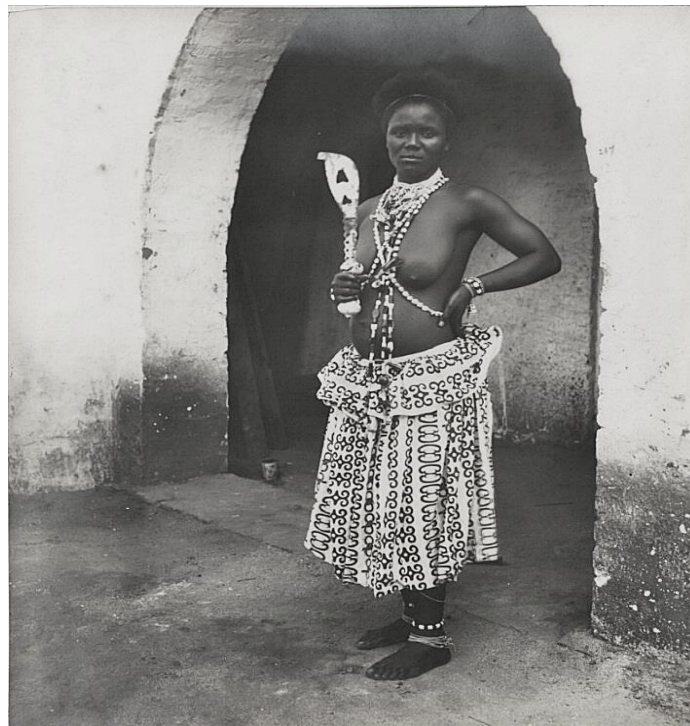


Figure 2.1 A Priestess Healer on the Gold Coast

In honour of the deity who had visited her, she wore the appropriate garb, which included strings of beads around her neck, wrists, and legs. The sword she brandishes is technically part of her medical-ritual garb, but it also symbolises her authority and power as a healer priestess. The sword can also be a communicative tool with the deity when possessed. Source: The National Archives (United Kingdom) collections, catalogued under document record CO1069-34-88.

<https://commons.wikimedia.org/w/index.php?curid=18994140>



Figure 2.2 A Priestess Healer and her Servant, Accra

During medico-ritual dances, the priestess frequently uses the cow-tail switches she holds in her hands to speak with the deity that possessed her. The cow-tail switch can also be employed as a healing tool because it is always decorated with charms that propel the priestess into the ethereal world to communicate with the deity to obtain medical knowledge and mysteries surrounding the illness of her patients. (Source: <https://www.pinterest.dk/pin/29836416271836709/>)

Priestess healers on the Gold Coast played an integral role in the health needs of their communities and were on par with other traditional healers in terms of medical knowledge, respect and prestige. In their roles as healers, priestesses were well-versed in medicinal plants, but they more often than not acted as agents or conduits of deities from whom they got instructions on how to identify and treat various illnesses. Thus, they established a link between the Supreme Being, the Ancestors, and other spiritual entities. In this way, priestesses were able to relay messages from the sick directly to the spiritual entities (deities) and bring back instantaneous feedback. A deity is represented by a physical thing that is believed to be imbued with spiritual or ethereal power. Deities to the Gold Coast's Akan people might be represented physically by crudely sculpted figurines made of bone, stone, wood, or brass bowl filled with mystic

plants and sealed with wax which possesses spiritual entities.⁴² Because the Supreme Being who created deities and other spiritual forces also gave special responsibilities to priestesses to operate as mediums for the manifestation of the powers of the Supreme Being on earth, priestesses possessed the same spiritual powers and skill of healing as their male counterparts. To show their devotion to the deities honoured at the shrine, the priestess routinely poured libations and offered food as sacrifices to them alongside their prayers.⁴³ The priestesses' prayers and libations were medical rituals which often sought divine intervention and protection from the powers of evil that sought to afflict the populace with material and metaphysical ailments. As a result, it was common to see, in the compound of a priestess or a priest, an earthenware pot filled with roots, leaves and water into which rum was occasionally poured for healing purposes.⁴⁴

The priestess was responsible for diagnosing, treating, and preventing illnesses. They healed various ailments by exorcism, incantations, spells, and invocation of deities.⁴⁵ The next step in the therapeutic procedure was to call upon her deity and investigate any potential spiritual causes for the ailment she had just identified in her patient. A thorough understanding of the healing process requires a deep dive into the traditional medico-religious phenomenon of priestesses being possessed by deities. This is because European authors like Willem Bosman have misread and misrepresented these medico-rituals, labelling them as primitive and superstitious when they are actually neither. Bosman reported that the fetish priests he saw practising traditional medicine had "a great many superstitious techniques of curing ailments, which are a mixture of charms, and nonsensical ceremonies, that have nothing in them

⁴² Swithenbank, M. *Ashanti Fetish Houses*, (Ghana University Press: Accra, 1969). p.10

⁴³ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

⁴⁴ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1912*. London: Waterlow and Sons Limited, Printers, London Wall. p.94

⁴⁵ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

but what is horrid and barbarous."⁴⁶ What Bosman and other European observers did not understand was that the priestess needed to undergo that “nonsensical ceremony” or possession by her deity in order to learn the specifics of the patient's case, the plants or herbs to utilise, and the proper order to deliver the medication.⁴⁷ In essence, the gods mediated the priestesses' ability to heal. Thus, she was in a unique position as an earthly representative of many spiritual beings, from which she drew inspiration and direction for her curative and diagnostic work. For instance, as part of the disease diagnosis process, the priestess "first consults the diety to ascertain what wrong the patient had done towards the deity and to ask for forgiveness and mercy before treatment is commenced."⁴⁸

During the possession ritual, priestesses were decked with a concoction of medicinal plants meant to shield them from harm and transform them into communicators with the gods or deities.⁴⁹ By wearing their ceremonial regalia (a smock or white, black, or red cloth depending on the particular deity) and charms and decorating their bodies with ritual scars, they were able to "enter into ecstatic states to communicate with their deities or gods."⁵⁰ Drums accompanied unique magico-religious tunes meant to fortify her in preparation for possession by the divine. Some carried brass pan shrines to invite the gods to inhabit their bodies and direct their work as priestesses, herbalists, and healers.⁵¹ Many strange things happen to a priestess when a deity comes to visit her, including shrieking, rolling around on the ground, wiggling

⁴⁶ Willem Bosman, *A New and Accurate Description of the Coast of Guinea*. p.25

⁴⁷ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

⁴⁸ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1912*. London: Waterlow and Sons Limited, Printers, London Wall. p.94

⁴⁹ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

⁵⁰ Pieter, De Marees. [1602] 1987. *Description and Historical Account of the Gold Coast of Guinea*, translated by van Dantzig and Adam Jones. Oxford: Oxford University Press. p.85. See. Jonathan, Roberts p. 486

⁵¹ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

her body, and spouting incoherent phrases that can be deciphered only by her linguists.⁵² These medico-ritualistic practises performed by the priestess healer mark her passage from the material to the ethereal worlds. In this state, the deity takes complete possession of the priestess healer's body, so it is not unexpected that her words seem garbled. Only her linguist, trained and given medicine to help hear the voices of the deities the priestess serves, can translate her words. Ludewig Ferdinand, an eighteenth-century Danish trading merchant on the Gold Coast, gave a vivid account of his observation of local priestesses being possessed by a deity. He attentively observed that the priestess healers:

With staring eyes, they foam at the mouth, gasping for breath. They usually enter this state suddenly and unconsciously; they can, at times, be walking with a water pot or something else on their head, talking to someone walking beside them, and in an instant, she is possessed. I have seen some who have made all these contortions and yet kept the water pot on their heads.⁵³

This was undoubtedly the most crucial part of the healing procedure that a priestess healer performed. Without being possessed by a god, a priestess healer would not have access to the metaphysical mysteries of the patient's ailment and the specific healing herbs necessary to cure them. As healers, the priestesses could identify the specific ailments plaguing each patient who came to them for help. In treating patients, minor maladies like constipation, boils and headaches were categorised separately from more severe conditions like leprosy and epilepsy.⁵⁴ Although the onus was on the priestess to faithfully carry out her deity's healing instructions to the letter, the onus was also on the patient to listen carefully to the priestess and implement the deity's directives.⁵⁵

⁵² Ibid

⁵³ Jonathan, Roberts. "Medical Exchange on the Gold Coast during the Seventeenth and Eighteenth Centuries." p.486

⁵⁴ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

⁵⁵ Ibid



Figure 2.3 A Priestess Healer in her white apparel and powder smeared on her body, giving medical instructions through her Linguist to her patients.

Among the Akan ethnic group, when a priestess wears white apparel, it usually indicates that the spirit possessing her at that moment is a River Deity. Because the spirit now resides within her body, the priestess's linguist or helper can trust any medical advice they get from her. Source: The National Archives (United Kingdom) collections, catalogued under document record CO1069-34-87.

<https://commons.wikimedia.org/w/index.php?curid=18994140>

It was commonly held among Indigenous communities that the success of the treatment provided by priests and priestesses was predicated on the patient's trust in the deity and willingness to follow the prescribed course of action. For instance, in recounting her mother's interaction with a patient in her shrine, Maame Adwoa Ampafo Brakatu explained that:

My mother performed rites to get possessed so that the spirits or deities would tell her what to do when a sick person visited her shrine in search of a cure for his/her disease. In some cases, the gods themselves will reveal what sort of plants or medication should be made and administered to the sick person. The patient would be healed or returned to full strength if he or she followed the deities' directions to the letter.⁵⁶

Possession as a precondition for healing, as we have seen, exemplifies the oneness of the spiritual and material worlds, where the secrets and knowledge hidden in the former

⁵⁶ Ibid

are given to the latter through the representatives (priestesses), in order to identify and treat the diseases of a community or society. It is intriguing that the deities that possessed priestesses also transferred knowledge of cures to them. Possessed people may, for instance, be led in the forest and shown the medicinal plants, herbs, and roots that will mostly impact a patient's condition.⁵⁷ Insanity, infertility, impotence, blindness, convulsions, and even leprosy were all treatable by priestesses thanks to their magical abilities and the therapeutic knowledge they gained from the deities.⁵⁸ As the community's traditional healer, the priestess was accorded the respect and power to dispense medicinal treatment. Multiple routes of medication delivery were used. Some of these methods involved putting the medication up one's nose, inhaling it, putting it in a drink or bath, or through incision.

The priestesses of the Gold Coast also played a crucial role in preventing diseases. As representatives of their deities, priestesses exposed potentially harmful aberrant behaviours and practices. To most societies, priestesses served as the de-facto spiritual seers of ailments, providing guidance and recommendations on how to stay healthy.⁵⁹ Medico-ritual acts performed exclusively by women were believed to effectively prevent the spread of infectious diseases like smallpox in several Gold Coast societies. For instance, as a preventive measure against contagious diseases, the women of Labadi were instructed to gather and shout appeasive cries during the early morning hours, calling on the deity by name to have mercy on them and their children. Following the priestess's instructions, women form a large group and march in procession through

⁵⁷ Ibid

⁵⁸ Ibid

⁵⁹ Ibid

the town's streets to its outskirts, shouting and waving to scare away any potential diseases while also making sacrifices and other offerings to the deity.⁶⁰

As a means of prophylaxis against sickness attacks orchestrated by demonic spirits, Priestesses would inflict ceremonial incisions on their patients. For protection against evil spirits and illness, most Indigenous peoples turned to amulets and charms, which consisted of symbolic medical materials produced by priests and priestesses.⁶¹ Talismans, which were fashioned after various human body parts and organs and worn by Indigenous to ensure or restore health to those parts, were another essential preventive medication made by priests and priestesses.⁶²

Regarding medical training, it must be noted that the Gold Coast traditional medicine as a community-based health institution had its "own established patterns of behaviour, its purpose and its group members."⁶³ To be accepted in society and recognised as a specialised traditional medical practitioner, a priestess was required to undergo special magico-religious training under the tutelage of a fully-fledged practitioner. This statement supports Jonathan Robert's argument that "access to these supernatural powers required spiritual research into diseases and professional training by men and women who were able to channel deities and interpret their will."⁶⁴ In a similar vein, John Beecham observed that in the eighteenth-century Asante territory of the Gold Coast, "fetish men and women apply themselves assiduously to the study of the healing art and acquire such a knowledge of the properties of herbs and plants as

⁶⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1912*. London: Waterlow and Sons Limited, Printers, London Wall. p.94

⁶¹ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

⁶² Ibid

⁶³ Patrick, A. Twumasi. "Ashanti Traditional Medicine." *Transition*, no. 41 (1972): p.50. <https://doi.org/10.2307/2935116>.

⁶⁴ Jonathan, Roberts. "Medical Exchange on the Gold Coast during the Seventeenth and Eighteenth Centuries." p.486

enables them to effect the cure of many complaints."⁶⁵ Thus, nothing restricted women from presenting themselves to be trained in the art of healing as priestesses and medical practitioners. Therefore, contrary to what we have been led to think by some scholars, women were not excluded from traditional medical training or fetish healing activities. Both men and women went through comparable steps in becoming traditional healers. However, as indicated by Twumasi, "both men and women are accepted as trainees but are trained separately at appropriate shrines."⁶⁶ Thus, fetish houses indirectly served as traditional medical training institutions that ensured the professional training of new practitioners or priestesses. Such an institution offered the fully-fledged the opportunity to monitor the progress of the incoming priestess healer keenly.



*Figure 2.4 A Fetish House, Kumasi*⁶⁷

Historically, fetish homes served as the primary place of education for priestesses and priest healers seeking to enter the medical profession. Around fetish dwellings, it was typical to find gardens full of therapeutic plants. Since priests and priestesses were not permitted to enter the forest to gather herbs on sacred days, they grew them nearby in case of an emergency. Source: The National Archives collections, catalogued under document record CO1069-31-29.

<https://commons.wikimedia.org/w/index.php?curid=18994140>

⁶⁵ John, Beecham. *Ashantee and the Gold Coast: Being a Sketch of the History, Social State, and Superstitions of the Inhabitants of Those Countries: With a Notice of the State and Prospects of Christianity among Them.* (1841).p.204. *The Open Library.* London: J. Mason. https://openlibrary.org/books/OL17935724M/Ashantee_and_the_Gold_Coast.

⁶⁶ *Ibid.*, p.50

⁶⁷ It served as a medical institution for the training of priestesses and priests. Also, it was a dwelling place of a fully-fledged traditional medical practitioner.

A priestess's acceptance into the conventional medical training institution was contingent upon her having a dream or waking experience with her family or lineage deity.⁶⁸ This implies that the acceptance criteria for the traditional medical priesthood included a candidate's specific link with a particular deity who desired to possess the new priestess in order for her to commence the practice. Those who initially encountered a deity typically, "entered the service of some fully-fledged practitioner of the particular god/deity who had expressed itself in them."⁶⁹ Ideally, priestesses received medical education and training at shrines, the earthly dwelling places of deities/gods endowed with magico-religious powers.

To prepare the arriving priestess to "think, act, and feel like a traditional medical practitioner," the traditional medical institutions were required to impart "professional knowledge, skills, and identity" to her.⁷⁰ The future priestess had to respect particular taboos of the god or divinity she would serve while undergoing rigorous medical training. For example, she was forbidden from engaging in sexual activity on holy days of the deity, socialising with peers of her own age, and consuming certain foods and animals.⁷¹ The training lasted for two to three years, depending on the trainee's determination, willingness, and seriousness to acquire the professional medical knowledge to enter practice as a fully-fledged traditional medical practitioner.⁷² As part of the magico-religious training, the incoming priestess was taught the locations, names, spiritual properties and therapeutic uses of several plants and trees available in society. An intriguing aspect of the training worth noting is the exposition of the trainee to her deity's dance patterns and rhythms, processes of getting possessed by the deity,

⁶⁸ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

⁶⁹ Patrick, A. Twumasi. "Ashanti Traditional Medicine." *Transition*, no. 41 (1972): p.50.

⁷⁰ *Ibid.*, p.50

⁷¹ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

⁷² *Ibid*

divination and the making and use of charms for protection and healing.⁷³ To learn to speak with or get guidance from her spiritual entities, the trainee (priestess) had to acquire the skill of divination, which involved the use of cowrie shells, stones, sticks, and bones.⁷⁴

After completing the medical training successfully and becoming a respectable fully-fledged practitioner, the priestess was believed to have acquired the skill, knowledge, and ability to protect and heal people in her community. This was the *modus operandi* of all priestesses and priests who had gone through training because they were expected to cure sick people through the powers obtained from their deities/gods. Caring for the shrines dedicated to her god or deity was a responsibility that allowed the new priestess healer to gain greater access to healing abilities. The most common and prominent shrines owned by priestesses of the Gold Coast's dominant ethnic group (the Akans) were brass-pan shrines placed atop hand-carved chairs.⁷⁵ Akan priestess healers were most often associated with these temples since stools symbolise political authority, and women have long been viewed as the wellspring of men's political power and authority. Therefore, it is reasonable to assume that the priestesses' prominence in Akan society's three most important institutions—medicine, religion, and politics—is reflected in the brass-pan shrines placed atop stools in the temples' inner sanctuaries. Since shrines were primarily owned by a single family or group of people, priestesses and priests served as shrine custodians. It is evident that there existed parity in the medical responsibilities, practices and training for priests and priestesses on the Gold Coast during the pre-colonial period. By virtue of the

⁷³ Ibid

⁷⁴ Robert, W. Wyllie. "Ghanaian Spiritual and Traditional Healers' Explanations of Illness: A Preliminary Survey." *Journal of Religion in Africa* 14, no. 1 (1983): 49. <https://doi.org/10.2307/1594933>.

⁷⁵ Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

practitioner's knowledge, he/she freely offered medical services to patients and society at large.

2.4 TRADITIONAL FEMALE HERBALISTS ON THE GOLD COAST: MEDICAL PRACTICES AND EUROPEAN OBSERVATIONS

The traditional health practices and *materia medica* on the Gold Coast often relied heavily on herbs. According to James Anquandah, there are numerous examples of medicinal pots used to store herbal concoctions dating back to the fourteenth century, evidencing the widespread usage of herbal treatments on the Gold Coast.⁷⁶ The common folk of the Gold Coast were able to address their health concerns due to herbalists' expertise. They went by several names in different cultures on the Gold Coast. *Odunsini* is the local Akan name for a herbalist, *Kpeima* (Dagomba), *Tsofatse* (Ga), and *Gbedala* (Ewe).⁷⁷ It should be stressed that these names were genderless and applied to both male and female herbal healers. Women's role in this crucial aspect of traditional medicine was established without question and was not up for debate in oral traditions. They had the same experiences and used the same herbal remedies as men. Women of advanced age who had acquired an indisputable mastery of tropical plants were mostly the primary conduits via which this knowledge was transmitted from one generation to the next among the various Gold Coast ethnic groups. In my own experience as a young boy growing up in a small rural town, I found that most of the area's herbalists were mature women with many years of knowledge in the profession. In her discussion of how she was able to learn the fundamentals of traditional herbology with little to no interference, Maame Abena Yiadom offered the opinion that:

⁷⁶ James, R. Anquandah. "Accra Plains, Dangmeland: A Case Study in the Eclectic Approach to Archaeological and Historical Studies." FASS Bulletin: A Publication of the Faculty of Social Studies 1. Legon: University of Ghana. (1996). p.8

⁷⁷ Marian, Ewurama Addy. "Traditional Medicine." p.3

Even as a young child, I remember walking around my neighbourhood and noticing the many kinds of herbal plants grown and utilised as fences. More often than not, my parents, older siblings, and I grew medicinal plants in our home's gardens. As my mother always told me, growing medicines on compounds was done so that people could have access to it more quickly in case of an emergency. Our parents taught us how to use herbs on the trip to the farm to treat things like prolonged bleeding from cuts and to counteract the effects of a snake bite right away. Whenever we were sick, my mom would go out to the garden or property, gather herbs, and make us a medicinal drink to help us feel better. When we were kids, my older sister and I accompanied our mom to the kitchen whenever she made medicine. My mother showed us how to prepare a home remedy for medical crises by boiling plants in pots and combining different herbs. Thus, my mother first taught me the fundamentals of plant medicine, including how to combine herbs to alleviate common complaints such as a headache, eczema, yaws, and common fever.⁷⁸

In every community, people learned the basics of therapeutic herbs. Everyone, regardless of gender, was provided access to the fundamentals of herbariums and their functions.⁷⁹ This statement disproves the consistent notion that men controlled and dominated African countries' traditional herbal therapeutic practices. There is no denying that many native Gold Coast women had extensive knowledge of edible and medicinal plants and how to use them to heal everyday maladies. Women in several ethnic groups' communities were traditionally responsible for making medication to cure everyday illnesses in their own families with the remedies they created at home.⁸⁰ More often, women with herbal knowledge added nutritional and therapeutic plants to family diets to prevent illness and strengthen their resistance to common ailments.⁸¹ It should not come as a surprise that women played an active role in this field of traditional medicine on the Gold Coast, given that across cultures and periods, women have been traditionally viewed as considerably more in tune with nature than males. As has been mentioned previously, given that many women on the Gold Coast predominantly

⁷⁸ Interview with Maame Abena Yiadom, at her residence, Kumasi, 5th October, 2022

⁷⁹ Ibid

⁸⁰ Ibid

⁸¹ Interview with Maame Ama Benewaa, at her residence, Kumasi, 11 October, 2022

prepared homemade medications for their families, they had a tremendous advantage in knowing about and being able to treat illnesses that required herbs.

