# A Historical Study of the Impact of Colonial Rule on Indigenous Medical Practices in Ashante: A Focus on Colonial and Indigenous Disease Combat and Prevention Strategies in Kumase, 1902-1957



**Samuel Adu-Gyamfi**

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## DECLARATION

I hereby declare that this submission is my own work towards the PhD and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the university, except where due acknowledgement has been made in the text.

Samuel Adu-Gyamfi (PG9232606) _____ _____

Signature Date



**Certified by:**

Dr. W.J Donkoh _____ _____

Supervisor Signature Date

Dr. Charlotte Mensah _____ _____

Supervisor Signature Date

**Certified by:**

Mr.Vincent Dodoo _____ _____

Head of Department Signature Date

(History and Political Studies)

## ABSTRACT

The study addresses the question of lack of in-depth study of the history of medicine in Asante and Kumase specifically. The study is an attempt to fill this lacuna. It examines the influence of the Colonial Administration on indigenous medical practices in Asante and Kumase as well as a focus on Colonial and Indigenous diseases combative and preventive strategies in Kumase.

The study traces how indigenous medical practices have continued to be in existence from the nineteenth century to the first half of the twentieth century Asante. It accesses untapped information that deals with the operations of indigenous healers in Kumase and its environs as well as colonial influence. One of the noted influences include the permission granted the Asante Confederacy Council by the Colonial Administration to register indigenous physicians who were known to be genuine. Attestation mostly came from chiefs or native heads whose jurisdictions the practitioners practised and usually it had to be assented to by the *Nsumankwaafieso*.

The closure of witch-finding shrines in Asante and Kumase specifically is one of the noticeable colonial influences. Significantly, there was the development and adoption of some modern techniques and practices in indigenous medical practices and the cessation of such practices as witch finding which was considered injurious to humans by the standards of the Colonial Administration. It also studies the impact made by the Colonial Administration among other things, the registration of unqualified midwives in Kumase and the establishment of Child Welfare Clinic in Kumase and its consequences for the people of Asante.

The study highlights the contribution of the Colonial Administration in curing of diseases as well as disease prevention and health promotion in Asante. The information gleaned from various archival sources and interviews threw light on how the Colonial Administration used legislation to influence the way of life of the people of Asante from 1902 to 1957 to ensure that disease transfer was hampered and health promotion effected. The consequences of such colonial influence are carefully documented.

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DEDICATION

This thesis is dedicated to the more than enough God, my wife, Nhyira Adu-Gyamfi, my mother, Hannah Gyamfi and the late Prof. Kwesi Andam.

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ABBRREVIATION

AMB – Anti Mosquito Brigade

AHB – Aboabo Health Board

CSM – Cerebro Spinal Meningitis

IPH – Indigenous Priest Healer

KNUST – Kwame Nkrumah University of Science and Technology

KPHB – Kumasi Public Health Board

KTC – Kumasi Town Council

MAG – Manhyia Archives of Ghana

PRAAD – Public Records and Archives Administration

TBA – Traditional Birth Attendant

TBS – Traditional Bonesetter

TCS – Traditional Circumcision Surgeons

# CHAPTER ONE

# INTRODUCTION TO THE STUDY

## 1.0 Background to the Study

From the earliest time, man has faced the challenge of meeting his health needs. The constitution of the World Health Organization (WHO) defines health as "the state of physical, mental and social well being and not merely the absence of disease or infirmity".[1] This definition underlines health as an integral part of what a people need in order to realize their full potential and derive satisfaction from life. Oral traditions have shown that the people of Kumase and Asante as a whole faced the challenge of providing health care from very early times. In fact, all humans have in one way or the other shown resilience in fighting anything that has the potential of threatening their existence including diseases.