Although it is well-known that herbalists use herbs to heal patients, it is less well-known that herbalists on the Gold Coast also made appeals to the spirits who resided there. Female herbalists and their male counterparts were not as dependent on or obligated to serve the gods as were priests and priestesses in order to gain knowledge of herbs and their medicinal purposes. Despite their belief that all plants with therapeutic properties were sentient beings, they were guided to them by their own spirits or those of their ancestors rather than by the gods. Dreams in which their own spirits or an ancestor instructed them to utilise the root, bark, or leaves of a particular tree or plant for healing certain ailments were the primary means by which most of them learned about and mastered the use of medicinal plants.⁸² As a result, we may say that spiritual principles played crucial roles in their approach to healthcare. This statement by a female herbalist sums up the esoteric aspect perfectly. Her expertise in herbalism led to her widespread recognition in the profession. According to her:

When you look at a tree or plant, you need to look at it not just as a mere tree on the pathways, roadsides or in the middle of farmland or forest. Rather, you must see and regard a living/spiritual being in the tree. This is because every tree possesses life, and spiritual entities dwell in them. No medicinal leaves, roots or bark of trees could be obtained for healing purposes without appealing to the spirits in them.⁸³

Both male and female herbalists traditionally used spirit communication with medicinal plants, including both speaking with and listening to the plants' shamanic guardians. Women in some societies of the Gold Coast played an outsized role in practising herbal medicine due to cultural and historical restrictions that meant only women had access

⁸² Interview with Maame Yaa Mansa, at her residence, Kumasi, 30th September, 2022

⁸³ Ibid

to some of the plants used to treat enigmatic diseases. For instance, women of the Akan ethnic group solely wielded power to undertake medico-religious rites to gain access to certain sacred medicinal plants. To obtain these sacred plants, the women would go into the woods at midnight armed with eggs and alcohol, strip down to their underwear in front of the magical plant, and beg the tree's spirit for permission to harvest leaves, stems, and roots for medicinal use.⁸⁴ Those males who disregarded these routines put their own health and well-being at risk, so they could not take on women's traditionally reserved roles in these medico-religious practices. It was widely held that one's health and life would be jeopardised if one did not adhere to the prescribed medico-religious procedures when acquiring such therapeutic herbs. Therefore, these tasks were typically handled by female herbalists (mostly middle-aged women) who specialised in the field. They could delegate these tasks by preparing and fortifying some women to fetch such sacred medicinal plants in the forest.⁸⁵

In their roles as traditional medical practitioners and healers, female herbalists could observe the plants and trees in their environment and learn how they interacted with one another to promote health in the local population.⁸⁶ Like their male counterparts, female herbalists would perform in-depth examinations of their patients before using their expertise in herbs to treat them. They knew what pathological symptoms to look for in a community-wide illness. When Gold Coast patients presented with symptoms like pallor, shivering, a high heart rate, a foul discharge, or convulsions, they usually turned to herbalists for advice.⁸⁷ Herbalists (both men and women) among the Adangbe people of the Gold Coast reportedly employed plants such as

⁸⁴ Ibid

⁸⁵ Ibid

⁸⁶ Ibid

⁸⁷ Ibid

Anyumokudale and *Ijede* to treat fainting and mental diseases, respectively, and *Blakatso* (*Ficus platyphylla*) to alleviate acute stomach disorders.⁸⁸ Among the most potent herbs used by the herbalists of this culture were *Hatso* (used to treat fever, ulcers, and asthma), *Nyinyra* (used to treat fever and jaundice), *Salotso* (used to treat diarrhoea, ringworm infection, and constipation), *Ahuatso* (used to treat venereal diseases and cardiac diseases), and *Kpetekplebi* (used to treat diarrhoea, fever, sterility, asthma and ulcers).⁸⁹ Also, they considered microorganisms and poor diets as causes of some diseases the locals suffered. Female herbalists advocated for preventative measures like personal hygiene and thoroughly boiling food to combat diseases. As a result, they regularly counselled people on the importance of hygiene and a diet rich in plant-based nutrients. Having determined the nature of the patient's illness through diagnosis, they next provided them with a set of directives and guidelines to follow in order to regain health. The herbalists often advised their patients to prepare a plant's stem, root or leaf in some way (by cooking, grinding, or pounding) in the hopes that the protection or healing properties of the plant would be imparted to them through these processes.

According to popular belief, the ancestors or a higher power sanctioned herbal treatment - therefore, if a patient diligently followed the herbalist's instructions, they would be healed. It is worth noting that the female herbalists' assistants kept detailed mental records of every patient's condition and treatment.⁹⁰ The herbalist adhered to a time-honoured practice and insisted that she be compensated for her services only after the patient had been successfully treated for the disease or condition.

⁸⁸ James, Anquandah. "African Ethnomedicine: An Anthropological and Ethno-Archaeological Case Study in Ghana." *Africa: Rivista Trimestrale Di Studi e Documentazione Dell'Istituto Italiano per l'Africa e l'Oriente* 52, no. 2 (1997): p.295.

⁸⁹ *Ibid.*, p.295

⁹⁰ Interview with Maame Yaa Mansa, at her residence, Kumasi, 30th September, 2022



Figure 2.5 Four Coomassie Women: Two of them beating (pounding) herbs in a mortar, 1884.

Traditional medication preparation procedures included pounding herbs in a mortar. Herbalists' knowledge of how to best prepare their plants' medicinal properties were either gleaned from years of experience or revealed to them in a dream from a venerable relative.

Source: <https://www.google.com.au/search?q=images+of+fetish+girls+in+the+Gold+Coast&tbm=isch&source>

Some European accounts indicate that Indigenous female herbalists on the Gold Coast also performed surgical procedures, including scarification and cupping, as part of their traditional medicine repertoire – two invasive surgical procedures used in Gold Coast's traditional medicine. Based on his research, Henry Meredith, an anthropologist, highlighted that some women around the coast were responsible for the manual procedures of scarification and cupping that required hand dexterity, which these women readily exhibited.⁹¹ These female herbal medicinal practitioners, who served as traditional physicians and surgeons, could easily remove guinea worms by gently

⁹¹ Henry, Meredith. *An Account of the Gold Coast of Africa* London: Printed for Longman, Hurst, Rees, Orme, and Brown. (1812). <https://archive.org/details/anaccountgoldco01meregoog/page/n4/mode/2up> . p.233. see. D. Maier. "Nineteenth-Century Asante Medical Practices." *Comparative Studies in Society and History* 21, no. 1 (1979): p.68. <http://www.jstor.org/stable/178452>.

slicing the skin onto a stick, so no worm remnants remained in the host's body.⁹² Boils were treated by lancing and slicing them open to remove the pus inside.⁹³ Meredith praised the Fante women's herbal skills, noting that their selection of individual roots and herbs reveals "no mean understanding of botany" and that "there is scarcely a plant without its special virtue" among them.⁹⁴

According to European sources, Indigenous Gold Coast herbalists and other traditional medical practitioners had an exceptional understanding of the healing properties of plants. As such, it is reasonable to argue that the Indigenous female herbalists of the Gold Coast, who played a significant role in the traditional health system, also deserve the same accolades and respect accorded to male herbalists/healers. This is because, similar to male herbalists, female herbalists had a broad range of botanical knowledge concerning the parts of specific plants to cure a given patient. Due to their immense herbal and healing knowledge, European travellers and anthropologists always knew that Indigenous Gold Coast women were a force to reckon with in the traditional medical field. Their accounts and travelogues, although broadly talking about native herbs and traditional male healers, still explicitly show that Gold Coast women knew and understood the local pharmacopoeia and its rules for curing diseases. For instance, Margaret Joyce Field, an anthropologist who investigated the ethnomedical practices among the Ga ethnic group of the Gold Coast, opined that:

Many ordinary bush people – farmers, hunters, old women and others have a great knowledge of the ordinary pharmaceutical properties of herbs. The common people's use of herbs is always along tried and tested lines. They know that *sese* root will dull pain and induce sleep, as boiled yam and meat soup will cure hunger and restore strength. We find the same herbs repeatedly used for

⁹² Jonathan Roberts. P.486

⁹³ Ibid

⁹⁴ Henry, Meredith. *An Account of the Gold Coast of Africa* (1812) p.233. See, D. Maier. "Nineteenth-Century Asante Medical Practices. p.73

the same purpose, and these widely used remedies are usually pharmaceutically sound.⁹⁵

Not only does Field's observation highlight the efficacy of herbs in treating certain conditions, but it also highlights the prominence and participation of women in the Gold Coast's herbal medicinal community. It is not a coincidence that Europeans living on the Gold Coast turned to studying the pharmacological properties of the local herbaria to fortify themselves against the tropical diseases endemic to the Guinea Coast. Lord Hailey, in his "An African Survey" regarding the study of native medicines, argued that "not all those who practice native medicine in Africa can be dismissed as witch doctors; many are muchly respected, and it is indeed possible that the study of herbs used by some of them might add to the list of remedies, such as quinine, which the pharmacopoeia owes to primitive medicinal practices."⁹⁶ These claims are evidence of the African people's unwavering faith in and respect for Indigenous herbalists and their extensive understanding of traditional medicine. In addition, evidence from European sources indicates that early European traders on the Gold Coast integrated the local herbaria into their pharmacopoeia due to its potency, as demonstrated through healing by the Indigenous herbalists. The *Regimento da Mina*, a Portuguese manual drawn up by the King of Portugal in 1529, describes the Portuguese and Gold Coast inhabitants' commercial interactions and some medical practices. According to David Birmingham, the guide (*Regimento Da Mina*) suggests that the Portuguese found it useful to study and employ Elmina (a community on the Gold Coast) pharmacopoeia in addition to medications acquired from Europe.⁹⁷ This indicates that Europeans who arrived on the coast were aware of the people's knowledge and approaches to diseases. Although the

⁹⁵ James, Anquandah. "African Ethnomedicine: An Anthropological and Ethno-Archaeological Case Study in Ghana." p.292

⁹⁶ Native Medicines, GH/PRAAD/ CSO 11-1-454A

⁹⁷ David, Birmingham. "The Regimento Da Mina." *Transactions of the Historical Society of Ghana* 11 (1970): pp.1-2.

European observers consistently tagged the healing practices by the natives of the Gold Coast as superstition, the local pharmacopoeia and the efficacy of herbs used by the herbalists could not go unnoticed.

Throughout the eighteenth and nineteenth centuries, European missionaries, travellers and trading merchants commented extensively on the herbs, herbal knowledge and how native herbalists of the Gold Coast treated diseases. In the accounts of the European trading merchants on the Gold Coast, "laxatives, emetics, diarrhetics, and analgesics"⁹⁸ were among the most common uses for plants prepared by both lay healers and professional herbalists. The herbalists used the available tropical herbs in "concoctions, potions, decoctions, suspensions, and powders"⁹⁹ to treat various ailments worrying the Indigenous population. Willem Bosman, a Dutchman who spent fourteen years on the Gold Coast in the eighteenth century in the service of the Dutch West Indian Company, provides an illuminating account of the Indigenous Gold Coast's herbal usage by herbalists. In Bosman's view, the first and most likely recourse to the tropical diseases by the natives of the coast was herbal remedies. When examining the local herbarium and its usage, Bosman opined that:

The Chief medicaments here in use are first, especially Limon or Lime Juice, Malaget, otherwise called the Grains of Paradise, the Roots, Branches and Bumms of Trees, and Green Herbs, which are impregnated with an extraordinary Sanative Virtue.¹⁰⁰

Bosman was stupefied by how well the herbal remedies suggested by the Indigenous herbalists (men and women) worked, and he averred that he had witnessed them "cure

⁹⁸ Jonathan Roberts. "Medical Exchange on the Gold Coast during the Seventeenth and Eighteenth Centuries." p.489

⁹⁹ Ibid. p.489

¹⁰⁰ Willem, Bosman. *A New and Accurate Description of the Coast of Guinea*. (1705). p.221. See. Maier, D. "Nineteenth-Century Asante Medical Practices." *Comparative Studies in Society and History* 21, no. 1 (1979): p.66.

his own compatriots when European physicians had given up hope."¹⁰¹ This reinforces the stories of two Basel missionaries, Andreas Riis and Johannes Zimmerman, who were treated for malaria and fever by a local herbalist on the Gold Coast after conventional medicine failed to do so in 1832 and 1834, respectively. After being cured, Riis condemned Dr. Tietz, the European physician in Christianborg castle, as being useless, saying that in his perspective, all the patients treated by Dr. Tietz perished, but those treated by the native herbalists and healers survived.¹⁰² The rate at which Indigenous Africans, and for that matter, Gold Coast herbalists, achieved success in the treatment of great and dangerous wounds and ailments stunned Bosman. In describing the efficaciousness of the herbs retained by the herbalists on the coast, he avouched that the "green herbs, which are the principal remedy in use, are of such wonderful efficacy."¹⁰³

Surgeon Henry Tedlie, who travelled to the Asante area on the Gold Coast as part of a British Mission led by Thomas Bowdich in 1817, expands upon the descriptions of traditional herbal remedies seen in European chronicles and travelogues. He also collected a significant sample of native "plants, recorded their local and possibly scientific designations and species, and detailed the pharmacopoeia preparations while listing a dozen maladies commonly experienced by the people. Tedlie enumerated roughly 37 common plants used for various treatments."¹⁰⁴ Evidence showed that many of the herbs collected by Tedlie helped with digestive issues, while

¹⁰¹ Ibid., p.224

¹⁰² Adam, Mohr. "Missionary Medicine and Akan Therapeutics: Illness, Health and Healing in Southern Ghana's Basel Mission, 1828-1918." *Journal of Religion in Africa* 39, no. 4 (2009): p.444.

¹⁰³ Ibid., p.224

¹⁰⁴ James, Anquandah. "African Ethnomedicine: An Anthropological and Ethno-Archaeological Case Study in Ghana." *Africa: Rivista Trimestrale Di Studi e Documentazione Dell'Istituto Italiano per l'Africa e l'Oriente* 52, no. 2 (1997): p.291.

others were used to treat skin conditions.¹⁰⁵ The traditional herbalists of the Gold Coast were seen to cure fever by having the patient take regular baths in warm water, after which the patient would be massaged with certain plants and herbs.¹⁰⁶ Some of the herbal medicine used by the Indigenous herbalists in treating fever included "*Cryptolepis Sanguinolenta*, a yellow root that contains anti-malarial alkaloids, *Rauwolfia caffra*, a type of milkweed, the barks of *Khaya senegalensis*, and *Sarcocephalus esculentus*."¹⁰⁷ In addition, some European observers and anthropologists regarded dysentery as dangerous and fatal in warm climates such as Gold Coast. Meredith was utterly overwhelmed with the successes native herbalists achieved in treating dysentery among the population. As noted by Meredith, in treating dysentery, the herbalists first used "extreme purgatives to empty the patient's bowels, after which astringent and stimulating clysters were introduced."¹⁰⁸ All these accounts and observations by European travellers and anthropologists attest that herbalists, as traditional medical practitioners, sustained the lives of the Indigenous people through their expertise long before Western medicine was imposed on the Gold Coast by the British. Evidence from oral histories and European observers confirms the prominent role Indigenous women of the Gold Coast had in the traditional medical system due to their herbal knowledge and healing powers. It also demonstrates the parity in the work of both male and female herbal specialists on the Gold Coast.

¹⁰⁵ Maier, D. "Nineteenth-Century Asante Medical Practices." *Comparative Studies in Society and History* 21, no. 1 (1979): p.67

¹⁰⁶ Henry, Meredith. *An Account of the Gold Coast of Africa* (1812). p.235

¹⁰⁷ Jonathan, Roberts. "Medical Exchange on the Gold Coast during the Seventeenth and Eighteenth Centuries." p.489

¹⁰⁸ *Ibid.*, p.243

2.5 THE GOLD COAST'S TRADITIONAL BIRTH ATTENDANT(S)

TBAs were typically middle-aged or older women who had been through multiple pregnancies with extensive experience in childbirth and caregiving.¹⁰⁹ Some learned the techniques and practises of this vital branch of traditional medicine through their mothers or other older female relatives, while others picked them up via extensive practice for several years.¹¹⁰ It was a common practice for women, especially mothers passing their knowledge on to their daughters, to keep each other informed on developments in the medical sector.

According to the oral traditions of the Gold Coast's various ethnic groups, procreation was necessary for society to survive. Matters of reproduction were a significant concern for an entire society. Not only were children needed to ensure and continue society's existence, but their labour was crucial to its economy, primarily based on agriculture during the pre-colonial period. As a result, barrenness, impotence, or infertility were severely stigmatised across the Gold Coast's diverse cultural groupings, including those of the Asante and other Akan people.¹¹¹ There was widespread prejudice against those who suffered from these conditions because many saw their infertility as a threat to human survival and society's continuous existence. Among the TBAs, while it was thought that a person's fortune played a role in whether or not they were able to have children, it was also believed that demonic spirits could be the source of such a problem.¹¹² However, their explanations for a woman's inability to conceive were not strictly premised on only the activities of evil forces, an explanation labelled superstitious by some European anthropologists. The TBAs

¹⁰⁹ Interview with Maame Abena Yiadom, at her residence, Kumasi, 5th October, 2022

¹¹⁰ Ibid

¹¹¹ Ibid

¹¹² Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

recognised that a woman's inability to conceive could be due to factors other than evil powers, such as a biological problem. For instance, the TBAs believed that removing conception-inhibitive diseases or conditions like *Babaso* (gonorrhoea) through herbarium could aid a woman in conceiving a child. Infertile women were given a mixture of herbs to chew, drink or insert to eliminate diseases that blocked or prevented them from conceiving.¹¹³

Every pregnancy stage was considered a significant life event that demanded thorough monitoring and special attention to preserve the health of the mother and her unborn child. This meant that the Traditional Birth Attendant's duty was to ensure the mother's and child's physical and spiritual safety and shield them from possible harm.¹¹⁴ As a result, TBAs in every Gold Coast culture provided comprehensive care for the general well-being of the mother and her unborn child during the whole pregnancy, delivery, and postpartum periods. As part of their prenatal care, expectant mothers were given pointers on maintaining a healthy lifestyle during their pregnancies, including what to eat and drink, what exercises to perform, and what could harm their unborn children.¹¹⁵ Drinking alcoholic beverages and eating foods high in protein were strongly discouraged for pregnant women. There was a strict ban on drinking alcohol when expecting a child due to concerns that it could harm both the mother and the unborn child. Some alcoholic drinks, such as *Akpeteshie* (primarily derived from palm trees through a fractional distillation method), were once thought to induce malformation in a foetus if ingested by pregnant mothers.¹¹⁶ It was also risky for a pregnant woman to drink, as she could endanger her unborn child if she got too inebriated. She might

¹¹³ Ibid

¹¹⁴ Ibid

¹¹⁵ Ibid

¹¹⁶ Ibid

stumble or fall when intoxicated, endangering herself and her unborn child. Overgrowth of the baby, caused by an excessive intake of protein meals, could have negative consequences for the pregnant woman's health. Pregnant women were encouraged to do light activities that would help strengthen and prepare them for child delivery but were not expected to engage in strenuous work like weeding or other activities that could harm the unborn child.¹¹⁷ Therefore, a transgression or disobedience to the TBA's medical advice by the expectant mother was undoubtedly regarded as the root cause of the complications she experienced during childbirth.

TBAs gave women herbal concoctions beginning at conception and continuing through delivery for two main reasons – the well-being of both the expectant mother and her unborn child.¹¹⁸ At the outset, information gathered from the Ga-Adangbe and the Akan people suggests that TBAs gave herbal remedies to expectant mothers with the express intention of making them and their unborn children more potent from the first to the fifth month of pregnancy.¹¹⁹ Nabutsie (*Erythrina Senegalensis*), a plant used to help pregnant women and strengthen the foetus in the womb, was one example of the medicine they provided.¹²⁰ It is important to note that TBAs on the Gold Coast knew that children could be born in the seventh to ninth month. Premature or prolonged childbirths that did not fall within these two possible time frames were considered unnatural and warranted thorough enquiries.¹²¹ As a result, pregnant women were given herbal concoctions to prepare them for delivery from the fifth month onward. For both TBAs and expectant mothers, these times were crucial.

¹¹⁷ Ibid

¹¹⁸ Interview with Maame Abena Yiadom, at her residence, Kumasi, 5th October, 2022

¹¹⁹ Ibid

¹²⁰ Ibid

¹²¹ Ibid

At this point in the pregnancy, the foetus has developed sufficiently to be delivered from the expectant mother's womb, and the mother experiences a wide range of stressful emotions and sensations. This can be characterised as a period of intense emotional and physical strain. More likely, it was believed that malevolent spirits and those with evil eyes become more prevalent during these times of pregnancy and could use the opportunity to attack the mother in an effort to prolong her labour and delivery.¹²² TBAs gave pregnant women slick medicinal herbs to insert vaginally and through enemas to fight off such attacks and propel them to an uncomplicated delivery.¹²³ In addition, they were given *Abe or Nanakinasaki (Elaeis Guineensis/oil palm fruits)* to aid blood formation and production of natural milk to feed the baby after birth.

During the final months of pregnancy, the TBAs closely monitor the expectant mother. The Akan culture placed great importance on a pregnant woman's *nteteho* (the sense of discomfort caused by the baby's movement around the uterus) as a signal that the moment of her delivery was drawing close.¹²⁴ The day or moment a TBA noticed intense fluid secretion from the pregnant woman's cervix meant it was almost time to deliver her child.¹²⁵ Per natural phenomena, babies were expected to come from the uterus to the cervix with their heads and not any other body part. It is puzzling to modern observers how ancient midwives could have anticipated such situations. Perhaps, one may wonder how these practitioners or traditional midwives identified that the unborn child was coming through the natural way (thus coming with the head). The TBAs claim that through lived experience and several years of practice, they got to know the body

¹²² Interview with Maame Adwoa Ampafo Brakatu, at her residence, Kumasi, 19th September, 2022

¹²³ Ibid

¹²⁴ Ibid

¹²⁵ Ibid

part the baby was coming with by observing the belly of the pregnant woman. In their view, the expectant mother's stomach should be shrunk under normal circumstances and not overly rigid throughout her labour's final weeks.¹²⁶ Another technique was to place a finger in the woman's cervix and feel the area or body part of the baby which was forthcoming. It was believed that in the weeks leading up to birth, the baby shifts from the uterus and comes closer to the cervix; therefore, this phenomenon made it simpler to detect which way the baby was coming.¹²⁷

No incisions needed to be made if the birth was not going to happen naturally. If the babies were not coming out the correct way during labour, it is clear that the TBAs did not have the necessary expertise to operate and help the distressed women. Regarding medical intervention, a TBA's only job was to give the mother a dose of particular herbs that would encourage the birth to occur naturally.¹²⁸ However, if the mother in labour was unable to deliver naturally with the help of the herbs, the last resort for the TBA was for her to manually turn the baby. Complications during childbirth, such as protracted labour and delivery, could be fatal for both the mother and the child. Some therapeutic herbs helped the labouring mother give birth more rapidly, relieving her of some of the agonies and suffering that the delay would have otherwise caused.

The postpartum period's medical adventures were crucial in pre-colonial Gold Coast childcare practices. The mother and the TBA had to devote much time and energy to this endeavour. TBAs continued to provide round-the-clock care for women and their infants for some time after delivery. They prepared special herbal medicine to aid

¹²⁶ Ibid

¹²⁷ Ibid

¹²⁸ Ibid

children with weaker bones who took a long time to walk. In warding off spiritual attacks by evil spirits against the vulnerable babies, TBAs mostly prepared talismans and charms around the babies' necks, wrists or legs.¹²⁹ These experienced women were the protectors and health providers of African mothers and their children long before the colonial rule and Western medical practices made their way to the Gold Coast.

As this chapter has shown, Indigenous Gold Coast women played a crucial role and featured prominently in all aspects of the pre-colonial traditional medical system. These women practitioners worked just as hard as their male colleagues to improve the health of their communities. One's knowledge of medicinal plants and their uses in treating sickness was more important than one's gender when it came to practising medicine in traditional communities on the Gold Coast.

¹²⁹ Ibid

CHAPTER 3

THE IMPOSITION OF WESTERN MEDICINE ON THE GOLD COAST AND NATIVE WOMEN'S EXPERIENCES

3.1 INTRODUCTION

This chapter exposes the discrimination and gender biases against native women in western medicine and practices. It portrays how native women on the Gold Coast, unlike their male counterparts, were sidelined in the recruitment and training of native health practitioners by the British colonial government. Despite the second chapter of this research showing that both oral sources and European travellers' accounts affirm that the Indigenous women actively participated in all aspects of the traditional system, the imposition of Western medicine coupled with European patriarchy ensured their exclusion in the fields they had been practising equally with men. The colonial agenda of imposing Western medicine to improve the health and living standards of the people on the Gold Coast restricted native women from becoming Sanitary Labourers and Inspectors, Dispensers and Nurse-Dispensers, and Medical Doctors.

3.2 THE HEALTH CONDITIONS ON THE GOLD COAST THAT LED TO THE IMPOSITION OF WESTERN MEDICINE

As it is widely known from European travelogues and the colonial histories of the Gold Coast, the first European contact with the Indigenous people occurred in 1471 when Portuguese sailors on an expedition to India in search of spices and other exotic products arrived on the shores of Shama (Elmina), a coastal city in the central region of modern Ghana. They had already established a foothold along this coast by 1482 when they constructed Elmina Castle to facilitate trade in gold and other valuable

commodities. As word spread of the region's affluence and profitable trade, many other European nations, including France, Britain, the Netherlands, Germany, and Sweden, flocked to the Gold Coast, and within a few years, multiple forts and castles were constructed along the stretch of the Gold Coast littoral.

The European traders and missionaries who established long-term communities along the Gold Coast also encountered the endemic tropical diseases of the area. Yellow Fever and Malaria were the two deadliest plagues that ravaged the European sojourners on the coast. It is important to note that numerous countries in tropical Africa had been struggling with these illnesses for decades. At the Pan-African health conference in Johannesburg, Dr. P. S. Selwyn-Clarke (Gold Coast representative) emphasised that "the first confirmed case of yellow fever in this region occurred in St. Louis, French Senegal, in 1778."¹³⁰ Similarly, data dating back to 1815 reveals that "Sierra Leone had long been considered the birthplace of yellow fever in West Africa due to a sickness with similar symptoms."¹³¹ The Gold Coast and most of tropical Africa were considered to be hyper-endemic. Since most Europeans presumably had no immunity to these diseases, they wreaked havoc on their lives to a devastating degree.¹³² On the Gold Coast, a rise in European morbidity resulting from yellow fever and malaria coincided with the expansion of European settlements along the littoral areas in the nineteenth century. For instance, in 1823, the Royal African Corps suffered a medical disaster when only "one person out of 128 white troops who disembarked at Cape Coast (the capital city of the central region of Ghana) survived and seventy out of 109 women and children who also landed on the coast in October

¹³⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1935*. London: Waterlow and Sons Limited, Printers, London Wall. p.88

¹³¹ *Ibid.*, p.88

¹³² *Ibid.*, p.89

of the same year died from the endemic tropical diseases within a short period."¹³³ The Gold Coast's Christian missionaries were perpetually vulnerable to the local microbes. According to these tales, the first Methodist missionary, the Reverend Joseph Dunwell, arrived in Cape Coast in 1835 and died within a few months, and several others perished in quick succession.¹³⁴

By 1840, six Danish governors living along the coast of Accra in the Christiansborg Castle lost their lives in quick succession after succumbing to the tropical diseases that ravaged the Gold Coast.¹³⁵ Unsurprisingly, the Danes eventually decided to sell their possessions on the Gold Coast to the British in 1850. Similarly, by 1872 the Dutch had also abandoned their possessions and left the Gold Coast, making the British the sole occupier of the region.¹³⁶ For reasons described by Stephen Addai, the consolidation of British power and influence on the Gold Coast led to a rise in the number of British officials, missionaries, and commerce merchants living there.¹³⁷ This meant that medical policy was essential to keeping people alive in the region. Nevertheless, it was not until 1883 that substantial attempts were undertaken to improve the population's health by establishing the first civil colonial hospital in Accra by Governor Rowe, who laid its foundation in 1880.¹³⁸ The building consisted of one two-storied block, a European Ward of four beds, a Native Ward of twelve beds on the upper floor, and a Dispensary and Nurses' quarters on the ground floor.¹³⁹

¹³³ Ibid., p.89

¹³⁴ Stephen, K. Addae. *The Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960*. Edinburgh; Durham USA: Durham Academic Press. p.15

¹³⁵ Ibid., p.10

¹³⁶ Albert. A. Buahen. 'Politics in Ghana 1800-1874', in *History of West Africa*, ii, ed. By J.F.A. Ajayi and M. Crowther (Essex, 1974), p.260

¹³⁷ Stephen, K. Addae. *The Evolution of Modern Medicine in a Developing Country*. p.29

¹³⁸ GH/PRAAD/ ADM-11-1-50.

¹³⁹ Ibid



Figure 3.1 A picture of the Colonial Hospital, Accra

Source: The National Archives (United Kingdom), catalogued under document record CO1069-29-37. <https://commons.wikimedia.org/w/index.php?curid=18993988>

Indeed, this period coincided with Charles Louis Alphonse Lavern's discovery of the malaria parasite and the advent of treatment and prevention strategies against malaria. Therefore, it is reasonable to argue that the formalisation and imposition of western medicine and practices are traceable to this period. However, in the initial stages, all medical efforts made by the British colonial government of the Gold Coast were geared towards the European population and a few non-official Africans who worked for the government. In the European's view, the natives had the opportunity of acquiring immunity in infancy against such diseases, unlike the Europeans, who were at risk. Such views are revealed in the reports of the routine division of malaria.

Immunity is high on the Gold Coast and throughout most of tropical Africa, which is at odds with the idea that diseases have recently swept through the region's native population. As long as the delicate equilibrium between infection and immunity is maintained or is not forcibly disturbed, residents of the Gold Coast likely have little to worry about in the way of devastating epidemics and mortality like those recorded against malaria in India.¹⁴⁰

¹⁴⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1929-1930*. London: Waterlow and Sons Limited, Printers, London Wall. p.75

Medical segregation was widely practised on the Gold Coast as a response to widespread misinformation about the Indigenous people's supposed resilience in the face of tropical diseases and the Europeans' apparent fragility to them. The importance of racial segregation was something Dr. Rice brought up as early as 1910. Boyce, dispatched by the Secretary of State to report on the 1910 pandemic, added, "in conclusion, I would place segregation of whites (non-immunes) in the forefront of all preventive measures at the present moment in West Africa."¹⁴¹ Because of this, the Colonial Office suggested setting specific areas for whites to live, "at least a quarter of a mile away from the African township."¹⁴² This preventative health measure was implemented to lessen the likelihood that "mosquitoes infected in the African quarter would spread the disease to the white neighbourhoods."¹⁴³ However, since locals were just as susceptible to the prevalent bacteria, the myth that they had a natural defence against sickness seemed groundless. For example, in a little hamlet about "60 miles inland from Accra, 1,500 out of a total population of 6,000 inhabitants fell ill with yellow fever, and 150 died."¹⁴⁴ As a result, by the end of the nineteenth century, significant efforts were made to extend European healthcare to more natives on the Gold Coast.

¹⁴¹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1935*.p.92

¹⁴² *Ibid.*, p.92

¹⁴³ *Ibid.*, p.92

¹⁴⁴ *Ibid.*, p.89

3.3 NATIVE WOMEN'S EXCLUSION IN THE COLONIAL SANITARY HEALTH BRANCH ON THE GOLD COAST

The European observers, administrators, missionaries, and anthropologists blamed the unsanitary practises of the locals and the unfavourable weather conditions of the Gold Coast for the high death toll among Europeans. Most European ideas on what caused tropical diseases centred on the miasmatic theory that polluted air spread illnesses. Hippocrates' dictum that "diseases are regular and mild accompanied by steady and seasonable times of the year, but in inconstant and unseasonable times the diseases are uncertain and difficult of cure"¹⁴⁵ was widely accepted in Europe. As a result, the abnormal weather patterns of heavy rainfall were commonly blamed for the high rates of European morbidity in Accra, Cape Coast, and Elmina. For instance, in the 1893 report of the medical doctor stationed at Elmina, he claimed that "prolonged dryness with heavy dews and mists at night which gave sufficient moisture promoted the malaria contagion."¹⁴⁶ He asserted that the "proximity of the lagoon Banyea, the long mud flats exposed by the receding tide, rises a sickening miasmatic odour."¹⁴⁷ Also, Dr. J.D. McCarthy, the Chief Medical Officer of Accra, expressed his disgusting atmospheric experience after heavy rainfall in Accra. After touring the town after a heavy downpour, he stressed that:

At the imminent risk of being infected by its poisonous emanations, I walked through the purlieu of the town one morning after a night's rain; the scene which met my view and the foul stench that arose from the black mud of lanes and compounds churned by natives and pigs are indescribable. Other conditions, such as filthy habits and indifferent foods, concur in raising the sick and death rate.¹⁴⁸

¹⁴⁵ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1886*. London: Printed for Her Majesty's Stationary Office, By Eyre and Spottiswoode. p.28

¹⁴⁶ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1912*. p.88

¹⁴⁷ *Ibid.*, p.88

¹⁴⁸ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1886*. p.32

It can be deduced from this statement that the supposed unsanitary living behaviours of the Indigenous people of the coast indirectly affected the atmosphere, which consistently contributed to disease outbreaks. The close quarters in which the Gold Coast's inhabitants lived were theorised as part of the reasons for the region's disproportionately high rates of illness and death during periods of extreme weather. The colonial administration saw these situations as bad and believed that the only way to save them was to create more open spaces in and around locals' homes so that grass and trees could be planted, which would act as natural purifiers and, in turn, enhance the natives' moral standing over time.¹⁴⁹ There was also the need to impose the supposedly civilised European ways of healthy living in the homes of the natives and convince them to access colonial hospitals for treatments. They reasoned this way because they believed that the Indigenous people were still morally immature and that external influences—political, economic, and moral—should have disproportionate control over their upbringing.¹⁵⁰ This vision could only be achieved through the activities of health workers. European medical professionals were dissuaded from working in the colony due to its bad reputation for the prevalence of dangerous infections. As a result, in dealing with the sanitation problems of the colony, the colonial authority had to rely on Indigenous people trained as African sanitary staff members (labourers and scavengers) and inspectors, working under the supervision of the few European medical practitioners and senior sanitary officers on the Gold Coast.

Given European ideas about women's roles in the home and the fact that it was already common knowledge that native women played an active role in the colony's traditional health system, it stands to reason that women would have been the ones

¹⁴⁹ *Ibid.*, p.32

¹⁵⁰ *Ibid.*, p.32

selected and trained for this crucial position which was much concerned with improving the domestic living standards among the natives. The native women of the Gold Coast should have been seen as the finest supervisors of their own living conditions in the domestic sphere if, as depicted by European gender conventions, women controlled the domestic realm, which indirectly affected society at large. Contrary to such expectations, the Gold Coast's Indigenous women were not included in the sanitary branch of the colonial health system when it was established around 1910. The report on the Addah neighbourhood's sanitary problems highlights the idea that the colonial authorities never considered hiring and training women in the health administration branch responsible for sanitation improvement. In 1887, Dr. Cole, stationed at Addah, reported to the chief medical officer of Victoriaborg, Accra, that despite purchasing two expensive carts from England for sanitary purposes in his station, filth and rubbish were allowed to accumulate in various parts of the town due to a lack of men to perform the sanitary work of the town.¹⁵¹ Hence, this statement by the medical officer implies that employing males would be the only solution to the town's squalor. As a result, he proposed the first formal incorporation of Indigenous people (men) into the colonial health agenda and activities of promoting and ensuring proper hygienic practices by asking for the "appointment of 12 men at 151 per month as scavengers and sanitary labourers."¹⁵²

Cleaning and weeding the marketplaces and streets, digging and closing waste dumps, and general scavenging were among the first tasks assigned to these native male sanitary labourers to ensure the upkeep of proper European hygienic conditions in different communities on the Gold Coast.¹⁵³ In 1911, the sum of £7,000 was voted in

¹⁵¹ *Ibid.*, p.58

¹⁵² *Ibid.*, p.60

¹⁵³ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1905*. p.17

the estimates for the recruitment and training of more scavengers and labourers on the Gold Coast to actively give their best towards promoting European hygiene.¹⁵⁴ As the 1912 Sanitary report indicates, with the £7,000 voted, 335 men were recruited, trained and employed in the colonial sanitary health branch as sanitary labourers and scavengers, while no woman was considered.¹⁵⁵ They were distributed in all outstations of Accra, Winneba, Saltpond, Cape Coast, Elmina, Secondee, Axim, Tarquah, Dunkwa, Apam, Anomaboe, Dixcove, Akuse, Chama, Kpong, Odumasi, Somanya, Aburi, Pram Pram, Dodowa, Mangoase, Nsawam, Pakro, Adawso, Koforidua, Quittah, and the Northern Territories.¹⁵⁶ Even during the interwar periods that required more native workers in the sanitary branch, preference was given to native men over women. The table below lists African Staff confirmed in their appointment as Sanitary Inspectors on 24th November 1933.¹⁵⁷

Table 1. List of native men appointed as Sanitary Inspectors

Name	Position
Denfu Nartey	Second Division Inspector
A.B. Azu	Second Division Inspector
J.E. Coleman	Second Division Inspector
A.A. Dourdoe	Second Division Inspector
T.B. Nkum	Second Division Inspector

¹⁵⁴ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1911*. p.56

¹⁵⁵ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1911*. p.57

¹⁵⁶ *Ibid.*, p.57

¹⁵⁷ African Staff, Medical department, regarded as having been confirmed in their appointment. GH/PRAAD/ CSO 11-1-196

M.T.M. Abladu	Second Division Inspector
P.A. Sackey	Second Division Inspector
J.C. Nortey	Second Division Inspector
E.B. Asuman	Second Division Inspector
V.P. Fletchyan	Second Division Inspector
B.C. Acquah	Second Division Inspector
Louis Commetey	Second Division Inspector
Bernard Ayivor	Second Division Inspector
Emmanuel Apea	Second Division Inspector
G.K. Addy	Second Division Inspector
Robert Larbie	Second Division Inspector
I.W. Amarteifio	Second Division Inspector
J.T. Senayah	Second Division Inspector
H.A. Berko	Second Division Inspector
S.T. Lartey	Second Division Inspector
R.A. Nortey	Second Division Inspector

Source: GH/PRAAD/ CSO 11-1-196. African Staff, Medical department, regarded as having been confirmed in their appointment.

The table blatantly displays the colonial medical system's preference for local men and its exclusion of native women in the colonial sanitary branch. Further investigation from the archival sources indicates that all the names listed in the table above are men; no women appear anywhere because they were never considered for recruitment and training to become sanitary health practitioners as were their male counterparts. Therefore, the first form of integrating natives into the colonial medical fields can be said to be discriminatory because recruitment and practices were based on gender lines. One can reasonably wonder if local native women if hired and properly trained, would not have been just as adept as their male counterparts in fulfilling these hygienic responsibilities. A wealth of anecdotal evidence demonstrates that native women on the Gold Coast had long been engaged in sanitation activities at both the household and community levels before the imposition of colonial rule. The traditional roles of women, which consist of keeping their houses tidy, might have been readily transferred into the public arena if they had been allowed to engage in the activities they had already been performing. It is possible to argue that the Europeans' perceptions of gender norms and behaviours would have been challenged by their (native women) presence and engagement in the public realm as sanitary labourers of the colony. Also, the colonial authority may have mistakenly concluded that native women lacked the physical power to engage in hygienic operations such as building latrines and digging and shutting waste dumps because of prevailing European masculinity standards, which held that only men could do work that was physically demanding but not women.

The role of native Africans in sanitation shifted over time, with men continuing to be favoured for these roles. In the early twentieth century, as the table below illustrates, there was a marked increase in the number of reported cases of malaria because it was believed that *Anopheles gambiae* and *Anopheles funestus*, the two

species responsible for malaria, were ubiquitously distributed throughout the Gold Coast wherever the requisite light or shade yields a suitable environment for their propagation.¹⁵⁸

Table 2. A table showing a marked increase in malaria cases

Year	Cases	Case mortality per cent
1900	107	5.60
1901	234	5.12
1902	310	4.19
1903	528	1.32
1904	478	1.25
1905	395	4.05
1906	377	1.06
1907	2,827	0.21
1908	2,535	0.19

¹⁵⁹Source: The data for this table was extracted from the Government of the Gold Coast, *Medical and Sanitary Report for the Year 1908*.

¹⁵⁸ Malaria in Tropical and Sub-Tropical Africa. GH/PRAAD/ CSO 11-1-447

¹⁵⁹ From the table, it can be seen that there were variations in the number of cases recorded for the years. While malaria cases increased for four consecutive years (1900-1903), they decreased for three consecutive years (1904-1906) and increased exponentially in 1907 while marginally decreasing in 1908. The case mortality per cent showed a consistently marked decrease in the death rate. This mortality rate decrease can be explained in two terms. The first reason for the decrease could probably be the discovery of malaria treatment in the form of quinine, and the research into tropical diseases through the Tropical School of Medicine established in Liverpool by the Colonial Secretary of State, Chamberlain, in 1898. The second reason would be the sanitary and medical activities of European medical doctors in the colony and both native and European sanitary workers.