The above argument ties in with what Twumasi puts forward in his book, *Medical Systems in Ghana*, when reference is made to Malinowski's assertion concerning the health needs of man that all the manifold activities of men are directly or indirectly related to man's health needs which is essential for his survival.[2] Twumasi has noted that the whole area of medicine as an aspect of human behaviour seems to fit Malinowski's assertion that human institutions are based on individual biological needs.[3] Recognizing that the presence of diseases would reduce economic activities and the satisfaction of other social needs, efforts were made during the pre-

[1] D. Longley, *Health Care Constitutions*, (London: Cavendish Publishing Ltd, 1996) 1
[2] P.A Twumasi, *Medical Systems in Ghana*, (Accra: Ghana Publishing Corporation, 1975) 1
[3] Ibid

colonial and colonial eras by the indigenous people of Asante and later, through cooperation with the colonial administration, to meet the health needs of the people.[4]

The major tool that was used prior to British control was indigenous medical therapies whereas from 1902 onwards, especially when Asante power had been toppled by the British, the colonial administration placed emphasis on European medicine. This notwithstanding, in twentieth century Southern and Eastern Africa, indigenous medicine was still considered as the dominant healing system and often regarded as the more appropriate mode of treatment by specialists and recipients. Stretching from Ethiopia, Tanzania, South Africa, and Zambia to Cameroon, Nigeria, and Ghana, indigenous African healing systems remained highly utilized by large segments of the rural population surveyed.[5] This notwithstanding, during the period 1902 to 1957, there was the co-existence of several medical therapies resulting in what could be termed as medical pluralism in Asante. In spite of the setbacks modern medicine seemed to have brought indigenous medical practices, the WHO has commended its operation and usage in several communities in Africa and elsewhere. For instance, anthropologists generally agree that in most non-Western societies, including Ghana, indigenous healers are the first resort in mental health problems and they continue to be used even after psychiatry systems are enlisted.[6]

Indigenous medical practice, so far as this study is concerned, refers to the activities of traditional priests and priestesses referred to in the work as Indigenous Priest Healers (IPHs) who had undergone training at various reputable shrines and possessed unquestionable knowledge

[4] Ibid
[5] K, Konadu, *Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and encounters with (Medical) Anthropology*, African Studies Quarterly, volume 10, Issues 2 and 3, 2008
[6] L. A, Leonore, P. G Uwe, *Cross Cultural Topics in Psychology* (USA: Greenwood Publishing group) (sites Jilek, 1993) 268

about Indigenous Ghanaian medicine, in the form of herbs, barks and roots of trees; persons who possessed unquestionable knowledge about Indigenous Ghanaian medicine acquired through a period of training at a reputable or under a competent herbalist, especially within the period 1902 to 1957. They also include specialists such as Traditional Circumcision Surgeons or *Wanzams*, Traditional Bone-Setters (TBS) and Traditional Birth Attendants (TBAs).[7] Modern medicine or biomedicine also referred to as scientific medicine so far as this study is concerned refers to the introduction of European medical therapies and influence in Asante and Kumase specifically during the colonial period.



## 1.1 Problem Statement

The inaccessibility of modern medicine and cost still made indigenous healers the resort for most Asantes during the period under study. The colonial government itself conceded its inability to provide medical care for all Africans in the Gold Coast. So in spite of its desire to claim hegemony in the area of medicine, it conceded space to herbalists and healers as registered through the *Asantehene's* council. This is the larger context of Indirect Rule, ruling vast geographical areas in Africa with limited colonial personnel and resources. It is this space that allowed indigenous religion and medicine to thrive in colonial Asante. Significantly, while the colonial government was skeptical about the skills of herbalists, IPH and other healers in Asante and Kumase specifically, it was compelled to take several measures, which included the passing of regulations and also assiduously did bio-prospecting in areas such as northern Ghana to look for medicinal herbs that could be commercialized and make a place like northern Ghana economically viable.

[7] Manhyia Archives of Ghana, Kumasi, MAG 1/1/102A, Correspondence between the Ghana Psychic and Traditional Healing Association, Ashanti Regional Secretariat and the *Asantehene,* 3rd August, 1963

Although, there seemed to be the question relating to European control of the medical field in the Gold Coast and Asante in particular, the land was not void of diseases. The principal causes of ailment were noted to be parasitic, malnutrition and environmental deficiencies. The prevalent diseases within the period from 1902 to 1957 included malaria, trypanosomiasis and tuberculosis infections among others. They were combated through the use of both indigenous and modern medical systems.