Despite the decrease in mortality rate, it is evident from the data that the cases recorded were still high, hence the need for more auxiliary sanitation workers in this vital health branch of the colony. The data on malaria cases allowed the Advisory Committee to the Colonial Medical Department in London to discuss concerns relating to Africa's Colonial Medical Service in 1909. Forming a specialised department to address the sanitation issue in each colony was endorsed as one of the meeting's most consequential decisions.¹⁶⁰ This was the point at which the Towns, Police, and Public Health Ordinance of 1878, a law aimed at improving public health, was actually enforced in the Gold Coast. Such an increase in malaria cases necessitated the immediate focus on recruiting and training more Indigenous people in the sanitary health branch to prevent the disease in all towns and communities on the Gold Coast. While this changed the status of African men in the colonial sanitary healthcare sector, native women remained marginalised and were not considered agents who had the potential to contribute to the sanitary branch's activities as labourers and officers. Men were given extra opportunities to learn about scientific approaches to maintaining public health. The native men's position in the sanitary branch gradually evolved into Mosquito Brigades with several public health responsibilities. In light of their newfound prominence in colonial public health, they were divided into several gangs and assigned specific tasks, such as cleaning the streets, collecting recyclables and emptying trash cans.¹⁶¹ They were recruited to serve as mosquito brigades and given training in collecting any or all things that might be used to hatch mosquitoes. Thus, these groups of native men in the colonial health sector were put across all outstations to inspect and destroy mosquito larvae, limit their breeding places and treat them with kerosene.¹⁶² Importantly, they

¹⁶⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1909*. p.5

¹⁶¹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1911*. p.56

¹⁶² Government of the Gold Coast, *Medical and Sanitary Report for the Year 1909*. p.10

became advocates for quinine prophylaxis in the Gold Coast, spreading the word to locals about its life-saving effects.¹⁶³ As part of the colonial sanitary staff in the Ashanti territory, these native men listened to special lectures on vaccination from European medical doctors. They learned how to vaccinate as the Vaccination Ordinance of 1919 was implemented in Juaso, Odumase, Konongo, and Atindie, as well as the coastal areas of the Gold Coast.¹⁶⁴

Unlike women, native men were accorded another opportunity in the colonial health sector as junior sanitary inspectors. Along with their European supervisors, they investigated numerous residences to identify filth and other unacceptable living circumstances. They worked with Senior Sanitary Inspectors (Europeans) by accompanying them on "house-to-house visitation, filling up depressions, cleaning, digging and grading ditches, and inspecting gutters in all towns in the colony."¹⁶⁵ As junior sanitary inspectors, they had the power to persuade the general public that preventing the most prevalent ailments was more important than treating them once they manifested.¹⁶⁶ In Ashanti, for example, native sanitary inspectors who oversaw villagers' sanitation and layouts seized every opportunity to impress upon the locals the need to maintain clean dwellings and communities by conducting inspections and holding meetings.¹⁶⁷ This position given to native men in the colonial health system gave them an advantage over women on the Gold Coast. As indicated in the 1911 medical and sanitary report, sanitary inspectors were given considerable powers under the various ordinances of the Gold Coast. Their importance in the colonial health system is revealed by an officer who stressed that:

¹⁶³ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1908*. p.13

¹⁶⁴ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1920*. p.15

¹⁶⁵ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1911*. p.56

¹⁶⁶ Village Dispensaries, establishment in Ashanti. GH/PRAAD/ CSO 11-3-44

¹⁶⁷ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1928*. p.36

Here, apart from the deterrent effect of prosecution for offences against sanitation, spreading knowledge of hygiene amongst the people depends largely upon the individual efforts of our Sanitary Inspectors.¹⁶⁸

This indicates that while these junior male sanitary inspectors and their supervisors were tasked with educating various native households, especially women, they also had the power to prosecute and fine them if they infringed on colonial sanitary laws.¹⁶⁹ Native women were mainly blamed for breeding malaria in their respective homes due to their storage methods for domestic purposes. Constant supervision was required from the inspectors and mosquito brigadiers to prevent the people, especially women, from keeping water standing in barrels or pots in their homes.¹⁷⁰ The inspector explained that "the earthen pots or calabashes used for domestic storage were concealed in different places, and they were generally dirty and dark in colour, making it difficult to determine the presence of larvae of mosquitoes."¹⁷¹ Thus, the officers even assumed that the domestic storage materials used by native women in their homes were possible breeding grounds for mosquitoes. It was a common practice for sanitary officers to primarily utilise the Mosquitoes Ordinance (which allowed for fines of up to £5 for larval offences) on mosquitoes that developed in containers and chatties inside homes and compounds.¹⁷² Sanitary officers had the right of entry into the homes of natives between the hours of 6 a.m. and 6 p.m. Since it is common knowledge that native women were in charge of the domestic sphere, they often got charged with larval offences in their homes, unlike men.¹⁷³ A group of women in Accra staged a protest outside the Government House in January and February 1912 because of the sanitary inspectors' repeated intrusion in their private life by prosecuting them with various larval

¹⁶⁸ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1911*. p.64

¹⁶⁹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1898*. p.320)

¹⁷⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1910*. p.34

¹⁷¹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1909*. p.11

¹⁷² Government of the Gold Coast, *Medical and Sanitary Report for the Year 1912*. pp.96-97

¹⁷³ *Ibid.*, p.97

offences.¹⁷⁴ The native women who demonstrated against the officers maintained that "there was no water that did not contain mosquito larvae" and that they were "being punished for what was virtually an act of God."¹⁷⁵ Their exclusion from the sanitary branch enabled men to exploit, interfere, control, and even influence their domestic lives.

Colonial sources show that sanitation was crucial to the medical practices of the colonial administration in its jurisdictions. This is because the natives' observance of good hygienic practices would have a consequent effect on the Europeans' well-being. The idea of enforcing European sanitary knowledge and practices on the Gold Coast was to cause a change in the "unhygienic" behaviour of the natives (men and women). It was not supposed to be about the "smattering knowledge of books but drawing out the latent mental capabilities through every portal of sense. Such an education would make the natives fit to comprehend the value of the benefits of civilisation."¹⁷⁶ With this in mind, in 1905, the colony's government launched an initiative to have its funded schools begin providing basic lessons in hygiene and sanitation to the territory's children (boys and girls).¹⁷⁷ European Medical Doctors gave talks to educators, who then taught the students at their respective schools. In addition to the instructions given to the schoolchildren in schools, simple pamphlets were printed in the commonest native languages for distribution.¹⁷⁸ Nonetheless, it is ironic that despite both sexes being offered education or knowledge in sanitation, only native men were preferred for the roles of junior sanitary inspectors. Why, despite girls and boys

¹⁷⁴ Ibid., p.96

¹⁷⁵ Ibid., p.96

¹⁷⁶ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1887*. London: Printed for Her Majesty's Stationary Office, By Eyre and Spottiswoode.p.33.

¹⁷⁷ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1907*. London: Waterlow and Sons Limited, Printers, London Wall.p.10

¹⁷⁸ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1910*.p.56

receiving sanitation education in schools, were only men enlisted and given specialised training to do sanitary inspection and vaccination? It is safe to infer that in the colonial administrators' view, women needed only basic knowledge to be used within the domestic sphere and were not to be employed as health workers in the colony because they lacked the intellectual capabilities to grasp the complex scientific methods of sanitation. In this way, native women's influence was only meant to be perceived within the confines of the home rather than in the broader community or public spheres. A statement by a medical doctor in one of the outstations of Gold Coast affirms this assumption of probably excluding women from the colonial sanitary branch. In his explanations of the people to be recruited and trained as sanitary inspectors, the medical officer opined that Sanitary Inspectors are given considerable powers under the various ordinances, and it is essential that they should be persons of probity and intelligence, capable of exercising an educational influence upon those with whom their work brings them into contact.¹⁷⁹

This comment and the fact that native women were barred from working in the sanitary field demonstrate the widespread belief held among European colonialists that native women were intellectually inferior. Although it was known that certain Indigenous women shared the same level of education as their male contemporaries, no efforts were made to recruit or train any of these women for the role of sanitary inspector. Interestingly, a particular medical officer's statement revealed that a crop of educated women was present on the Gold Coast, who should have probably been considered in the sanitary branch. According to the officer, for the side of sanitary work at his station, it occurred to him that "a number of educated native women might be trained and sent

¹⁷⁹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1912*.p.64

out into the principal towns."¹⁸⁰ Yet, only local males were given priority for jobs in the colonial government's sanitary service. Even when there were vacancies and more natives were needed in the sanitary branch, men were the only people considered. For instance, in 1913, there were seven sanitary inspector vacancies in the outstation of Cape Coast, and with the "increased pay scale offered, it was hoped to attract and bring the staff up to full strength with a better class of men."¹⁸¹

Because of the European gender standard of women's subordination to the home, colonial authorities saw it as fair to give native men the power to govern and instill discipline in the native women of the Gold Coast. This follows from their observation that Indigenous women, in contrast to their male counterparts, posed significant challenges to the spread of European medical methods. Even though both men and women were generally opposed to European medical practises (as evidenced by the event that occurred at Galoo, a place in the Ada district on the Gold Coast, where men and women burned the huts erected for medical purposes by the District Commissioner in 1887),¹⁸² more men accessed European treatment than women. According to medical and sanitary reports, the Ada district experienced a smallpox epidemic in 1887, and the native Galoo population despised the European medical practise of isolating patients as a preventative measure against the illness. It is a common knowledge that the natives on the Gold Coast had their own medical means of dealing with the smallpox disease. They treated it by inoculating or exposing unaffected people to the disease so that they develop immunity against it. Therefore, it can be argued that the people preferred their own mode of treatment of the disease to

¹⁸⁰ Ibid., p.64

¹⁸¹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1913*.p.17

¹⁸² Government of the Gold Coast, *Medical and Sanitary Report for the Year 1887*.p.49

the European medical approach of isolation. In his report to the colonial governor about the incident, the medical officer of Ada explained:

Isolation of the cases was one of the precautionary measures adopted to check the progress of this disease, but the people are very much averse to be removed from their houses. At Galoo they burnt the huts erected for their reception and treatment by the District Commissioner to show their disinclination to go there.¹⁸³

From data collected on patients admitted and treated in colonial hospitals on the Gold Coast in the late nineteenth century, we can see evidence that more local men than women sought European medical attention there. For instance, in 1888, the medical officer of Accra reported that out of the 501 admissions at the colonial hospital, 480 were men, and only 21 were women.¹⁸⁴ In the Kwittah district, when medical reliefs were granted to persuade natives to accept European treatment, the statistics show that 1000 males presented themselves for treatment in the colonial hospital while only 393 females presented themselves.¹⁸⁵

Indigenous women did not favour European treatment and practices, which is why they did not seek treatment in greater numbers in the colonial hospitals. Colonial authorities believed that recruiting and training women as colonial sanitation officers would have jeopardised the "civilisation" mission because Indigenous Gold Coast women opposed European health practices that challenged their way of life. When placed next to European gender standards that have consistently linked civilisation and culture with men, it becomes clear that Indigenous women were only to be seen as passive recipients of civilisation (hygienic knowledge) from men. In the long run, the knowledge imparted to them by men would "raise the standard of living, marking

¹⁸³ Ibid., p.49

¹⁸⁴ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1888*.p.36

¹⁸⁵ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1887*. p.64

progress from savagery to refinement."¹⁸⁶ It has been noted that women on the Gold Coast's traditional community-based health system enjoyed full equality of access to and participation in any field. Excluding them from having a continued active role in healthcare was a change in native cultural norms. The policy of hiring and training exclusively males assigned men the responsibility of maintaining public sanitary health while women were supposed to be focused on homemaking. The colonial reports affirm this claim because, as sanitary health officers, these men were deemed capable of checking epidemics and possessed the ability and skill to reduce contagious diseases associated with unsanitary living conditions.¹⁸⁷ This approach pushed native men to the forefront of public health initiatives while women were relegated to the sidelines.

3.4 NATIVE WOMEN'S EXCLUSION FROM THE COLONIAL DISPENSARY FIELD

British colonial authorities on the Gold Coast utilised dispensaries as a way to discredit traditional medicinal methods as being rooted in superstition, by making this branch of medicine (dispensaries) an integral part of the colonial health system. Village dispensaries were the solution to the natives' strong opposition to western medical practices and their refusal to access the colonial hospitals in greater numbers for treatment against tropical diseases. In 1887, C.H. Eyles, the Assistant Surgeon in charge of Axim, gave up when he endeavoured to start vaccination in the colonial hospital because the natives did not show a keen interest in it. According to him, "the natives do not appear to be acquainted with the value of vaccination."¹⁸⁸ European medics conceded that it was challenging to persuade locals to adopt a different healthcare

¹⁸⁶ Ibid., p.33

¹⁸⁷ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1921*. London: Waterlow and Sons Limited, Printers, London Wall.p.21

¹⁸⁸ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1887*. p.21

system than the one their families had used for generations.¹⁸⁹ They reasoned that unless the “civilized” medical treatment were adequately supervised, the locals would continue to use native cures in the vast majority of situations since their faith in “civilized” medical care was far weaker.¹⁹⁰ Therefore, in order to move beyond the hospital setting and make western treatment and practices closer to the Indigenous population, European medical officers and surgeons such as Dr. J.D. McCarthy, Dr. J. Numa Rat, Dr. Sylvester J.B Cole, Dr. F.W. Sullivan, Dr. C.H. Eyles, Dr. J. Spilsbury Smith, Dr. Freeman and many more were tasked with the responsibility of undertaking public or village dispensary activities in their respective outstations on the Gold Coast. This decision was based on the assumption that if European doctors and surgeons were able to establish successful dispensaries and treatments in rural areas, it would be a subtle way of demonstrating to the natives that Western medicine (or "white man's juju") was superior to traditional or Indigenous practices.

Dr. J. Farrell Easmond's report from February 1888 reveals that as well as providing medical care, European doctors and surgeons also served as dispensers in their outposts, where they helped ease the suffering of the Indigenous population.¹⁹¹ Most patients were taken care of for conditions involving connective tissues and ulcers.¹⁹² Next in line was "filaria Medinensis, followed by subacute and chronic rheumatism and then syphilitic illnesses."¹⁹³ In addition, several patients were seen for treatment of catarrhal gastrointestinal and respiratory mucous membrane disorders.¹⁹⁴ As a result of the persistent dispensary activities of the European medical men and

¹⁸⁹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1888*. p.19

¹⁹⁰ *Ibid.*, pp.19-20

¹⁹¹ *Ibid.*, p.22

¹⁹² *Ibid.*, p.22

¹⁹³ *Ibid.*, p.22

¹⁹⁴ *Ibid.*, p.22

surgeons, the number of natives who received western or European medicine and treatment gradually increased. The records show that in Cape Coast, "a total of 184 natives treated during the first quarter of 1888 increased to 479 in the last quarter of the year."¹⁹⁵ Dr. Cole, the medical officer of the Addah outstation, also stressed that he treated 806 native patients that same year.¹⁹⁶



Figure 3.2 A Village Dispensary

Source: The National Archives (United Kingdom), catalogued under document record CO1069-43-85.

When the first public dispensary activities commenced in the North Western section of the Northern Territories in February 1927, Dr. Saunders believed that their treatments and medical activities boosted the natives' confidence in western medicine. He emphasised that:

The fear of anaesthetics has been primarily abolished in the Tumu district. The effect of the removal of large elephantiasis, the immediate and dramatic restoration of sight by an entropion operation on a patient whose eyes had been closed in painful spasm, the removal of tumours without fire -all these things must tend to cause confidence and will facilitate future medical work in the area.¹⁹⁷

¹⁹⁵ Ibid., p.22

¹⁹⁶ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1887*. p.58

¹⁹⁷ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1928*. P42

At this point, public or village dispensaries on the Gold Coast were carried out exclusively by European male medical professionals, as no locals of the Gold Coast had been recruited or qualified to work in this field of medicine within the colonial health system. It is important to note, however, that the colonial authority began making efforts to recruit and train nine native men, excluding women, as auxiliary dispensers as early as 1887; these men were restricted to working only in the colonial hospital and were not permitted to practise in any villages or public dispensaries as they had no expertise in comprehensive healthcare yet.¹⁹⁸ Despite this limitation imposed on the men, gender biases against native women are still seen due to the preference for native men to be recruited and trained as dispensers in the colonial hospital while women were sidelined.

Unlike women who were not even considered for such roles, these local men were afforded the opportunity and privilege to serve as Dispensary Pupils in the hospital dispensary during certain periods of the year.¹⁹⁹ The minimum period of training was three years.²⁰⁰ After their training as Dispensary Pupils, they had the privilege of becoming private practitioners as druggists if they passed the Druggist examination. Messrs. Quao and Pobee were among the earliest native men recruited and trained by the colonial government who passed their druggist examination.²⁰¹ Native men were consistently favoured over women despite the fact that they did not demonstrate superior intelligence when being recruited and trained in hospital dispensaries. As indicated by Dr. Cole, most of them (male pupil dispensers) "failed time after time to pass an examination for a license under Ordinance No. 14 of 1892."²⁰² Also, the

¹⁹⁸ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1887*. p.180

¹⁹⁹ *Ibid.*, p.180

²⁰⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1902*. p.19

²⁰¹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1887*. p.180

²⁰² Government of the Gold Coast, *Medical and Sanitary Report for the Year 1912*. P.6

statement of Dr. Alick E. Knight, the assistant colonial surgeon of the Accra colonial hospital, supports this argument of the biases against native women and the preference for only male hospital dispensers. In his report on the colonial hospital at Accra and its dispensary branch for the year ending 31st December 1901, Dr. Knight stressed that:

I consider this branch to be fairly satisfactory, but I would also like to see a better class of men taking up the work, more of the stamp of the older men. In connection with these men's training, I strongly believe they should have some opportunity to learn a little about first aid to the wounded and elementary medicine.²⁰³

Women were not offered a single opportunity in this field, even though the men recruited were not really up to the task. The above statement by the colonial surgeon sheds light on why these native men were nevertheless favoured for posts as local dispensary practitioners, although they were not intellectually better. A form of sexism, which is probably the desire to restrict native women's active participation in the colonial healthcare system as practitioners, is the only plausible explanation for their exclusion. Again, this statement demonstrates the colonial government's resolve to restrict medical authority and education to males while relegating women to the realm of domestic life. The exclusion of Indigenous women from dispensary training programmes and the exclusive training of males is indicative of the male monopolisation of knowledge and an attempt to confine medicine's therapeutic role to males.

It was not until 1929 that the colonial government decided to incorporate natives into public or village dispensaries in order to effectively popularise European medicine and practices in the colony and reduce the burden on European medical doctors and surgeons who doubled as village dispensers. Presumably, this decision was

²⁰³ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1901*. P.19

partly due to the First World War effects on the entire population of the British Empire and her colonies. Arguably, the Indigenous population in all British territories fell following World War One. In addition, by 1928, many locals on the Gold Coast still had not been exposed to Western medicine and techniques due to the limited number of colonial hospitals and the government's policy of restricting village dispensary travels to the small number of European medical practitioners and surgeons who were then accessible. Therefore, in order that medical services may be extended even more widely than the past years, "a scheme of training native dispensers in increasing numbers in such a manner as to render them suitable for posting to places in the bush lying outside the stations ordinarily served by medical officers was worked out, and it was hoped to make a commencement during the ensuing year of 1930."²⁰⁴

The scheme focused on an all-male recruitment approach with no recognition for women.²⁰⁵ Dr. Inness based the model of this scheme on pre-existing models in Sierra Leone.²⁰⁶ Specifically, the plan from November 1929 was to educate eighty certified dispensers (native men) within the next fifteen years to provide first aid and work as assistants to the district medical officers in their respective areas.²⁰⁷ The pupils to be trained as Nurse-Dispensers were expected to already be enrolled in nursing. In 1930, the Secretary of State officially sanctioned this plan, which was thereafter adopted as the Nurse-Dispenser Scheme.²⁰⁸ Considering that the Nurse-Dispenser scheme's stated goal was to train suitable individuals from the ranks of Nurses-In-Training and 2nd Division Nurses, it stands to reason that native women should have been allowed to be educated as dispensers since they were already in the qualifying

²⁰⁴ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1929*. p.11

²⁰⁵ Scheme for Training Nurses and Dispensers. GH/PRAAD/ CSO 11-1-677

²⁰⁶ Ibid

²⁰⁷ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1935-1936*. p.35

²⁰⁸ Ibid., p.35

field as Nurses-In-Training and 2nd Division Nurses. Although, it is important to note that the first wave of Indigenous people to be recruited into the nursing sector (the qualifying entry field of nurse-dispensary) on the Gold Coast were men, women were later officially acknowledged and allowed to enter the nursing profession. So, by 1930, when the Nurse-Dispenser Scheme was introduced in the Gold Coast, a small number of local women had been recruited and trained alongside their male counterparts in the nursing industry. The statistical data for 1931 stipulates that the total number of 2nd Division Nurses and Nurses-In-Training in the Gold Coast Hospital was 75, out of which 60 were males and 15 were females.²⁰⁹ This information indicates that the qualifying field for recruiting and training village or public dispensers was not exclusively the male domain. Therefore, it is hard to make sense of the fact that native women were excluded from the colonial dispensary profession. Confronting the reality that native women on the Gold Coast were excluded from the village or public dispensary positions even after colonial officials like the Colonial Secretary stated that selection into this field should be based on “merit, aptitude, and age to avoid unfairness to the existing nursing staff”²¹⁰ is baffling.

Like the colonial sanitary branch, this profession (nurse-dispensary) gave the native men special privileges and opportunities in the colonial health system at the expense of women. Under this scheme, the pupil was intended to become an officer who could run a village dispensary and act as a dispenser in general hospitals and a nurse if needed.²¹¹ The Nurse-Dispenser student worked as a nurse-in-training in the wards at Gold Coast Hospital for the first two years of his education, took some pharmacy classes in the second year, and spent the third and fourth years of his

²⁰⁹ Scheme for Training of Nurses and Dispensers. GH/PRAAD/ CSO 11-1-677

²¹⁰ Village Dispensaries, Central Province. GH/PRAAD/ CSO 11-1-678

²¹¹ Scheme for Training Nurses and Dispensers. GH/PRAAD/ CSO 11-1-677

education at the dispensing school to get certified as a dispenser.²¹² The colonial government trained them and licensed them as druggists.²¹³ In addition to the training given as a druggist, "a candidate underwent other training, such as anaesthetics, the practice of medicine with the diagnosis and treatment of certain diseases, which an ordinary druggist does not require."²¹⁴

By the end of 1935, fourteen Nurse-Dispensers had completed their training, and these people were available for work at approved village dispensaries.²¹⁵ Available Nurse-Dispensers were typically put in charge of government hospitals and dispensaries provided by native authorities in Wiawso in the Sefwi-Aowin region, Kete Krachi in the northern section of Togoland, under British Mandate, and Salaga in the Northern Territories.²¹⁶ This system of Nurse-Dispensers in charge of remote dispensaries was seen as beneficial by colonial authorities since it purportedly reduced much needless suffering.²¹⁷



Figure 3.3 Dispenser's Training School, Accra

The photo clearly shows that all the Dispenser's Training School pupils were men.
Source: The National Archives (United Kingdom), catalogued under document record CO1069-37-97.

²¹² Government of the Gold Coast, *Medical and Sanitary Report for the Year 1935-1936*. p.35

²¹³ Dispensers School at the Gold Coast Hospital. GH/PRAAD/ CSO 11-1-418

²¹⁴ *Ibid*

²¹⁵ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1935-1936*. p.35

²¹⁶ *Ibid.*, p.36

²¹⁷ *Ibid.*, p.36

The indigenous authorities on the Gold Coast worked with the colonial authority to successfully limit women's participation in this aspect of colonial medicine and healthcare. Concerning their development initiatives, the Native Authorities saw the establishment of dispensaries as of utmost importance.²¹⁸ Most of the Native Authorities demanded the services of colonial dispensers and, consequently, sent only men to be trained in that field. For instance, in March of 1934, Nana Kwame Tano II (Omanhene of Sefwi-Wiawso) and his sub-chiefs submitted a proposal to His Excellency, Mr. Geoffry Alexander Stafford Northcote (the acting governor and commander-in-chief of the Gold Coast colony). They proposed having a village dispenser (a male) based in Wiawso who would travel to the other villages, most of which were quite a distance away.²¹⁹ While the response of the acting governor reveals his excitement about the native's recognition and demand for western medicine and treatments, it also reaffirms the discrimination against native women in the dispensary field of the colony. In an address offered by the acting governor to the Omanhene of Sefwi-Wiawso at a palaver held at Sefwi-Wiawso on 18th August 1934, he stated that:

Your request is that a travelling dispenser should be stationed in this district. I am glad to hear that request because it means that the true interest of your people is in your heart, Omanhene, and in the heart of your council. It is a matter which I should have liked to have granted if I had been able, but, at present, there are no dispensers available, although some are in training, and every year we put more young men into the school in order to train more dispensers.²²⁰

From the address above, it is evident that native men were the only priority of the colonial authority to receive training and work as colonial dispensers in villages. It is not surprising that even though the Omanhene of Akyem Abuakwa argued before the Gold Coast's Select Committee in 1939 that a lack of staff should not hinder the work

²¹⁸ Village Dispensaries, establishment in Ashanti. GH/PRAAD/ CSO-11-3-44

²¹⁹ Village Dispensaries, Central Province. GH/PRAAD/ CSO-11-1-678

²²⁰ Ibid

of village dispensaries,²²¹ he apparently never contemplated sending any female from his territory to be trained as a dispenser. His only worry was whether or not the Director of Medical Services (D.M.S.) thought the number of young men learning to be dispensers was sufficient to deal with the growth in local dispensaries.²²²

Even in a report from the Assistant Chief Commissioner (A.C.C) of the Asante territory dated 15 April 1946, the preference for male dispensers and exclusion of women was reiterated. According to the A.C.C., the D.M.S. informed him that the medical department would train men for employment as dispensers by Native Authorities and that they would be routinely inspected and overseen by a medical officer.²²³ The colonial government advised that most dispensaries be constructed and maintained by the NAs' in response to the NAs' requests for dispensers in their communities.²²⁴ It was the responsibility of the colonial government to train the dispenser(s), and when "he was ready, it would be on the part of the Native Authority or administration to help pay part or all of his salary and, perhaps, part or all of his expenses for a motor car."²²⁵ Consequently, most NAs' paid for and sent men from villages to the colonial dispensary school. A report from the Gold Coast medical department in June 1946 suggests that the colonial government staffed 22 Native Authority dispensary attendants who received some training in first aid.²²⁶ The dispensary system was the backbone for conducting surveys and monitoring the progress of widespread treatment for endemic diseases like malaria, yellow fever, trypanosomiasis, and yaws.²²⁷ Medical expertise was, thus, sufficient among the

²²¹ Scheme for Training Nurses and Dispensers. GH/PRAAD/ CSO 11-1-677

²²² Ibid

²²³ Village Dispensaries, establishment in Ashanti. GH/PRAAD/ CSO-11-3-44

²²⁴ Ibid

²²⁵ Village Dispensaries, Central Province. GH/PRAAD/ CSO-11-1-678

²²⁶ Village Dispensaries, establishment in Ashanti. GH/PRAAD/ CSO-11-3-44

²²⁷ Ibid

Indigenous males selected because they had adequate education and training in this area of medical and scientific studies. This opportunity gave them an edge over women in this aspect of the medical field of studies.

3.5 THE DISCRIMINATION AGAINST NATIVE WOMEN IN MEDICAL EDUCATION ON THE GOLD COAST

In light of the demographic decline that the First World War brought to the British Empire and her colonies, the British Imperial Authority began to examine the situation in her overseas possessions with new scrutiny. The Gold Coast and other British West African colonies faced shortages of colonial medical practitioners. Perhaps, among the many recommendations, the most significant conclusion reached at the 1925 Conference of Senior Medical Officers of the British West African Colonies held in Accra was that “a school of medicine should be established in British West Africa so that Africans could receive a comprehensive medical education and treat their own people.”²²⁸ For this reason, in 1927, the Secretary of State for the Colonies established a committee to plan the establishment of a medical college in British West Africa to train Indigenous medical practitioners.²²⁹ In 1928, the committee submitted an in-depth report detailing the expense of constructing the new medical college and educating at least 250 medical assistants.²³⁰ Unfortunately, the Colony's economy was hit hard by the worldwide slump, and thus, plans to establish a medical school on the Gold Coast had to be put on hold. An alternative solution to this problem was the colonial government's initiative to offer scholarships to African students to enable them to study medicine in the United Kingdom.²³¹

²²⁸ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1935-1936*. p.35

²²⁹ *Ibid.*, p.35

²³⁰ *Ibid.*, p.35

²³¹ Medical Training of Africans. GH/PRAAD/ CSO 11-7-2

Arguably, this was the first time the colonial administration had shown keen interest and willingness to commit resources to ensure that some natives obtained European medical knowledge to become medical doctors who would gradually take charge of their country's health issues. In 1930, the colonial government offered to award one or more medical scholarships annually, valued at £300 per annum for five years, with a free 2nd class passage to England and an outfit allowance of £50.²³² A Selection Board comprising the Principal of Achimota College, the Director of Medical Service, and the Director of Colonial Scholars was instituted. It was planned that the selection committee convene annually in November, with the scholar or scholars departing for England the following September.²³³ The general public was notified about this initiative in a public gazette. In the *Gold Coast Confidential* newspaper of June 1930, it was stated that "it is hereby notified for general information in and after the year 1930, and until further notice, one or more scholarships may be awarded annually to suitable candidates to study medicine in the United Kingdom and obtain a registrable qualification therein."²³⁴ To provide elementary, secondary, and tertiary education across the Colony and the Ashanti Territories, Brigadier General Sir Gordon Guggisberg established the Prince of Wales College, Achimota, on the Gold Coast.²³⁵ It became the backbone of the government's preliminary medical training of Indigenous scholars on the Gold Coast before they would proceed to the U.K. for further studies. Selected scholars were required to commence preliminary medical training at this college to prepare them for the London First Medical Examination.²³⁶

²³² Ibid

²³³ Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-3

²³⁴ Ibid

²³⁵ Report on Achimota College for the year 1930. Printed at the College Press. p.3.

²³⁶ Medical Training of Africans. GH/PRAAD/ CSO 11-7-2

Although it was a laudable initiative and a positive step for the colonial government to offer training in western medicine to some natives, the policy's implicit sexism toward women cannot be ignored. Indirectly, the educational requirement for this medical scholarship and the curriculum of female education on the Gold Coast rendered female students ineligible for the medical scholarship, barring any woman from entering medical school to become a medical practitioner on the Gold Coast and elsewhere. Indeed, the boys on the Gold Coast had an advantage in the competition for the colonial government's medical scholarships and medical school admissions because of their unique access to certain subjects at the elementary, intermediate, and secondary education levels. In the case of the Gold Coast's Achimota College, for instance, the male students were required to participate in programmes like science (nature study, agriculture, physics, botany, chemistry) and physical training, while the female students were forced to study domestic science.²³⁷ By examining the colonial educational policy of limiting girls to domestic science and boys to science on the Gold Coast, we can see that prejudices about women's intellectual capacity impacted the colonial educational programme. Due to preconceived views about women's inferiority to men, the colonial authority undoubtedly thought that women could not handle learning these "complicated" subjects because they required "great intellect," which women were presumed to lack.

In terms of the educational qualification for the government's medical scholarship, A.G. Frazer, the Principal of the Prince of Wales College/Achimota College, said the London Matriculation Examination was sufficiently high, and therefore, it was reasonable to offer the scholarships to students or candidates who

²³⁷ Report on Achimota College for the year 1929. Printed at the College Press. p.3.

possessed some knowledge of physics, chemistry, botany and zoology.²³⁸ He emphasised that the selected scholars would struggle in their first year of medical school without this background. Because of the prerequisites set forth by the school principal, only male students were automatically eligible for the scholarship and admitted to medical school. This was because, unlike female students, male students had already been exposed to the study of science. According to the D.M.S., the members of the selection board unanimously agreed that:

In selecting a candidate for a scholarship, a student who has successfully started a university science course at Achimota or elsewhere and shown proficiency should, if otherwise suitable, be given preference over one who has only matriculated. Because such a candidate had already undergone a test in science, his preliminary scientific education in medicine would be shorter and less expensive to Government.²³⁹

If this criterion was even employed among the males who had access to scientific information, then women, who were denied a foundation in science education, were eliminated from consideration for a medical scholarship by the Selection Board. Furthermore, since the colonial administration asserted that providing medical training to people who had just completed secondary school with little scientific knowledge would be too expensive, one can only imagine how much more expensive they thought women's medical training would be. This view makes it abundantly clear that the colonial government never considered promoting women's medical education. This explains why Colonial Secretary Arnold Hodson's explanations of the scholarship period indicated that the administration assumed that Gold Coast medical scholars would be men. Hodson explained that:

On arrival from the Gold Coast in England, the scholar will report *his* arrival to the Director of Colonial Scholars, who will instruct *him* on the institution

²³⁸ Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-3

²³⁹ Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-3B

selected for *him* and give general advice for *his* welfare whilst in the United Kingdom.²⁴⁰ (Emphasis, mine)

His comments imply that the anticipated scholarship receivers were supposed to be men. In 1930 Mr. C.H. Bannerman, a native of the Gold Coast who became a medical officer and practised on the Gold Coast, received an award of £150 a year for six years from the King Edward VII Scholarship Fund to pursue professional education in medicine at Edinburgh University.²⁴¹ However, in January 1931, Mr. Francis Edward Oku-Ampofo of Amanase on the Gold Coast became the first Gold Coast Government Medical Scholar when he was selected as the first recipient of the government medical scholarship.²⁴² In February of 1931, he enrolled in classes at Achimota in preparation for the London First Medical Exam and proceeded to the United Kingdom in September 1932.²⁴³ In the years leading up to 1939, the government continued to sponsor some students to pursue medical degrees. Their names, respective dates of receiving the awards and locations, either studying preliminary medicine at Achimota College or proceeding to the United Kingdom, may be found in the table below.²⁴⁴

²⁴⁰ Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-3

²⁴¹ Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-19

²⁴² Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-3

²⁴³ Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-19

²⁴⁴ Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-10

Table 3. Names and study locations of the Gold Coast male medical scholars sponsored by British colonial government.

Name	Date of award	In the U.K. or at Achimota
J.E. Oku-Ampofo	September 1932	United Kingdom
C.O. Easmon	April 1934	United Kingdom
F.D. Martinson	July 1936	United Kingdom
R.A.A. Quarshie	July 1936	Achimota
E.J. Djoletto	April 1937	United Kingdom
K.A. Taylor	May 1938	Achimota
H.S. Bannerman	April 1939	Achimota

The Second World War disrupted this policy, so there was a halt in offering more scholarships to students to pursue medicine in the U.K. The unsatisfactory academic performance of both J.E. Oku-Ampofo and R.A.A. Quarshie shows that not all the male scholars selected were intellectually superior or exceptional. Nevertheless, women were not allowed to try out their intellectual capabilities in this crucial field. Due to Mr. J.E. Ampofo's inability to complete the course within a reasonable time and despite numerous warnings, the scholarship was revoked on January 1, 1938.²⁴⁵ Mr. R.A.A. Quarshie, on the other hand, did not do well enough at Achimota College to pass the London First Medical Examination.²⁴⁶

²⁴⁵ Medical Training of Africans by Scholarships. GH/PRAAD/ CSO 11-7-19

²⁴⁶ Ibid

However, by 1941, scholars like C.O. Easmon and F.D. Martinson had arrived on the Gold Coast as medical officers after completing their studies in the United Kingdom. Although the colonial administration did not guarantee employment after their studies, they were gradually incorporated into the colonial medical service as Junior Medical Officers (J.M.O). For instance, Mr. C.H. Bannerman, on his return to the Gold Coast after his medical studies, was appointed a J.M.O²⁴⁷ Through this form of employment, they worked under the European Senior Medical Officers, who were members of the West African Medical Service (W.A.M.S). So, it can clearly be seen that all those who received the colonial government's medical scholarships were men. Meanwhile, the Colonial Secretary's official report on September 12, 1930, indicates that Messrs. Cadbury Brothers Ltd of Bournville, Birmingham, England, instituted the only scholarship opportunity offered to native women on the Gold Coast. This scholarship scheme of £5000 only reinforced the gender biases against women because it offered no training in medicine; it aimed to promote education among women in literary education, child welfare, hygiene, vocational work and any special training which may be considered beneficial to the colony's women.²⁴⁸ Therefore, it makes sense that the first native medical practitioners of the Gold Coast did not feature any native women. It is not a coincidence that men dominated and continue to dominate the medical field and the health system. This is because the opportunity offered to men at the expense of women prepared them (men) to take over the country's health system during and after colonial rule ended.

²⁴⁷ Ibid

²⁴⁸ GH/PRAAD/ CSO 11-7-16

CHAPTER 4

**THE CONCENTRATION OF NATIVE WOMEN IN THE COLONIAL
NURSING AND MIDWIFERY FIELDS**

4.1 INTRODUCTION

This chapter reveals the motive behind the professionalization of nursing and how it gradually became a female profession on the Gold Coast by 1945. The reasons that inspired and triggered the colonial authorities to intensively concentrate native women in midwifery are also explored and analysed. This chapter also exposes the unethical collaboration between the European medical officers and European ladies in charge of the colonial maternity hospitals to subject human tissue samples from pregnant native mothers to laboratory experimentations without their knowledge or consent.

**4.2 NURSING AS A FEMALE PROFESSION IN THE COLONIAL GOLD
COAST SOCIETY**

It is commonly believed that women have historically dominated the nursing profession because it has traditionally been seen as their role to take care of ailing family members. However, some scholars have not seen gender struggle and sexism as the main reasons for the concentration of women in this subservient role in the medical field. Many authors who have studied the evolution of the nursing profession in Ghana—including Stephen Addae, Dossiah Kisseih, and Mary Owusu—have failed to consider this when discussing the relegation of native women to the role of nurses throughout colonial times in Ghana.²⁴⁹ Thus, no previous research has investigated the

²⁴⁹ See. Mary, Owusu. *History of professional nursing from the Gold Coast era. The golden jubilee of SRN training in Ghana.* (1995) Accra, Dossiah, A.N. Kisseih. "Development in nursing in Ghana." (1968) *International Journal of Nursing Studies* 5, Stephen, Addae. *History of Western medicine in Ghana 1880-1960.* Durham: Durham Academic Press (1996).

reasons and mechanisms by which a profession (nursing) that men on the Gold Coast initially dominated suddenly became a female profession. As the previous chapter of this work reveals, a thorough analysis of the available archival evidence indicates that there was a concerted effort only to admit native women in submissive medical roles (such as nurses) to pave the way for men to dominate and monopolise medicine as doctors and leaders.

British colonial nursing activities began in India with the establishment of the Colonial Nursing Associations, which were tasked with deploying European nursing sisters to India to care for European officials in the colony between 1892 and 1895. In Ghana a colonial hospital and medical department were established in 1880 to improve the health of the Gold Coast's population. It quickly became clear that the region's handful of European medical officers needed the help of nurses to meet the enormous challenge before them. In addition, the colonial administration anticipated that such initiatives would require the involvement of Indigenous persons who the European authorities would teach. As a result, the colonial administration undertook an experiment in 1897 by bringing two European nursing sisters on a three-year trial to the Gold Coast to care for the sick in the colonial hospital and train native staff for the Gold Coast hospital.²⁵⁰ It is important to note that during this period, nursing had not been professionalised on the Gold Coast, and the training of the locals did not follow any systematic procedures. There was an expectation that the European nursing sisters would train locals with basic formal education (at least a 7th Standard Examination Certificate) and a working knowledge of English.²⁵¹ As indicated by W.R. Henderson, the Chief Medical Officer of Victoriabourg, Accra, the European nurses on trial carried

²⁵⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1899*. p.316

²⁵¹ GH/PRAAD/ CSO 11-7-16

out their work satisfactorily. In his report on the nurses' performance in the colony, he opined:

The European Nursing Sisters have been most devoted and self-sacrificing in their attention to the sick and in training the Native Nursing Staff; lectures are given, and classes for the practical teaching of nursing are regularly held and have proved of great benefit to the probationers.²⁵²

At the end of 1900, it was determined that their efforts had been very successful, and it was decided to increase their number to four and to station one nursing sister at the new hospital established in Cape Coast.²⁵³ During this period, English women such as Miss Fladgate, Miss Deeks, and Miss Wallace oversaw all nursing operations on the Gold Coast.²⁵⁴ The colonial administration preferred to train native men as nurses in colonial hospitals during this period. For instance, Henderson complained that there was "some difficulty in obtaining the services of very good men as nurses and dressers."²⁵⁵ In fact, suggestions were made that the colonial administration adopt measures to attract a more desirable demographic of native men to this service sector, as the boys who had previously been trained had been (according to one male colonial doctor) "unteachable savages."²⁵⁶ This indicates that the native men recruited purposely for this service were not intellectually better or up to the task than women. Yet, some scholars and historians argue that the Gold Coast women's initial exclusion in the colonial nursing field was based on factors including education because girls on the Gold Coast had not yet received any formal education.²⁵⁷

²⁵² Government of the Gold Coast, *Medical and Sanitary Report for the Year 1899*. p.316

²⁵³ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1900*. p.254

²⁵⁴ *Ibid.*, p.13

²⁵⁵ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1901*. p.13

²⁵⁶ *Ibid.*, p.19

²⁵⁷ See. Christine p.6

The claim that native women were excluded from the profession at the time in question because they had no formal education is flawed. This assertion is belied by data showing that as early as 1894, the colony had eight schools specifically for girls, enrolling 749 students, with an additional 1,451 girls attending classes in the boys' department.²⁵⁸ Thus, native girls received or were already exposed to formal education. The fact that the number of boys who received formal education was higher than girls does not imply that females did not receive any formal education. The apparent explanation for the native women's exclusion in nursing at the initial stages is gender bias because, from reports, the age at which native girls took the 7th Standard examination was about $16\frac{1}{2}$ years, which in the colonial administration's view, was too young for an African girl to study nursing.²⁵⁹ This situation could be considered part of the broader colonial agenda of sidelining native women in the colonial health system and medical fields because age should not have restricted their entry if they demonstrated intellectual capabilities. Even the gradual acceptance of native women in the nursing field, later on, started with subjugation to lower ranks or grades in the field because while most of the trained male nurses ranked as Chief Nurses and 1st Division Nurses, the prominent ranks for most of the female nurses were Second Division Nurses.²⁶⁰ Why, then, did nursing come to be dominated by women?

The available records indicate that two main factors accounted for the concentration of native women in nursing. The policy of only training male Nurse-Dispensers led to the eventual concentration of native women in nursing. After World

²⁵⁸ Government of the Gold Coast, *Report of the Director of Education for the Year 1894*. London: Waterlow and Sons Limited, Printers, London Wall.

²⁵⁹ GH/PRAAD/ CSO 11-7-28

²⁶⁰ GH/PRAAD/ CSO 11-1-677

War II, African men were increasingly advanced into rank of dispensers by the colonial administration.



Figure 4.1 European Nursing Sister, giving lessons to African male nursing students.