The central issue or problem is that the non-statistical historical data or information concerning the impact of British Colonial rule on indigenous medical practices in Kumase and Asante in general as well as the fight against diseases and prevention has not been fully captured by earlier historical works or studies. Some significant indigenous medical practitioners who have knowledge of the folklore of the people of Asante and either witnessed or whose practices were influenced by the British Colonial Authority are available. A study like this that could make use of these sources that may not be available in the near future was appealing.

## 1.2 Aim/Objectives

The study aims at providing ample historical evidence with the view to establishing or confirming British colonial influence as a means through which indigenous medical practices in Asante and Kumase in particular were reformed and diseases and epidemics were prevented.

The following are specific objectives of the study:

- To identify some of the indigenous medical practitioners in Asante and the training they received.
- Find out the impact of the British Colonial Administration on the following: IPHs, Herbalists, TBAs, TBS, and *Wanzams*.
- Identify some of the diseases that infected the people of Kumase and the efforts made by both the Colonial Administration and the indigenous people to provide cure and prevention.
- To study the efforts made by chiefs, headmen and the Colonial Administration to keep a clean environment to prevent diseases as well as the activities of the Kumasi Public Health Board (KPHB).



**1.3 Research Questions**

1. What were some of the indigenous medical practices in Kumase and Asante in general and the organizational base which supported these indigenous medical practitioners?
2. What kind of training did these indigenous medical practitioners receive?
3. To what extent did the policies of the Colonial Administration lead to changes in indigenous medical practices in Kumase?
4. What were the prevalent diseases in Kumase and its environs as well as the methods used by both the indigenous and colonial Administration to cure such diseases?
5. In what circumstances did the Colonial Administration co-operate with Native Heads and Headmen to keep Kumase clean?
6. What role did the Kumase Public Health Board (KPHB) play in forestalling the occurrence of epidemics in Kumase from 1924 onwards?

## 1.4 Theoretical Perspective

A study such as this, concerned with continuity and change in indigenous medical practices as well as different approaches to disease combating and prevention as a result of Colonial influence, which brought some form of social change, requires a perspective that incorporates certain features of rational model, functionalist model, and the institutional approach.[8] The rational model takes into account the fact that men plan consciously and take into account not only their successes but also their recognized failures.[9] However, the functionalist model focuses on the scepticism about formally stated goals as the main ends of organizational behaviour, and the emphasis, which is placed upon the integration of the social system. The institutional approach will be discussed later.

In an argument for orderly and directed social change, the question has been how to bring change in an orderly fashion.[10] It is important to point out that some elements of the rational and functionalist model should permit us to focus on both cooperative and conflicting actions on the part of the indigenous people of Asante and the Colonial Administration in their attempt to effect a positive social change, with respect to the perceptions of the people towards disease prevention and cure. In approaching this problem, the objective has been to formulate at least in an exploratory way, an adequate historical explanation of the interaction between European medical policies and indigenous medical systems in Asante in meeting the health needs of the indigenous people. The functions of society are basically determined by their set objectives, which emanate from their needs and are mostly influenced by their way of life or culture. In

[8] H, Simon., *Organization* (New York: John Wiley and sons, 1958) 128-130
[9] P.A, Twumasi, *Medical Systems in Ghana*,
[10] G.H, Mead, "The problem of society" Reprinted in Strans A. (ed.), *The Social Psychology of George Herbert Mead* (Chicago: University Press, 1952)

writing the history of medicine of the people of Asante, certain events that were sometimes consciously planned by the leadership of existing institutions of the indigenous people including the institutions of the Colonial Administration would be useful.