This image suggests that European nurses were there to train men. **Source:** The National Archives (United Kingdom), catalogued under document record CO1069-43-57. <https://commons.wikimedia.org/w/index.php?curid=18994140>

With the male dominated Nurse-Dispenser scheme in motion, “every male Nurse-In-Training entering the service had one desire – to eventually become a dispenser and work independently, without female supervision.”²⁶¹ Apparently, the colonial administration and the native men regarded the Nurse-Dispenser Scheme as an opportunity for male nurses to move beyond their female counterparts in the colonial medical fields. Creating this avenue for native men to pursue education in higher medical fields at the expense of women came with a cost which negatively affected the colony’s nursing capacity. The Nurse-Dispenser scheme deprived the colonial hospitals of more nursing staff because the people recruited and trained as Nurse-Dispensers were male Nurse-In-Training pupils who were, at that time, the dominant gender in the nursing field. The best men in the nursing service were taken away yearly, and only a

²⁶¹ Ibid

few less skilled ones were left.²⁶² This act resulted in a severe shortage of nurses in the Gold Coast Hospital and the outstation hospitals on the Gold Coast. The Director of Medical Service brought up this precarious situation to the notice of the colonial governor in a letter dated April 13, 1939. In the letter, he stressed that:

The net effect results of the system have been to bleed the hospital nursing staff for the sake of the dispensing side, so much so that not only are our hospitals inadequately staffed with nurses but dangerously so.²⁶³

Thus, while the colonial administration endeavoured to train more native men as dispensers or Nurse-Dispensers, the number of trained nurses required to staff the hospitals on the Gold Coast became fewer. For instance, the statistics demonstrate that in 1939 the Gold Coast Hospital in Accra had in all seventeen 2nd Division male nurses, “of whom five were employed in special duties in the Xray department, out-patient department, venereal disease clinic, and theatre, leaving only twelve for day and night duties in the wards and all relief purposes.”²⁶⁴ Ten of the seventeen male nurses were expected to enter the dispensing school.”²⁶⁵ Even as of 1940, there were 85 nurses and Nurses-In-Training in the Gold Coast hospital, with 50 forming part of the Nurse-Dispenser Scheme, leaving only 35 for ordinary duties in the wards.²⁶⁶ The implication is that patients were not getting the necessary attention that would have been offered if adequate nursing staff had been available. As a result, the few African nursing staff were compelled to prolong their already long duty hours to work overtime.²⁶⁷

Consequently, the nursing branch of service could no longer withstand the drain from the dispensing school, so the D.M.S. suggested a separate mode of selecting

²⁶² Ibid

²⁶³ Ibid

²⁶⁴ Ibid

²⁶⁵ Ibid

²⁶⁶ Ibid

²⁶⁷ Ibid

pupils for both branches of medical services. Since the colonial government still wanted to maintain the scheme of an all-male Nurse-Dispenser training and native men consistently aimed to become dispensers, native women automatically became the target of the colonial government to replace their male counterparts who had advanced to a higher position in the colonial medical field. With the intention of making the nursing field a female sphere or profession, the grades of Chief Nurse and 1st Division Nurse, which existed for only men, gradually became associated with female nurses. This statement is affirmed in a dispatch update of the Nurse-Dispenser scheme sent by G.C. Du Boulay (the Acting Governor of the Gold Coast colony) to Lord Passfield (the Colonial Secretary). In the dispatch dated 1939, the acting governor emphasized that:

The grades of Chief Nurse and First Division Nurse will be abolished in the case of men, and in their case, posts above the grade of Second Division Nurses will be classified as Dispensers, First Division Dispensers, and Chief Dispensers. The training of female nurses will continue as at present, and the grades of First Division Nurse and Chief Nurse will be retained for them.²⁶⁸

This marked the gradual removal of men and the intentionally planned concentration of women in the colonial nursing field. In 1939 the Gold Coast hospital employed 81 nurses-in-training, of which 44 were female and 27 were male.²⁶⁹ The Princess Marie Louise Hospital, established in 1926, also decided to restrict the training of nurses to only females.²⁷⁰ However, without hostels where the girls could be placed under adequate supervision, it was difficult for either the Gold Coast hospital or the Princess Marie Louise hospital to entice more native females to choose nursing as a career. Due to the lack of safe housing, parents were also unwilling to allow their daughters to pursue nursing as a career.²⁷¹ The D.M.S. relayed this issue to the colonial governor.

²⁶⁸ Ibid

²⁶⁹ GH/PRAAD/ CSO 11-7-28

²⁷⁰ Ibid

²⁷¹ Ibid

The D.M.S. stated that “at present, the absence of any hostel for the young women who are in training deters many parents from giving their assents to their daughters to take up nursing as a career.”²⁷² In addition, as revealed by the D.M.S. in his letter to the colonial governor, Sir Alan Burns, in 1943, the unavailability of a hostel made it even more challenging to attract better types of girls to pursue nursing on the Gold Coast.

The D.M.S. indicated that:

A factor which militates against the recruitment of the better type of girl is the absence of any hostel where girls under training may be housed under proper supervision. I have been informed that parents of better class are unwilling to allow their daughters to take up nursing as a career largely because, during their course of training, they are left to fend for themselves in the matter of lodgings. Moreover, certain ladies with whom I have discussed the proposal have assured me that the provision of a hostel would ensure a much better class of candidate.²⁷³

The colonial government of the Gold Coast made concerted efforts to intensify the concentration of women in nursing and finally designated the field as a female profession in 1945. This was because, in 1943, the colonial administration expected that a large number of male nursing orderlies would be demobilised after World War II and best employed in the dispensary health units, which formed the centres in rural areas for medical treatment and health “propaganda”.²⁷⁴ In this sense, it can be argued that the colonial administration no longer saw nursing to as befitting native men on the Gold Coast because they were perceived to be levels above such a subsidiary field controlled by European nursing sisters. On November 6, 1945, the colonial administration passed a bill instituting an ordinance to allow for the registration and training of nurses and to regulate their profession.²⁷⁵ Parts of the regulation show the intention to make the nursing field strictly a female profession. The gradual

²⁷² Ibid

²⁷³ Ibid

²⁷⁴ Ibid

²⁷⁵ The Nurses Ordinance, 1945. GH/PRAAD/ CSO 11-1/643

incorporation of more native women in the colonial nursing field was inevitable because that was the only means of placing and restricting women to their supposedly rightful place as subsidiaries of male doctors and dispensers in the medical field.

Prior to 1943, there were no systematic courses of training laid down and in operation by the Gold Coast Hospital and the Princess Marie Louise Hospital, the two main training centres for nurses on the Gold Coast. In order to concentrate more native women in nursing, the colonial government's first plan was to introduce the Colonial Development and Welfare Act that sought to establish a central nursing school in Kumasi and later in Accra and Cape Coast, where all nursing training would be given.²⁷⁶ It was underlined in the nursing scheme by the D.M.S. that preparations be made for training female nurses exclusively, who were required to staff existing hospitals.²⁷⁷ The D.M.S. emphasized in the scheme that:

If the experiment should be a success, I envisage the training of both male and female nurses at Kumasi ultimately for so long as male nurses will be continued to be employed in the hospitals. But for a beginning, it is proposed that arrangements be made for the training of female nurses only until it is seen how the experiment will work out.²⁷⁸

This experiment of training only females ensured that they were gradually concentrated in the nursing field of the Gold Coast. Certainly, they were expected to work under the European male medical practitioners who controlled the colonial hospitals.

²⁷⁶ GH/PRAAD/ CSO 11-7-28

²⁷⁷ Ibid

²⁷⁸ Ibid



Figure 4.2 British Medical Officer and an African Female Nurse examining a child

What the colonial government hoped to accomplish with its gender-biased healthcare policy is depicted in this image. This serves the government's goal of having men hold positions of medical authority while women are relegated to supporting roles; the women (trained African nurses) would then convince their African sisters to bring their children to European hospitals so that the medical authority (men) there could treat them. **Source:** The National Archives (United Kingdom), catalogued under document record CO1069-46-7.

The nursing scheme was purposefully designed to attract a “better class” of girls into the nursing profession. In order to entice suitable girls of parents in reduced circumstances to pursue nursing, the D.M.S. suggested that three scholarships be granted annually by the government. If three scholarships were to be awarded each year, it was expected that the government’s liability for scholarships would be around 12 pupils. The scholarship amount was estimated at £21 annually and £3 as pocket money.²⁷⁹ It is unsurprising that due to all these efforts, the colonial administration gradually attracted native women throughout 1945 and steadily concentrated them in nursing, as shown in the table below.

²⁷⁹ Ibid

Table 4. A table showing the number of native women recruited and trained as nurses after the Colonial Government implemented the Nursing Scheme in 1945.

Date	Intake, Pre-Nursing	Intake, Nursing Training	Total in Training	Fully Trained Nurses
1945	5	0	0	0
1946	33	5	5	0
1947	35	33	38	0
1948	40	35	73	0
1949	40	40	108	5
1950	38	40	115	33
1951	40	38	118	35
1952	40	40	118	40
1953	38	40	118	40
1954	40	38	118	38

Source: GH/PRAAD/ CSO 11-7-28

After establishing the Kumasi nursing training centre and securing a temporary hostel to accommodate the pupils, 12 girls or trainees were expected to begin their training on January 1, 1944, with Dr. Savage and Miss Storrier in charge.²⁸⁰

²⁸⁰ Ibid

However, as shown in the table above, pre-nursing training and actual nursing education formally commenced in 1945 and 1946, respectively. Dr. Savage was appointed Superintendent in Charge, and Miss Storrier as a Sister Tutor.²⁸¹ An English and a Science mistress were recruited from the United Kingdom to be part of the teaching staff of the nursing school in Kumasi. Based on the argument that girls who completed the 7th Standard Examination were too young for nursing education, potential female candidates selected and trained under the scheme were required to be offered one year of pre-nursing training before fully enrolling in nursing education. The Achimota College was responsible for providing the girls with this form of post-primary or pre-nursing education. This form of pre-nursing education exposes the European gender misconceptions about female intellectual capabilities because the courses to be read by girls largely had a scientific bias when compared to the dispensary school courses that boys studied. While boys of the dispensary school's science courses were broad, the pre-nursing program's scientific courses for the girls primarily concerned with elementary chemistry, physics, and simple biology.²⁸² In addition, courses such as civics, domestic economy, elementary infant welfare and dietetics were included in the program to reinforce European gender ideals and remind women of their place in society.²⁸³

When it came to nursing education, learning English was a mandatory prerequisite. The English curriculum's components were speech, reading, writing, reciting, and acting out plays. Most importantly, under this nursing scheme, the girls' nursing education on the Gold Coast mostly centred on the idea that diseases might be

²⁸¹ Ibid

²⁸² Ibid

²⁸³ Ibid

avoided via careful behaviour modification.²⁸⁴ This meant that the nursing curriculum's overarching goal was to instill in students (girls) the value of preventative medicine. Evidence abounds for this limiting practice of preventive medicine by nurses, as L.A. Northcroft (the Director of Medical and Sanitation Services) opposed any form of injections given to patients by both the native nurses and the European nursing sisters. The D.M.S.S. stressed that “no person other than a Registered Medical Practitioner should be allowed to give any kind of therapeutic injection.”²⁸⁵ As advice to the medical practitioners in charge of hospitals in the colony, Northcroft stated that “if I were in charge of a hospital, I should insist on conducting all injection techniques myself and would not allow even a Nursing Sister to administer an injection to any patient under my charge in the hospital.”²⁸⁶ This statement from the D.M.S.S. implies that administering medicines was limited to men. Female nurses, European or African, were only allowed to offer advice or comfort.

With about 191 native girls fully trained by 1954,²⁸⁷ the colonial administration had achieved its policy and motive of totally concentrating native women in the nursing field of the colony. This idea is an explicit restriction of native women to only one aspect of the medical field, which contradicts the privileges and freedom that native women had previously had in engaging in any aspect of the traditional medical field during the pre-colonial period. Thus, the professionalization of nursing as a female field can be said to have altered native women's place and power in the practice of medicine of the colony.

²⁸⁴ Ibid

²⁸⁵ GH/PRAAD/ CSO 11-4-21

²⁸⁶ Ibid

²⁸⁷ GH/PRAAD/ CSO 11-7-28

4.3 COLONIAL MIDWIFERY: THE ENFORCEMENT OF EUROPEAN MOTHERCRAFT IDEALS AND THE OBJECTIFICATION OF NATIVE MOTHER'S BODY PARTS FOR EXPERIMENTS

On the Gold Coast, European “colonial mothercraft ideals” included the beliefs, practices, and policies promoted by British colonial authorities regarding motherhood, childbirth, and child-rearing. These ideals were shaped by the prevailing beliefs about race, gender, and civilisation, as well as the colonial government’s political and economic interests. One of the main goals of the colonial mothercraft was to control and regulate the reproductive practices of colonised native women on the Gold Coast. British colonial authorities believed that the health and hygiene of Indigenous women and children were essential to the development and stability of the colony. Therefore, they sought to promote European-style medical practices and discourage native practices that they considered to be primitive and barbaric. With the belief that native cultures were inferior and needed to be replaced by European civilisation, the British colonial government sought to educate colonized women on the Gold Coast in European ideals of femininity, motherhood, and domesticity. Thus, the European mothercraft ideals were a means of social control and cultural imperialism rather than the outcome of any genuine concern for the well-being of mothers and children on the Gold Coast.

Native women were demonstrated to be the primary providers of traditional midwifery or birth attendant services in the first phase of this research. However, to reinforce and impose European gender norms, the colonial administration concentrated more native women in colonial midwifery. This is evidenced by the colonial government's agenda of building maternity facilities and child care clinics and

increasing midwifery education. The statistics provided in the previous chapter have shown that native women on the Gold Coast were more likely to reject European medicine and health practices when compared with their male counterparts. Native women's resistance was, thus, seen as a significant obstacle to the colonial imperialist agenda of civilization and the moral enlightenment of those seen by Europeans as "savages". Although early British colonial imperialism on the Gold Coast showed little concern for the well-being of native mothers and their children, this changed during World War One due to the necessity of population increase to the imperial economy and military goals.

Several European medical practitioners expressed concerns about the welfare of mothers and children on the Gold Coast. For instance, Dr O'Brien argued that "the case of young children and the education of native mothers are matters now ripe for consideration."²⁸⁸ Dr. Nanka Bruce raised awareness of maternal and newborn mortality rates in 1915. Chief Medical Officer Dr. Rice recommended an investigation of maternal and infant mortality a year later.²⁸⁹ In June 1917, a committee led by Mr. Crowther, including Dr. Quartey Papafio, Mr. Wellacout, and Mrs. Hutton Mills, submitted their recommendations to the administration of Sir Hugh Clifford.²⁹⁰ The committee determined that maternal and infant mortality rates were higher than they should be due to improper labour and delivery practices, inadequate care for newborns, poor nutrition, and unsanitary living conditions that facilitated the spread of diseases like malaria and yellow fever.²⁹¹ From the committee's report, it can be inferred that native mothers and their traditional birth attendants were blamed for the maternal and

²⁸⁸ Maternity Hospital, Accra, Fees. GH/PRAAD/ CSO 11-4-1

²⁸⁹ Ibid

²⁹⁰ Ibid

²⁹¹ Maternity and Infant Welfare Movement: Statistics Relating to Accra. GH/PRAAD/ CSO 11-4-9

infant mortality increase, supposedly due to ignorance. As a result, they recommended the establishment of a maternity hospital and a training facility for midwives who would also educate African mothers on proper child care and hygienic practices. Unfortunately, the colonial administration could not fund the construction of maternity hospitals and midwifery training centres during this period due to financial restrictions in the colony and the British empire due to World War One.

Nevertheless, the 1920-1921 report, which claimed that “out of 1,000 babies born alive in Accra, some 400 died before reaching one year,”²⁹² made Governor Sir Gordon Guggisberg intensify the steps in building a maternity hospital and a training centre for native women to be trained as midwives. To demonstrate the government’s commitment to maternal and child welfare, Guggisberg’s administration supplied drugs and dressings to Dr. Jessie Beveridge, who had opened a small infant welfare centre at Christiansborg in 1921.²⁹³ On 19th May 1928, the colonial government finally opened the maternity hospital in Korle-Bu, Accra, to train midwives and attend to the health needs of native expectant mothers and their babies.²⁹⁴ G.M.L. Summerhayes was put in charge of this newly opened maternity hospital. That same year, a new hospital and clinic were opened in Kumasi by Lady S. Wilson, the wife of Sir Samuel Wilson (the Secretary of State of Colonies).²⁹⁵

As a means of encouraging more native women to forego the assistance or services of traditional birth attendants in favour of the Gold Coast's maternity hospitals, the government proposed that “all advice and treatment for the native mothers before

²⁹² Ibid

²⁹³ Ibid

²⁹⁴ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1928-1929*. p.41

²⁹⁵ Ibid., p.39

and after their confinements and until the baby is a year old in the out-patients department and wards were free of charge.”²⁹⁶



Figure 4.3 *Maternity Hospital, Accra, opened in 1928* (Source: Government of the Gold Coast, *Medical and Sanitary Report for the Year 1928-1928*. p.39)

This initiative by the colonial government was purposely done to entice native mothers to seek European healthcare for themselves and their babies. According to the D.M.S.S., it was believed that if costs were not levied, native women would be encouraged to use the new facilities, whereas if prices were imposed, they might choose not to use them.²⁹⁷ At the official opening of the Accra Maternity Hospital, His Excellency Ag. Governor T.S.W. Thomas reaffirmed the viability of this plan. In his remarks, the interim governor stressed the following:

Now I do not wish to try your patience any longer, but I would, in a last word before declaring the new Maternity Hospital open, ask all of you who are here today – my African friends chiefly, to tell your relatives and friends all about this fine hospital and encourage all those that are heavy with child, rich or poor, Ga, Fanti, Hausa, Twi, Kroo and all other tribes, to come here and avail themselves before and during their hours of travail of the skilled advice and treatment that is provided absolutely free of charge.²⁹⁸

²⁹⁶ Maternity Hospital, Accra, Fees. GH/PRAAD/ CSO 11-4-1

²⁹⁷ Ibid

²⁹⁸ Ibid

In order to compete with the traditional birth attendants, six native female nurses with two years of general training in the Gold Coast Hospital were proposed by the government to be trained as nurse-midwives for a year in the management of labours and the care of babies.²⁹⁹ The government and European Nursing Sisters' prejudices against the Gold Coast's traditional birth attendants played a major role in this decision. They were considered antagonistic to European medical techniques and a threat to the spread of European medicine and the goal to civilise the native population. It is not shocking that the European Nursing Sisters held the TBAs' childbirth and mother care techniques accountable for the high rates of maternal and newborn death and other health problems, including umbilical hernias and dental caries. Lady G.M.L. Summarhayes claimed that umbilical hernia was prevalent amongst the infants of the colony, "usually due to ignorant treatment by native midwives, such as leaving the cord too long, as it was a custom to leave it long enough to reach the baby's knee."³⁰⁰ Interestingly, her research into hospital births disproved her claims about the TBAs; it was discovered at the postnatal clinic that a similar percentage of hospital-born babies as home-born babies delivered by native midwives had umbilical hernias (TBAs).³⁰¹ Therefore, this medical issue had nothing to do with the birth delivery methods used by the TBAs.

Consequently, in 1929, a dental surgeon for the colonial government reported that widespread dental caries among school-aged children was attributable to the neglect of native mothers who stubbornly stuck to native advice and practises.³⁰² This was the case in places like Kumasi, Sekondi, Accra, Cape Coast, Gambaga, Tamale,

²⁹⁹ Ibid

³⁰⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1929-1930*. p.199

³⁰¹ Ibid., p.199

³⁰² Ibid., p.10

Navrongo, and Wa. However, further investigation of the archival data demonstrates that such assertions or allegations were untrue and were not due to native mothers' carelessness and adherence to traditional norms in caring for their children. As a result of introducing new meals to the locals, which altered their diets, the areas mentioned above had a dramatic increase in cases of dental caries among school children. The colonial dental surgeon reported this source of dental cavities in his subsequent reports to the D.M.S. He highlighted the following in his report:

Beyond the Volta, where modern methods of living, altered habits and diets, the use of imported food and other similar factors attendant on the advance of our civilisation have not as yet penetrated, the teeth of the children were remarkably well preserved, the supporting and nourishing tissues of the mouth were comparatively sound.³⁰³

This remark proves that the problem was not caused by local mothers and their advisors (TBAs), but by a shift in food introduced by colonizers that led to an increase in childhood dental caries in communities that had adopted European modes of living. Despite these revealing pieces of evidence proving the innocence of TBAs and their practices, both the colonial administration and the European Nursing Sisters still harboured the view that the local "untrained midwives" (traditional birth attendants) should gradually be replaced by her "trained sisters" (nurse-midwives).³⁰⁴

By early 1930–1931, it was believed that all the first batch students in the midwifery programme would have graduated and be ready to lead the charge in the civilizing mission of forcing and embedding European mothercraft principles in native mothers.³⁰⁵ Indeed, the first student to complete her training passed the Midwifery Certificate examination in March 1930 and was employed as a Government midwife in

³⁰³ Ibid., p.10

³⁰⁴ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1928-1929*. p.39

³⁰⁵ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1929-1930*. p.50

Accra.³⁰⁶ Three more completed their training in April of the same year. Based on this, a critical mass of educated midwives was expected to emerge eventually, providing "the leaven of enhanced theory and practise."³⁰⁷ This leaven of improved theory and practice was referred to as the means of saving thousands of lives allegedly needlessly destroyed due to ignorance and superstition.³⁰⁸ This reasoning underpinned the 1929 government initiative to codify a statute governing the licensing and practise of midwives on the Gold Coast. Thus, the ordinance coming into force implied that it was illegal for any woman untrained and unlicensed by the colonial government to practice as a midwife in the colony. In other words, the ordinance was meant to practically exterminate the traditional birth attendants from the field of midwifery to be replaced by their sisters who had become the "daughters of imperialism."³⁰⁹



Figure 4.4 G.M.L. Summerhayes with first batch of newly trained midwives holding babies they delivered at the Old Maternity Hospital at Korle Bu in Accra (Source: Anonymous, Korle Bu Hospital. 1923-1973. Golden Jubilee Souvenir. Accra, 1973)

³⁰⁶ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1929-1930*. p.204

³⁰⁷ Maternity Hospital, Accra, Fees. GH/PRAAD/ CSO 11-4-1

³⁰⁸ Ibid

³⁰⁹ The term, "daughters of imperialism," used in this context refers to the native girls or women who had received European maternity and child welfare training to practice as colonial midwives to enforce the European mothercraft ideals in the colony.

The preference for the daughters of imperialism (educated female midwives) to replace the traditional birth attendants was borne out of colonial competition, as the traditional birth attendants continued to oppose and reject the European mothercraft ideals and maternal practices despite several quarterly demonstrations and talks held by European midwives and nurses to influence the traditional birth attendants' birth delivery and maternal practices. As revealed by G.M.L. Summerhayes, the lady officer in charge of the Accra Maternity Hospital:

Quarterly demonstrations and talks have also been held for the untrained African midwives-but it is evident that it is more important that every effort should be put into the thorough training of educated girls and women of a high standard to take their place in the near future.³¹⁰

The preceding statement suggests that the success of European concepts of maternal welfare hinged in great part on how quickly trained African girls or women could replace traditional birth attendants who were regarded as uneducated. However, given the government's clear indication that trained midwives did not need to be of very high intellectual or scientific attainments, but rather so long as they acquired the principles of "cleanliness" and "non-interference" as related to childbirth,³¹¹ the term "educated local midwives" can be argued as mere rhetoric and falsification. Therefore, the so-called midwifery training for Indigenous women consisted more of moral instruction than actual science. The fundamental goal of the colonial midwifery agenda on the Gold Coast was clearly the imposition and spread of European mothercraft values on the native mothers to improve their "moral upbringing," which was perceived to be inferior. Without a doubt, this highlights the colonial government's agenda to train a disproportionate number of Indigenous women or girls as midwives.

³¹⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1928-1929*. p.143

³¹¹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1929-1930*. p.51

According to G.M.L Summerhayes, pregnant women on the Gold Coast habitually sought advice and treatment from native women who were perceived as untrained and operated solely on superstition throughout their pregnancies.³¹² Therefore, native girls or women who had received formal training in European child welfare and birthing practices were regarded as the best crop of imperialist collaborators to persuade native mothers to bring their children to maternity hospitals and infant clinics. Women on the Gold Coast initially viewed maternity hospitals with skepticism, and this attitude remained for some time. The authorities reasoned that this problem persisted because it was “against native custom for a woman to give birth anywhere other than her own kitchen.”³¹³ Native mothers' refusal to avail themselves in maternity hospitals appeared to colonial authorities to jeopardize their goal of imposing European mothercraft values and practices. As a result, efforts and solutions were implemented to address this difficulty. In dealing with the issue of expectant mothers refusing to present themselves at the maternity hospitals, the D.M.S. stressed that “what is wanted at this stage of the country’s hygienic development is a corps of midwives who are competent to conduct labour in the patient's home, using such materials as are likely to be obtainable there.”³¹⁴ This declaration shows that the government was determined to take any measures necessary to accomplish its mission. As the plan was for these trained midwives to oversee births in their patients' homes, they were also expected to recognise the early warning signs of potentially challenging labour so that they might arrange for more specialised assistance for the expectant mother when the time came.³¹⁵ In this way, it is clear that domiciliary instruction

³¹² Ibid., p.51

³¹³ Maternity and Infant Welfare Movement: Statistics Relating to Accra. GH/PRAAD/ CSO 11-4-9

³¹⁴ GH/PRAAD/ CSO 11-7-28

³¹⁵ Ibid

assumed a central role in preparing young women for careers as midwives on the Gold Coast.

Propaganda by colonially-trained African midwives and newly trained African female health visitors were supposed to spread the word about maternal hospitals. Training for female health visitors focused on fundamentals, including hygiene, physiology, and childbirth. As part of their efforts, they made house calls and monitored the puerperal periods of local women. For instance, in 1928, 114 pregnant women were cared for at home under the watchful eye of Indigenous women who had been educated as health visitors.³¹⁶ Additionally, in 1930 they made 646 visits to ladies in the puerperium period.³¹⁷ With the goal of spreading awareness of the importance of welfare centres, antenatal visits, and household hygiene through propaganda, the Gold Coast League for Maternal and Child Welfare was officially launched between 1928 and 1929, with Lady Slater as the president.³¹⁸ In the view of the Director of Medical Service, there was a need for intensive education to influence the lives of the natives, thereby ensuring success in the civilizing mission on the Gold Coast. In arguing for the need to intensify propaganda on the Gold Coast, the D.M.S. stressed that:

Native ignorance of the true nature of disease remains one of the greatest obstacles in the way of progress. Superstition and semi-religious accounts of diseases' origin and the processes by which an individual may be infected still abound. The need for gradual enlightenment of the Africans by means of persistent (although not blatant) propaganda cannot be more strongly emphasized.³¹⁹

As part of their propaganda efforts, members of the Gold Coast League for Maternal and Child Welfare were tasked with performing community-wide services by making

³¹⁶ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1928*. p.143

³¹⁷ *Ibid*

³¹⁸ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1933-1934*. p.7

³¹⁹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1935*. p.79

numerous home visits, during which they educated the residents about European standards of care for expecting mothers and infants, as well as about personal and household hygiene.³²⁰ Thus the ladies of the League got in touch with native mothers in their own homes and discussed problems about cleanliness and the rearing of babies and children that ran counter to European standards and practices. The League united European and native women who had received European training to exert imperialist control over the private spheres of Gold Coast native women through the imposition of western mothercraft ideals. Indeed, it must be admitted that in one way or the other, the League was successful in its quest to enforce western mothercraft methods on native mothers and also influence them to access colonial Maternity Hospitals in larger numbers. This imperialist success was revealed by Lady G.M.L. Summerhayes when she was expressing her satisfaction with the League's successful propaganda work, which had popularized European mothercraft and the colonial Maternity hospitals in the colony. In her report to the Director of Medical Service, Summerhayes opined that:

The propaganda work carried out by the members of the Gold Coast League for Maternity and Child Welfare is of the greatest utility and has gone a long way towards popularising both ante-natal and infant welfare work. The best thanks of the Colony are due to these ladies for their arduous and self-sacrificing work, particularly to their President, Lady Slater.³²¹

The following table corroborates the claim that the imperialist league of maternal and child welfare was successful in its mission on the Gold Coast because, as shown below, the number of native mothers using colonial maternity hospitals rose significantly within a few years of the league's existence and activities. The table below shows a nine-month steady increase in the number of native mothers' who accessed the Maternity Hospital, Accra, from May 1928 to March 1929.

³²⁰ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1928*. p.36

³²¹ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1929-1930*. p.50

Table 5. A table showing a nine-month steady increase in the number of native mothers who accessed the Maternity Hospital, Accra. Sources: Government of the Gold Coast, Medical and Sanitary Report for the Year 1928-1929, p.138

	May and June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Total
Antenatal (New Cases)	96	61	51	61	65	88	106	116	82	109	835
Antenatal (Old Cases)	105	87	94	120	150	165	233	316	317	389	1,976
Postnatal (New Cases)	14	9	13	14	35	29	29	33	34	38	248
Postnatal (Old Cases)	15	9	23	31	64	51	55	90	99	103	540
Total	230	166	181	226	314	333	423	555	532	639	3,599

The introduction of baby shows during Health Weekdays and Months in the British colony of the Gold Coast was also unquestionably the pinnacle of the achievements of the imperialist league for maternal and child care. They succeeded in

persuading more native women to take pride in the European mothercraft ideals. Native mothers who had accepted European mothercraft ideals demonstrated their dedication by presenting their babies for assessment by the league's members. By presenting their babies during this event, native mothers on the Gold Coast indirectly demonstrated that they had reared their babies according to the colonial or imperialist principles of child welfare practices.



Figure 4.5 Baby Shows, Kumasi 1929

The techniques of European mothercraft were widely disseminated thanks to these Baby Shows. At this stage, it is clear from the photo that the League succeeded admirably in getting more native women to adopt and appreciate European approaches to child care. (Source: Government of the Gold Coast, *Medical and Sanitary Report for the Year 1929-1930*. p.46)

The governor's wife honoured the best-looking infants in the competition and presented the remaining babies with consolation awards.³²² These awards were an attempt to encourage native mothers who did not receive the grand prize to continue striving to perfect European mothering craft. On the other hand, winners of these shows' grand prizes were undoubtedly inspired to keep pushing themselves to the limit to maintain their winning streaks. Thus, it may be argued that during this time of colonial dominance on the Gold Coast, the goal of creating maternity facilities, concentrating more native women in this field, and teaching them to enforce European birthing techniques and mothercraft ideals was accomplished.

Available archival materials, however, demonstrate that there was more at play than simply achieving this goal of enforcing European mothercraft. Maternity facilities became a means by which native women's tissue and blood samples could be collected for laboratory testing by colonial male medical practitioners. This has not been noted by previous historians. Colonial medical practitioners proposed that the placentae of pregnant women were malarial infectious and were supposedly the leading cause of preterm deliveries among Indigenous women.³²³ In a report to the D.M.S., G.G. Butler, the medical officer in charge of the colonial laboratory, argued that, "active malaria infection of the placentae thus appears to be an important cause of premature delivery."³²⁴ Without their knowledge or consent, colonial doctors began to study native women's placentae and blood samples. Under the guise of concern for maternal and child health, European doctors were actually searching for immunities they might transfer to whites.

³²² *The Gold Coast Independent*. Accra, Gold Coast: November 6, 1926, p.1357.

<https://catalog.crl.edu/Record/d45948e0-06b1-5b89-93fb-7a91a62f441c>

³²³ Government of the Gold Coast, *Medical and Sanitary Report for the Year 1930*. p.102

³²⁴ *Ibid.*, p.102

Meanwhile, from Butler's own investigations, the so-called malarial infectious placentae did not affect the health of the unborn child in the parturient women examined.³²⁵ However, they still conspired with the colonial midwives and lady officials in charge of the maternity hospitals to bring the placentae and samples of maternal finger blood of native mothers who gave birth at the maternity hospitals for laboratory examinations to detect suspected malarial diseases. For the consistent delivery of placentae and maternal finger blood samples, G.G. Butler had nothing but praise for lady G.M.L. Summerhayes, the lady officer in charge of Accra Maternity Hospital. G.G. Butler stressed the connection between the colonial laboratory and the maternity hospital again, saying:

In case any light could be thrown on this relationship, close cooperation with the Maternity Hospital has been maintained as well as an examination of placentae from a majority of the cases during the last year. G.M.L. Summerhayes, who is in charge of the Maternity hospital, has provided all the details of history and maternal and infants conditions, and without this aid, no results could be obtained except bare statistical details: it is, therefore, to her that all the credit of any results, if any, must go.³²⁶

For this reason, it should come as no surprise that in 1930 G.G. Butler received 328 placentae and maternal finger blood samples from the Accra Maternity hospital, of which G.M.L. Summerhayes was in charge.³²⁷ It is important to note that a thorough examination of the archival materials shows that the notion that local women's placentae may have harboured malarial illnesses that caused preterm deliveries was a fabrication based on concealing the purpose of exploiting and using the placentae, cord blood, and finger blood samples for serological tests. The colonial medical officers believed it would "fill an important gap in the methods of diagnosis and open up a new line of study of malaria and any immunity that it may convey and possibly some further

³²⁵ *Ibid.*, p.104

³²⁶ *Ibid.*, p.105

³²⁷ *Ibid.*, p.102

information on blackwater fever.”³²⁸ As indicated by G.G. Butler, “the opportunity of obtaining placentae from the maternity hospital gave the impetus to this new line of investigation.”³²⁹ After researchers in Honduras (Taliaferro) and Malaysia (Kingsbury) obtained unsatisfactory results in their searches for a precipitin test for malaria using different tissues, researchers shifted their focus to placentae, cord, and finger blood samples as their primary experimental materials of choice. To that end, roughly 200 placentae were collected on the Gold Coast, and pieces were cut off to be sectioned.³³⁰ This was not research undertaken to better the health of native people, but to support the colonial project and better the lives of white colonizers.

The native mothers whose placentae were used, were not consulted before these research activities were undertaken. Convincing native mothers to visit colonial maternity hospitals to have their placentae and finger blood samples sent to and tested in labs was morally reprehensible since it violated long-standing cultural norms regarding the sanctity of the placentae. The placentae (akyiriade) are revered in the Akan tradition, which I learned during a talk with my late mother, Afia Afrakoma. According to custom, pregnant women who were delivered by traditional birth attendants (TBAs) were given their placentae right after birth.³³¹ Since the placentae were considered sacrosanct, neither the husband nor any other family members could touch or even see them.³³² Therefore, only the pregnant woman who had delivered had exclusive rights over the placentae, and custom demanded that she bury it somewhere without anybody's knowledge.³³³ This tradition amongst the Akan ethnic groups formed

³²⁸ *Ibid.*, p.109

³²⁹ *Ibid.*, p.109

³³⁰ *Ibid.*, p.109

³³¹ Author's personal conversation with his late mother, Maame Afia Afrakoma (also known as Madam. Linda Osei).

³³² *Ibid*

³³³ *Ibid*

the basis of the reverence of mothers as the Akan adage stipulates, “obey and respect your mothers because they are the only person(s) who knows the location of your placenta, which is deemed as your tree of life.”³³⁴ Not only was the research done without consent or permission, it was carried out in ignorance of the cultural and spiritual harm it would cause the women from whom they took tissue and blood samples from.

This long-held practice that taught children to honour and respect their mothers in full candour and humility was attacked and destroyed by the activities of colonial male medical officials, trained midwives, and the woman officers in charge of maternity facilities. This evidence highlights the layered nature and motivations of the colonial health agenda and civilizing mission on the Gold Coast. It provides a broader context for understanding why the colonial government sought to marginalise native women in higher medical fields. It is possible to understand the rationale behind why men in the colonies were entrusted with the authority and knowledge in higher medical fields, unlike their female counterparts. If Indigenous women had been allowed to study medicine, many, if not all, would have opposed these abhorrent procedures and practices since they went against cultural norms. The imperialists reasoned that it was best to corral these people into the subservient fields, where they could do nothing but follow orders. Furthermore, they treated native women as objects of nature that needed to be examined exhaustively by men in order to advance society, which meant repressing and marginalising them in the body of medical knowledge. Thus, the conceptions and assumptions of men rescuing society by lowering infant mortality rates

³³⁴ Ibid

on the Gold Coast and elsewhere were linked to the objectification of the bodies of local women for laboratory experimentation to benefit white colonists.

This chapter summarises the argument that Gold Coast women were encouraged to enter the medical fields not because the colonial authorities had faith in their abilities, but rather because having native women in subordinate medical roles was the only way to promote men who cooperated with imperialist policies to more senior positions within the medical establishment in the colony. If the colonial authority had not pushed native women into the subordinate roles of nurse and midwife, the objective of civilising the Indigenous people never would have come to fruition. Therefore, women were only valuable to the colonial medical establishment on the Gold Coast in their capacity as subjects of scientific inquiry and instruments for furthering British health objectives.

CONCLUSION

Women's practices in traditional African medicine and how the imposition of colonial rule altered their position in healthcare has received little to no attention from scholars and historians. The research in this project has shown that the Gold Coast relied primarily on traditional medicine before European colonisation. The traditional healthcare system was closely tied to local customs and traditional belief in dual (physical and meta-physical) causes of diseases. Thus, their conception of disease development was double-layered. This dualistic element of diseases formed the basis of the traditional medical practitioner's understanding of disease developments in the pre-colonial Gold Coast's medical culture. It informed them of the medical methods to treat the diseases they encountered. Knowledge about these diseases was easily accessible by anyone in the community. In times of medical emergency, members of every household had a basic understanding of the benefits and applications of several medicinal plants. Traditional healers, on the other hand, were experts in both herbalism and spiritism, and they used this expertise to cure a wide range of ailments. Even though the European sojourners believed the traditional healer's medical procedures were founded on superstitions, their testimonies demonstrated the effectiveness of the Gold Coast healer's methods. This lends credence to the claim that Europeans' misinterpretations and misunderstandings of native cultures, beliefs, and customs can be traced back to their limited knowledge of these topics.

Traditional healers, many of whom were women, played an important part in the traditional medical system by caring for and treating a wide range of illnesses and injuries suffered by members of their communities on the pre-colonial Gold Coast. Like their male counterparts, these female healers relied on many tried-and-true practices, from ritual incisions and incantations to herbal treatments. For example, among the

Akans and the Ga-Adangbes, women were responsible for gathering certain sacred plants and herbs and executing ceremonies to appease the spiritual forces responsible for particular maladies. This study's oral sources reveal that even at the household level, pre-colonial Gold Coast women were typically responsible for making various medicines for the emergency treatment of common ailments. They also knew about and used many different kinds of nutritional plants in their families' diets. Women of the pre-colonial Gold Coast also had an important role in birthing as traditional birth attendants. They helped pregnant women, new mothers and their children by offering them medical advice and treating their ailments, if any. All the female healers in their respective traditional medical fields were accorded the same respect and prestige as their male counterparts. These women were considered experts in their field, with their knowledge passed down from generation to generation.

Unfortunately, the arrival of European colonizers and the subsequent imposition of colonial rule on the Gold Coast in the mid and late-nineteenth century brought significant changes to healthcare delivery. British colonialism, accompanied by new medical practices, technologies and policies, gradually affected native women's roles in the colonial medical fields. The British colonial authority was so set on establishing its sway over the Gold Coast that it immediately opted to address the colony's sanitary situation, which was blamed for the plethora of deadly diseases that had killed off European missionaries and commerce merchants. Therefore, Governor Rowe set the groundwork for the construction of a colonial hospital in 1880, and the succeeding government formed the Sanitary branch under the Medical Department of the colonial hospital in an effort to enhance the colony's sanitary conditions. In light of this, colonial healthcare placed a premium on sanitation. When the colonial government decided to incorporate Indigenous Gold Coasters as scavengers and sanitary labourers, it would

have been reasonable to assume that the women who had previously served as practitioners under the traditional medical system would have been given training and employment opportunities. The archival material examined and analyzed in this project revealed the concerted efforts of the colonial government's decision to favour only men and purposely exclude native women in the sanitary fields of the colonial medical system. Over time, Indigenous men's roles in the sanitation sector shifted from those of labourers and scavengers to those of mosquito brigades and sanitary inspectors, while women remained sidelined. These men were granted tremendous authority, and Indigenous women who failed to cooperate were criminalised by colonial public health and sanitation regulations.

Native Gold Coast women's involvement in the colonial medical areas was severely repressed and stigmatised throughout the twentieth century. During this time, the colonial authority instituted sexist policies, like exclusively admitting and teaching native men to be village dispensers and sending some native men to school in the United Kingdom to become medical doctors. The government of the Gold Coast and other parts of tropical Africa set up village dispensaries to help with their civilising mission. The program's stated goal was to introduce and expand western medicine and practises among various Indigenous communities. As a side benefit, those native men who participated in the programme and received the education and training gained an advantage over their female counterparts in terms of employment in public health. Upon successfully completing their druggist examinations, these men worked for the government or as private practitioners. Despite the overwhelming evidence that the colonial authorities still needed more native dispensers to work in village dispensaries, coupled with the fact that the men they trained did not exhibit exceptional capabilities beyond what women could do, women were still prohibited from dispensary training

and instruction. Native authorities on the Gold Coast enabled this discriminatory strategy by sending only males from their villages to the dispensary school and then employing them with government assistance once they graduated. As a result of company policy, no women were allowed to work as dispensers on the Gold Coast. In this way colonizers reinforced patriarchal ideals, supplanted native women, and gave medical power to native men.

When it came to pursuing a career in medicine, the colonial educational system automatically disqualified female students from receiving scholarships to attend institutions like Achimota College and universities in the United Kingdom for preliminary and actual medical education and training. The reason for this disparity is that Indigenous men were given the opportunity to study subjects like mathematics, physics, and anatomy, while women were given a more narrow focus on domestic science. It was thus not an accident, as evidenced by archival documents, that education established for native women concentrated solely on domestic education and training. When the men who studied medicine abroad returned to the Gold Coast, they could work as private practitioners or could gain employment and work as junior government doctors in colonial hospitals. Thus, this study provides an explanation for why the leading African medical practitioners on the Gold Coast and elsewhere in Africa during the colonial period were all men. For this reason, I contend that the colonial administrations' exclusion of women was calculated and carried out via these discriminatory regulations in order to deliberately place men in positions of power and authority in the medical field. This is what authors Barbara Ehrenreich and Deirdre English mean when they talk of a constant gender battle, a male-led takeover of the medical fields, and the subjection of women who previously held influential positions

in these fields. African men collaborated with colonial plans to get medical power over women in exchange.