In Asante and other cultures in Africa within the period under study, knowledge of indigenous medicine was passed on orally from one generation to the other. Bodin has argued that history is placed above all branches of learning in the highest rank of importance and needs the assistance of no tool, not even of letters, since by hearing alone, passed on from one to another, it may be given to posterity.[11] Bodin's assertion is certified by Asante practice of oral transmission of indigenous medical knowledge from one person to the other for the sake of posterity. This notwithstanding, historical transmission of medical practices does not take place in isolation. There is the need to include the institutional approach, which involves all those cultural theories of human behaviour, to study the many ways in which men manipulate their environment in order to achieve their purpose.[12]

Significantly, the institutional approach focuses on the fact that human aims are achieved through organization. Therefore, the culture of a group is seen in terms of the purposefully directed activities of specific groups. Again, it does assume that the general content of cultural knowledge determines the forms and purpose for which groups are organized and the activities by which they hope to achieve their aims.[13] Three main elements are basic to the institutional approach. There is the concept of purpose, for the achievement of which members cooperate. There is also the concept of institutional group, that is, the group of members cooperating to

[11] J, Bodin, *Method for the Easy Comprehension of History* (New York: Octagon Books Inc., 1966) p28-29
[12] T, Parsons, *Structure and Social Action* (New York: McGraw Hill, 1951)
[13] Ibid

achieve the purpose. Lastly, there is the concept of the institution per se.[14] The study focuses on the larger societal context with some emphasis on institutional approach. To explain further, the societal context simply includes Asante in general and Kumase specifically. Institutions and personnel simply include indigenous medical institutions, that is, Traditional Bone-Setting, Circumcision surgery, Traditional Birth Attendants (TBAs), Herbal Healing and Indigenous Priest Healing (IPH) and their personnel. They also include the institution of chieftaincy and headmen, the agency of the Colonial Administration especially the Kumase Public Health Board (KPHB), Anti Mosquito Brigade (AMB) and their personnel. These institutions were either formed consciously or deliberately to meet certain social needs including medical needs. It is within the same thought that Hertzler pointed out that:

> Social institutions are purposive, regulatory and consequently primary cultural configurations, formed consciously or deliberately, to satisfy individual wants and social needs bound up with the efficient operation of any plurality of persons. They consist of codes, rules and ideologies, unwritten and essentially symbolic organizational and material implementations. They evidence themselves socially in standardized and uniform practices and observances, and individually in attitudes and habitual behaviour of persons. They are sustained and enforced by public opinion acting both informally and formally through specifically devised agencies.[15]

Hertzler's argument stresses the fact that institutions have roles to play in the development of communities. Thus, they serve the purpose of satisfying individual wants and meeting societal needs. It is as a result of this that a study such as this, which looks at the history of medicine in Asante, cannot overlook the institutions that have significantly shaped the course of development of medicine amongst the indigenous population at the time.

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[14] Ibid

[15] J.O, Hertler, *Social Institutions* (Lincoln; University of Nebraska press, 1964) 1-5.The work of Scupin gives significant information on psychological functionalism. R., Scupin, *Cultural Anthropology: A Global Perspective* (New Jersey: Pearson Education Inc., 2008) 132-133

## 1.5 Method of the study

The research is based on ethnographical and inter-disciplinary approach using written, oral sources and observations as sources of data. The researcher used the field interview technique to collect oral data. Information was also collected from archival sources. Similarities and contrasts in the various data collection tools used have been noted in this study.



Two major written sources have been used. They are primary sources and secondary sources. Some of the secondary sources used include information from books related to the history of medicine such as *History of Western Medicine in Ghana* (1997), *Health in Colonial Ghana, Disease, Medicine and Socio-Economic Change* (1981). Related topics in the field of medical geography namely, *Scientific Theory of Culture* (1944) as well as topics in medical sociology such as *Medical Systems in Ghana* (1975) and related topics in anthropology such as *Witchcraft in four African Societies* (1951) have been referred to. These sources were consulted because they have corpus of information that is relevant to the study. Journal articles covering bone-setting and indigenous medical practices were also used in writing the final thesis. Again, relevant information on bone-setting, Islamic medical practices among others was accessed from the internet. These written sources have been used in the research essentially to ensure that the work is in tune with historical research trends in the field of history of medicine. It is also to ensure that the thesis is not necessarily a repetition of what has already been written by some authors and researchers. The aim is to use the existing information as a base for further research to promote new findings in the field of study.

Also, one of the primary written sources used in this study are Archival documents. The Archives where primary data has been retrieved include Public Records and Archives Administration (PRAAD), Kumase and Accra respectively where data like the correspondence between The Colonial Secretary of State, District Commissioners, Secretary for Native Affairs, Infectious Disease files among others were accessed. Another depository where primary information has been obtained is the Manhyia Archives Ghana, Kumase, where information pertaining to the correspondences between the *Asantehene* and Chief Commissioners, memorandums and minutes of colonial commissions and committees including those of the Asante Confederacy Council were retrieved. The others include correspondence and annual reports from the Medical Officer of Health, rare books and publications. Some of the records collected from these archives were not very usable. Some of the sheets had become too faint and hardly legible, partly torn and sometimes, because of their fragile nature, extra caution was needed to extract information from them. Yet, in spite of the challenges, information derived from these materials added to the originality and authenticity of the research.

Also, oral sources have been used. Indigenous medical practitioners have been interviewed to retrieve information for the writing of this thesis. The criterion for the selection of the indigenous medical practitioners was based on the longevity of their practice, the perceived efficacy of their medicine based on testimonies of their clients, and their location, which is Kumase, the case study area. Different people in the location of Kumase were asked about the existence of various indigenous medical practitioners in their location. Once they were identified, respondents were asked how long they perceived these indigenous medical practitioners have been in practice. Testimony with respect to the efficacy of their

medicaments was also found out by interviewing those who were noted to have patronized their medicines or have close relations who habitually patronised the medicines of some of the practitioners who were identified. Based on the available information gathered from randomly selected respondents, these practitioners were further interviewed to retrieve first-hand historical information concerning the emergence of their practice and their mode of operation using the field interview technique.



Similarly, elderly men and women whose age range from sixty upward were randomly interviewed to corroborate archival evidence. The interviews helped in retrieving information from a sample size of eighty at different locations in Kumase and its environs. The interviewees included those who witnessed or were directly or indirectly impacted by the medical occurrences within the period under study. Most of the interviews conducted included open-ended questions. The open-ended questions were flexible and ranged over a wide variety of topics that were relevant to the objective of the study. Sometimes answers from respondents suggested a new line of questioning to the interviewer. This method was very effective because a historical study such as this requires that details pertaining to the nature or the mode of operations of these practitioners as well as the occurrences of the time the study seeks to capture had to be established. This was achieved as a result of the open-ended nature of the questions that were asked during the field interview.

Finally, observation of the traditional ways of doing things was employed as a data collection tool. The traditional medical practitioners who were interviewed were also observed while they went about their duties. The practitioners who were observed included herbalists, circumcision

surgeons or *Wanzams*. The practitioners were not only observed but were asked questions for clarification on some of their practices. The questions mostly bordered on what, why, when and where certain practices were required or done and their consequent successes and challenges on indigenous medicine. This line of questioning was adopted to ensure that the information gathered was in tune with the occurrences of the period under study. Overt method of gathering information was used.



The various sources used for the research were noted to have some distinctions and similarities. Observation, oral sources and written sources, have been noted as sources used to write the research report. During the fieldwork, it was observed that in employing observation as a data collection tool, much emphasis was placed on the forms, norms or styles as well as traditional methods or ways employed by the indigenous medical practitioners. The point of agreement between these two sources, that is, observation and oral sources was that in observing, the practitioners were required to answer some questions. Significantly, the observation as an ethnographic tool used was "researcher acts as observer", that is, the researcher observed without necessarily participating in what was undertaken by the indigenous practitioners or the group that patronized such medicaments.[16] This technique was used when the researcher visited places like, Agya Ahom's Health Centre where he spent three months observing and making notes of his operations and asking questions which demanded oral account. Similarly, the researcher spent two months at Adamu Allah Bar's Bone-setting Treatment Centre observing and making notes and asking questions pertaining to his mode of operations. Again, two months was spent following and examining trends in traditional circumcision surgery at Mohammed Fuseini's residence at Aboabo. Change with respect to Colonial influence was investigated especially with