Most importantly, this research provides answers and analysis to questions never asked or considered by scholars and historians of Ghanaian colonial history. Historians are tasked with investigating not only just what happened but also how and why certain events transpired. The history of nursing and midwifery in Ghana has been the subject of scholarly research, but no one has ever explored why and how nursing suddenly became a female-dominated profession and why and how women were intensively concentrated in midwifery. The data obtained and analysed for this study clearly show that the acceptance of native women in these subordinate medical roles was a deliberate colonial policy. The nursing profession became unattractive to most native men because they preferred dispensary which was a higher profession than nursing. Also, the native men were tired of being under the supervision of the European nursing sisters teaching them as nurses;³³⁵ thus, the step or initiative by the colonial government to designate nursing as a female field was taken to make it possible for men to enrol in dispensary schools and become dispensers. Another reason for the restriction of native women to subordinate medical roles was to impose European mothercraft ideals and oppose the traditional birth attendants, their birthing methods and practices, ultimately replacing them with their trained African sisters. As a final contribution to the colonial historical discourse, this study reveals the horrific extent to which the colonial authorities used some parts of the bodies of native women who gave birth in colonial maternity hospitals for scientific experimentation to benefit white colonizers. An intriguing subject that this study might have investigated if more data were present

³³⁵ GH/PRAAD/ CSO 11-1-677

in the Ghanaian archives is the continuity and changes in women's medical experiences in post-independence Ghana. Several archival files between 1957 and the 1960s are missing because they were destroyed after the first president, Dr. Kwame Nkrumah, was overthrown through a military coup in 1966. This research is a first step towards a more extensive analysis and investigation into the healthcare experiences of Gold Coast women. The experiences of Indigenous mothers and their infants at colonial hospitals, maternity wards, and pediatric clinics must be the subject of future study.

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APPENDICES



Date: 19 August 2022

To: Dr. Katherine McKenna

Project ID: 121399

Study Title: Women and Medicine on the Gold Coast and Ghana, 1880-1963

Short Title: Women and Medicine on the Gold Coast and Ghana, 1880-1963

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 09/Sept/2022

Date Approval Issued: 19/Aug/2022 12:14

REB Approval Expiry Date: 19/Aug/2023

Dear Dr. Katherine McKenna

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.**

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Research Plan Schedule-Michael Osei	Protocol	07/Jul/2022	

Debriefing Script	Debriefing document	04/Aug/2022	
Verbal Recruitment Script	Oral Script	04/Aug/2022	
Recruitment Script	Recruitment Materials	06/Aug/2022	
LETTER OF INFORMATION AND CONSENT FORM	Written Consent/Assent	18/Aug/2022	Revised
Interview Guide	Interview Guide	18/Aug/2022	Updated
Interview Guide 2	Interview Guide	18/Aug/2022	version update date
Interview Guide 3	Interview Guide	18/Aug/2022	version update date

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Time Commitment Table	Supplementary Tables/Figures	04/Aug/2022	

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario

Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Page 1 of 2

Sincerely,

Ms. Zoë Levi, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Page 2 of 2

Women and Medicine on the Gold Coast, 1880-1945.

Field Notes (Translated version)

Interview at her residence in Abuakwa-Tanosso, Ashanti-Region, Ghana, on 30th September 2022.

The participant's pseudonym in the study is Maame Yaa Mansa.

Maame Yaa Mansa is a Traditional Herbalist and a Birth Attendant who gained medical expertise from her late grandmother.

Researcher: Please, to those unfamiliar with traditional medicine, how would you define it?

Participant's Response: What I call "traditional medicine" is shaped in my mind by the ideas of my culture. The Akans and people of other cultures have a common understanding of traditional medicine as the practice of consulting with and receiving advice from spirits to identify, treat, and prevent a wide variety of illnesses and injuries. Nevertheless, not all treatment or medical practices require contact with spirits. You need to note that it was through traditional medical practices that our great ancestors treated several diseases and saved many lives for centuries before Akwasi Broni

(Whiteman) brought his so-called medicine. I must say that our ancestors even lived much longer than we are witnessing in today's so-called modern/advanced world.

Researcher: I need more clarification or details on two interesting things you pointed out. Please, what medical or healing practices did not require contact with spirits?

Participant's Response: Only highly trained traditional medical practitioners, including priests and priestesses, and to a lesser extent, herbal healers and traditional birth attendants (TBAs), relied on communication with the supernatural to understand how to treat patients. Herbal healers and TBAs, in contrast to priests and priestesses, who receive their medical instructions and practises from the deities they served, relied heavily on their own experience gleaned from years of practice and information from their ancestors, who reveal the properties and uses of plants to them in dreams. The ability to diagnose and treat common ailments in one's own family did not even include communication with the supernatural. This meant that even the family's youngest members got some exposure to the basics of herbal medicine.

Researcher: Why did specialized medical practitioners need to consult or contact spiritual entities in their medical practices?

Participant's Response: That is an important question because most people do not understand our medical culture. From what I learnt from my late grandmother and as a traditional medical practitioner myself, our understanding of diseases is based on socio-cultural beliefs and an understanding of our immediate environments. This belief was shared across all cultures on the Gold Coast. The belief that nothing happens without a cause existed, and it was justified by the two popular Akan proverbs stating that "there is no smoke without fire" and "if nothing touches the palm kernel, it does not rattle." For this reason, they concluded that sickness has never arisen by chance. Like human

beings constitute physical and spiritual forms (body and soul), diseases were also considered to constitute physical and metaphysical aspects. Therefore, the traditional healers needed to appeal to all two aspects of every individual to maintain a balance. Let no one deceive you that disease development has no spiritual elements. Most diseases have a spiritual component because the knowledge gathered from our environment suggests that we are surrounded by spiritual entities such as deities, dwarfs, forest monsters, witches and wizards who have the power to inflict people with different diseases. We believe that the Supreme Being created all these forces for a specific purpose. For instance, in our cosmology, deities are assigned a special responsibility by the Supreme Being to guide the course of life of people. Hence, they have the power to reward good people with good health for their good deeds and punish wrongdoers by striking them with illness.

Nonetheless, good people could also be struck with diseases by evil forces like forest monsters, witches and wizards. Therefore, the practitioners needed to understand all these concepts to maintain the balance between the physical and meta-physical realms. Pronouncements of curses linked to particular spiritual energies are easily manifested as psychical effects upon the cursed individual because of the influence of spiritual realm activities on the physical world. Since the spiritual and material realms are inextricably linked, it followed that a spiritual cleaning was necessary for the treatment of various physical ailments and vice versa. All the practitioners understood these concepts and principles of disease development and used them effectively in their practices.

Researcher: Was this vital information available to everyone, regardless of social status or gender?

Participant's Response: Because it was thought that the Supreme Being had imbued the entire cosmos with wisdom and made it available to anyone who sought it, the answer is yes, there was unrestricted or open access to such medical information. There was no gender discrimination in terms of knowledge acquisition. Women, Men, both young and elderly, were involved in all levels of medical knowledge. This wise saying or proverb supports the non-restrictive access and dissemination of medical knowledge among the people. We always say, "wisdom, truth or knowledge is like the giant baobab tree which a single person's arm cannot solely embrace. It can only be fully embraced if many arms come together." This proverb also aligns with the adage that an individual cannot solely monopolize wisdom or knowledge.

Researcher: What medical duties and procedures did women herbalists typically undertake?

Participant's Response: Like their male counterparts, female herbalists possessed a wide range of botanical knowledge involving the parts of specific plants to cure a given patient. Their medical duties and practices were not different from their male counterparts. They lived in harmony with nature and the environment. By observing the plants and trees surrounding them, they knew how the different elements of nature worked together to bring about good health to the local people in the community. They were among the most easily accessible traditional medical practitioners due to their expertise in local herbology through years of practice. Like any other medical practitioner, female herbalists diagnosed their patients before prescribing and administering medicine to heal the sick person. Here let me share some of my procedures in treating or finding solutions to alleviate certain ailments. At times, some patients present diseases that are extremely difficult to treat, even after combining

several herbs. In such situations, I always encounter my late grandmother in dreams, who then shows me certain plants, roots, and stems or directs me to other female herbalists who are more experienced than me for guidance. Also, at times through deep meditations accompanied by libation and prayers, my spirit reveals to me the kind of medicine or herbal plant to be used and the means to be administered to the patient. The methods of preparing and dosages included but were not limited to cooking, grinding, pounding, chewing, drinking, and insertion. The female herbalist's assistant records each patient's disease and treatment. Libations and prayers are very important because it usually appeals to the Supreme Being and the spirits that may have caused the diseases to show mercy towards the patient. The herbs, stems, or roots used to treat such ailments are always sacred. In most ethnic groups, women or female herbalists always had the right to fetch such herbs because some medico-rituals ought to be performed in front of the sacred plant, which men could not do unless women.

Researcher: Will sharing some glimpses of the medico-rituals that the women or female herbalists perform in front of those sacred plants be okay?

Participant's Response: They usually go for such sacred plants in an assigned timeframe, at midnight, dawn or mid-day. One thing to note is that trees or plants are living beings, and spiritual forces reside in them. That is why as herbalists, we always advise people to accord everything with respect and dignity. We always tell people that "when you look at a tree, you need to view it as not just a mere tree in the forest or farms. Instead, see it as a living being with the power to make something happen." As a result, we believe and truly know that certain rituals or rites must be performed before taking herbs, roots, or stems from the forest and anywhere. As herbalists, we communicate with herbs through the language of the spirit and listen to the voices of

the plant's spirits. So, the women or female herbalists usually go to the sacred plants armed with eggs and schnapps to perform appeasive rites to the spirits residing in the tree to allow them to take the herbs without any consequences. Some rituals even require them to strip naked before plucking some sacred herbs. Unfortunately, such sacred plants are not to be easily disclosed; else, I would have told you.

Interview at her residence in Krofrom-Kumasi, Ashanti-Region, Ghana, on 19th September 2022.

The participant's pseudonym in the study is Maame Adwoa Ampafo Brakatu.

The participant is a well-known practitioner in birth-attending roles and also possesses in-depth knowledge about the traditional medical practices of priestesses because her late mother was a fully-fledged priestess healer.

Researcher: Many stereotypes and misconceptions surround the fetish healers' field of the traditional medical system. Some people argue that the medical practices and procedures employed by the healers of this field are barbarous and superstitious. As a person whose mother was a priestess healer in this medical field, what are your thoughts on these issues?

Participant's Response: All I can say is that those who make those assertions are uninformed and unaware of cultural beliefs and ways of doing things. The fact that their practices or ways of doing things are not in tune with or not in line with ours does mean that beliefs and practices are fictitious. Every activity we undertake is justifiable and

could be substantiated with material evidence. Are priestess healers unable to heal people suffering from various diseases? Which people cured, prevented and protected communities for centuries before the Europeans came here with their own practices? Through what means were our Indigenous people healed? These are questions for you not to answer, but I will answer them. Priestess healers and other traditional medical practitioners provided all the medical care required to live a healthy life. The procedures and principles of medical practices have been handed down from generation to generation.

Researcher: Then, please kindly share with me the medical activities undertaken by the priestess healer(s). What were the roles and principles that influenced their medical practices?

Participant's Response: As a child who grew up in this community, I know you saw several priests' and priestesses' medico-ritual performances here. Now let me ask you this: Before the ban on curses imposed by the Asante Hene (King of the Ashanti Kingdom), when someone pronounced a curse by asking a particular deity to deal with someone who had wronged him or her, what happened? We all know that the deity kills the offender or culprits if rituals are not performed immediately to repeal the curse. That medico-ritual responsibility fell in the hands of the priest or priestess whose deity was called upon. This not only disproves the assumption that their medical treatments were based on superstition but also demonstrated one of the many crucial responsibilities of the priestesses. Also, they performed preventive health functions by exposing deviant behaviours and actions by the community members that cause harm or havoc. That is why priestess healers and their male counterparts treated diseases through herbalism and spiritism because the spiritual factors of diseases were

undeniable. Priestesses served and worshipped the Supreme Being by taking instructions from deities who were represented physically through objects or shrines. Deities were created by the Supreme Being, who is always regarded as the creator of all things and the sustainer of the entire cosmos. Often, there were family and community shrines where priestesses performed their medical duties. This means priestesses could be family or community shrine caretakers and leaders like their male counterparts. Among the Akans, the prominent shrines for priestess healers were brass-pan shrines which rested on hand-carved stools as a symbol of medico-political authority. This meant that their expertise was not limited to only the medical realms, but they could also participate in the political sphere since they had the power to make important decisions on days of festivals, harvests, rest and sacred days as instructed by her deity. As the caretakers of these shrines, they regularly poured libations and offered food to the shrine's deities as sacrifices to accompany prayer and to request protection against any diseases and evil attacks on the people of the family or communities.

Researcher: What about their methods of healing or their healing practices?

Participant's Response: Because they drew their medical knowledge and inspiration from the deities they served, they could not diagnose their patients without being possessed for the deity to take complete charge of their bodies. Possession was crucial to the healing practices because it was through this phenomenon that medical knowledge was imparted, and secrets of healing were revealed to the priestess by the deity. Knowledge about certain cures comes to the priestess when a deity possesses her. For instance, in her state of possession, the deity often leads her into the forest and is shown a special leaf, root, and stem to bring home to cure a patient. Possession simply shows the close interaction between spirits and human bodies. It equally exemplifies

the existence of unity between the spiritual and physical worlds. That is where the secrets and knowledge hidden in the former are revealed to the latter through the representatives to heal the illnesses of people in the community. For as far as I can remember, whenever a sick person came to my mother's shrine in search of medicine to heal his or her sickness, my mother would perform rites to become possessed, at which point the deity would instruct her on how to proceed. The deity may show the kind of herbs or medicine to be prepared and administered to the patient. The prepared medicine was given to the patient in various forms. Nose sprays, inhalers, elixirs, and sitz baths were all dosing methods. Spells and incantations were often used as part of the therapeutic procedures. If the patient strictly observed the deity's instructions, it was believed that he/she would be healed.

Researcher: What were the procedures or processes to be undertaken for priestess healers to be possessed by a deity?

Participant's Response: During possession, a priestess healer is generally decorated with medicinal plants, wears charms to protect her from evil attacks, and symbolically transforms into a communicator with the deities. Medico-ritual songs accompanied by rhythmic drum tunes were played to beckon the deity. She then carries the brass-pan shrines to allow the deities to easily possess her body, guiding her work as a spiritual leader and herbal healer. They always wore apparel that symbolized or gave clues about the deity possessing her at a particular time. The priestess acts in many ways, like shouting, rolling, and wriggling her body when the deity descends on her.

Researcher: How could one become a priestess healer?

Participant's Response: Even becoming a priestess required a special encounter with a particular deity who wanted the person to enter the traditional medical profession as

a priestess healer. In some families, to determine a successor of a priestess healer, young females in the family were gathered. Each, in turn, would carry the brass-pan shrine on her head until the deity chose one through possession. A fully-fledged practitioner would then train the selected person to become the shrine's caretaker and deities and enter the medical profession as a priestess healer. As part of her professional training, she was required to observe all the taboos of her deity, which included restraining herself from eating certain foods and animals and playing with her peers in the community. The training usually lasted for two or more years, depending on her seriousness in learning the profession and acquainting herself with medical practices of incantation, spell casting, and getting possessed by the deity.

Researcher: Historically, TBAs have faced criticisms and condemnation about their birthing practices as premised superstitions with no proper understanding of the problems. What do TBAs regard as the cause(s) of conception problems, and how did they tackle them?

Participant's Response: No system of practice in the world is entirely perfect. Although there were some challenges in our practices as TBAs, we still managed to achieve success in our field of practice by safely delivering pregnant mothers during their labour and protecting them and their newborn babies. For the TBAs, infertility may result from bad luck and evil forces. The TBAs held that a woman's ability to conceive might be improved by treating with herbarium for ailments or conditions that prevented pregnancy. Women unable to conceive were given a herbal concoction to chew, drink, or insert to rid their bodies of the conditions preventing pregnancy.

Researcher: What roles did TBAs play towards the well-being of pregnant mothers and their babies during and after labour?

Participant's Response: The Traditional Birth Attendant's duty was to ensure the mother's and child's physical and spiritual safety and shield them from possible harm. TBAs in every Gold Coast culture provided comprehensive care for the general well-being of the mother and her unborn child during the whole pregnancy, delivery, and postpartum periods. As part of our prenatal care practices, expectant mothers are given pointers on maintaining a healthy lifestyle during their pregnancies, including what to eat and drink, what exercises to perform, and what could harm their unborn children. During the final months of pregnancy, the TBAs closely monitor the expectant mother.

Researcher: How can you or TBAs know if it is a pregnant woman's labour time?

Participant's Response: The Akan culture placed great importance on a pregnant woman's *nteteho* (the sense of discomfort caused by the baby's movement around the uterus) as a signal that the moment of her delivery was drawing close. The day or moment a TBA noticed intense fluid secretion from the pregnant woman's cervix meant it was almost time to deliver her child.

Researcher: How can TBAs know if the baby is not coming with the head, and what steps can be taken to remedy the situation if it occurs?

Participant's Response: Per natural phenomena, babies were expected to come from the uterus to the cervix with their heads and not any other body part. Through lived experience and several years of practice, they got to know the body part the baby was coming with by observing the belly of the pregnant woman. The technique was to place a finger in the woman's cervix and feel the area or body part of the baby which was forthcoming. It was believed that in the weeks leading up to birth, the baby shifts from the uterus and comes closer to the cervix, so it was simpler to detect which way the baby was coming.

Interview at her residence in Krofrom-Kumasi, Ashanti-Region, Ghana, on 5th October 2022.

The participant's pseudonym in the study is Maame Abena Yiadom. She possesses basic herbal knowledge from her mother. When she was a young girl, she encountered a deity that wanted to possess her, but her family performed rites to free her from serving the deity. Yet, she still has episodes in her dreams where spirits show her certain medicinal plants. Her parent's decision to prevent her from entering the profession as a priestess healer was due to some personal reasons.

Researcher: Please, can you share with me how you acquired your basic herbal knowledge?

Participant's Response: Growing up in a community full of herbalists, TBAs and Priestesses, acquiring basic herbal knowledge was common and accessible. Every household was aware of the medicinal properties of the various plants in their immediate surroundings. That is why it was common to see medicinal plants as the fence in people's compounds. Traditionally, mothers were responsible for preparing homemade medications for the entire family. Mothers were responsible for passing down their herbal knowledge to their daughters, and fathers did the same for their sons. The first step toward wellness and longevity was gaining access to and understanding the basics of plant therapy. My first step toward learning about medicinal plants was to plant some with my mom and elder siblings in our garden. My mom always told me that medicine was grown in compounds so that people could access it faster in case of an emergency. On the way to the farm, she instructed us on how to use herbs to cure problems like a snake bite or excessive bleeding from a cut. When my mother prepared medicine, my older sister and I were there to help so that we could learn from her. She

taught my sister and me how to make a home remedy for medical emergencies by boiling plants in pots and blending different herbs. As a young child, it was always advisable to get closer to the elderly to gain more knowledge from them. Also, occasionally, I have visions or dreams where some spirits direct me to a plant and teach me its uses in disease prevention and cure.

Researcher: The births of eleven children must have put you in close contact with TBAs; as such, do you have any insight to share on their procedures?

Participant's Response: Childbirth was a serious activity that needed massive attention and care throughout the journey. Most societies frowned upon barrenness or infertility since childbirth ensured society's continuous existence. As a result, TBAs mainly were older women with several years of expertise and practice in the field. Their sole mandate was to monitor and safeguard pregnant mothers from conception to delivery and post-delivery. The welfare of the mother and unborn child's welfare was their crucial task. All their advice was geared towards the mother's general well-being and her unborn child. In order to avoid birth complications, pregnant mothers were to keenly observe all the medical advice and procedures given by the TBA. The TBA administered various herbs and medicines to pregnant women throughout the pregnancy period. Some of the plant medications were to strengthen the mother and her foetus, boost her ability to produce more breast milk for the baby and prepare her for easy or stress-free delivery during labour. However, whenever there were complications during childbirth, TBAs mixed certain herbs and administered them to the woman in labour to aid her in delivering the baby. Their work as TBAs continued even after the delivery of the baby. TBAs mostly treated diseases that afflicted mothers and their babies, except those beyond their expertise.

Interview at her residence in Krofrom-Kumasi, Ashanti-Region, Ghana, on 11th October 2022.

The participant's pseudonym in the study is Maame Ama Benewaa. Although she has expertise in plant medicine, she has refused to practice on a larger scale but only to use her knowledge during emergency health cases of her family members and her neighbourhood. According to her, the decision not to practice on a larger scale is based on her own personal choices and decisions.

Researcher: What are your experiences in this field of traditional medicine?

Participant's Response: I learnt herbal or plant medicine as a young girl because my mother and father had expertise in this field. One secret revealed by my mother to me was that I should always revere plants because the Supreme Being created them for human well-being. According to her, a good female herbalist should properly know her environment as she knows the details of her home or household. This is because the environment informed the herbalists of the available plants with the potential to alleviate illnesses. Most medicinal plants could never be brought home when certain rituals were not performed to appease the spirits residing in them. Some plants required money, cowries, eggs, kola nuts and schnapps to be offered as sacrifices in exchange for the therapeutic plants. My major concern for my family is to always ensure their well-being and health by including medicinal and nutritional plants in their diet.

CURRICULUM VITAE

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