[16] P. McNeil, *Research Methods* (USA: Routledge,1992) 82

the presence of European medical forms and policies present in Asante including Kumase. This was done by identifying some of the practices that were done away with as a result of colonial influence and those that have been refined. It was found out that archival documents gave detailed documentary information on what happened within the period under study. They served as a corroborative tool in the research. They corroborated evidence or information that was produced by oral sources as well as other written sources.



Inter-disciplinary approach was also used. Information from various fields of study especially in medicine, medical sociology, medical geography and anthropology were incorporated in the report. It is essential to note that the insight from these fields of study led the researcher to look for more information to authenticate his findings and better still, helped in the proper evaluation of the information gathered.

### 1.6 Scope of the Study

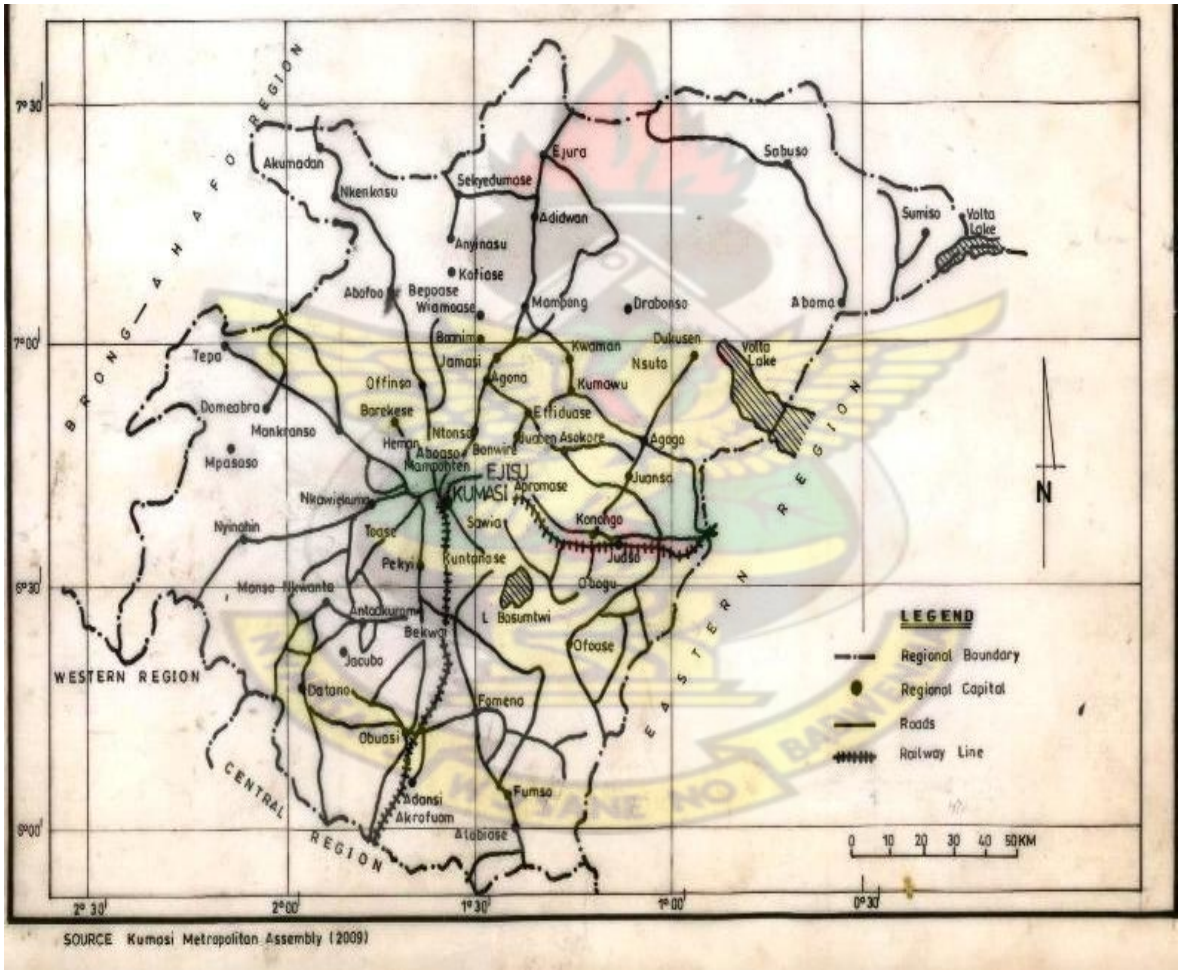
The study reviews indigenous medical practices and colonial influence in Asante, focuses on disease prevention in Kumase. This is because Kumase being the capital of Asante had several health challenges; the people were faced with several diseases including tuberculosis, malaria and bubonic plague among others. Asante benefited from indigenous medical practices and had strong colonial influence. It also benefited from colonial medical policies and strategies. The period 1902 to 1957 was chosen because modern medical therapies and strategies in Asante are perceived to be a by-product of strong European presence in Kumase by the end of the

nineteenth century.[17] However, by 1957, the powers of the Colonial Administration had waned, yet they left a great deal of influence amongst the indigenous population in Asante.

Below is Map One, showing Asante Region and its capital Kumase, the area under study. The map shows some of the areas in Asante that were either influenced or benefited from colonial administration's health policies.



MAP OF ASANTE REGION




**Map One**

[17] F.K Buah, *A History of Ghana*, 1995 (London: McMillan Education Ltd. , 1995) 96

## 1.7 Organization of the Study

The study comprises six chapters. Chapter one comprises background to the study, problem statement, objectives, method of the study and organization of the study. Chapter two is devoted to an extensive review of relevant articles, books, and related topics on the history of medicine. The review was done to ensure that there is a proper take off point in the research and to prevent the duplication of what has already been done by various researchers and writers in the field of study. Chapter three studies early medicine in Asante and the training of indigenous healers focusing on *Wanzams* (circumcision surgeons), Traditional Bone-setters (TBS) and Traditional Birth Attendants (TBAs) as case studies from 1902-1957. Chapter four focuses on colonial influence on indigenous medical practices in Asante. Chapter five studies the prevalent diseases that infected the people of Asante, indigenous and Colonial Administration's disease combat and prevention strategies from 1902 to 1957. It focuses on systems put in place by the Colonial Administration to make Kumase clean (Disease Prevention) and indigenous cooperation through Native Heads and headmen as well as the activities of the KPHB to forestall future occurrences of epidemics from 1902 to 1957. Chapter six deals with summary of findings and recommendations.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.0 Introduction

The review covers themes like social and ecological approach to the history of diseases, medicine as a form of social concern as well as indigenous knowledge and indigenous healing systems. The review was focused on these themes because they are relevant to the field of study. The works of Twumasi (1975) which focuses on indigenous medical knowledge and modern medicine, Addae (1997) whose work focuses on Western medicine in Ghana, Maier (1979) whose article focuses on various medical practices in Asante with much attention on indigenous medical practices, Akyeampong Ed. (2000) whose article also deals with diseases in west-Africa and gives much attention to environmental factors and several means of communication of diseases have been reviewed. The work of Patterson (1981) that deals with socio-economic approaches to diseases in the Gold Coast but also stresses other relevant information pertaining to the ecological and environmental changes has been reviewed. Rattray (1937) and Konadu (1998) whose works focus on indigenous knowledge and beliefs have been reviewed. Other works which include Onyinah (2009), Nadel (1952), Debrunner (1961), Field (1937), Lystad (1958), Beecham (1841), Bosman (1967), Frierman and Janzen (Ed.) (1992), Ampofo (1967) and Emeagwali and Falola Eds. (2003) have also been reviewed. These works focus significantly on the accounts of indigenous life of the people in the Gold Coast primarily focusing on their belief systems.

## 2.1 Social and Ecological Approaches to the History of Disease

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

> In leaving tropical environments behind, our ancestors also escaped many of the parasites and disease organisms to which their predecessors and tropical contemporaries were accustomed. Health and vigour improved accordingly, a multiplication of human numbers assumed a hitherto unparallel scale.[18]



According to McNeil, the disease epidemiology of the tropics represents a burden on development. He stated that is why Africa remained backward in the development of its civilization when compared to temperate lands like that of America, where prevailing ecosystems were less elaborated and correspondingly less inimical to simplification by human action. The deadly nature of the climate especially at the Gold Coast in the nineteenth century is buttressed by Cruickshank. He noted that there is sickness and fever as well as death in its balmiest gales.[19]

Significantly, several writers have put forward arguments that support the fact that McNeil was right about the rich biodiversity of the tropics and the presence of disease vectors that have afflicted humans and their livestock. Diseases in Africa include those rooted in the physical environment and those introduced through external contacts. He stated that diseases such as malaria spread by the anopheles mosquito, trypanosomiasis which is also known as sleeping

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

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

sickness by tsetse fly, onchocerciasis which is also known as river blindness caused by the black similium fly and schistosomiasis which is also known as bilharziasis caused by the snail are tropical diseases indigenous to West-Africa. It is essential to note that McNeil did not focus on diseases in the Gold Coast and Asante specifically. Yet, it is essential to note that diseases like malaria and trypanosomiasis were present in Asante.



Akyeampong though not contrasting the argument of McNeil has argued that other diseases were transmitted from host to host with an intermediary carrier without delay. He said many of these diseases have been introduced to West-Africa through external cultural contacts. Examples of such diseases are the common cold, measles, and chicken pox. According to Akyeampong, in present-day West Africa, most of the diseases that were present in 1900 have resurfaced with the notable exception of small pox. This buttresses McNeill's argument that diseases found in Ghana are not only those that are generated from within but also there are those that are brought in through external contacts. Most importantly, such assertions draw attention to the fact that communities in the Gold Coast especially Asante and those that were hitherto exposed to outside contacts either within Africa or Europe might have communicated diseases among themselves. This notwithstanding, what was seen to have been a major challenge so far as diseases are concerned were those diseases that were generated amongst the indigenous people. Akyeampong supports this argument especially when he stated, in the twentieth century, malaria which is generated as a result of the physical environment, remained the number one killer in Africa accounting for between twenty to thirty percent in school children and for the whole population.[20] It is important to point out that both McNeil and Akyeampong do not focus on

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

Asante and Kumase specifically. Again, it is also essential to point out that the focus of the writers was on the health conditions generally relating to Ghana and Africa, yet we found out that they treat issues that are generic especially in assessing the health challenges or diseases that infected the people of the Gold Coast. However, it is important to ascertain the kinds of prevalent diseases that were present not only in the Gold Coast but Asante. It is important to also stress that both McNeil and Akyeampong do not point out the various responses or actions undertaken by both the indigenous people and the Colonial Administration in combating or preventing such diseases. Again, it is important to note that the time scale and geographical coverage of Akyeampong's work is too broad for the details of any particular area to be included.

In spite of this, it is essential to point out that the evolutionary trend of Akyeampong's work is phenomenal. In tracing the continuity of the health hazard in the territory of Africa, he traced to ancient Africa when he cites Al-Bakari that the countryside of Ghana was unhealthy, not populous and it was not impossible to fall ill there during the time their crops were ripening. There was mortality among strangers during the time of the harvest. Akyeampong explained what Al-Bakari presented at the time as the abundance of flies during harvest when crops were ripening. He noted that the incidence of malaria would have been higher after the rainy season when crops would also have been ripening.[21] Invariably, the arguments put forward by Akyeampong in his reference to Al-Bakari cannot be delinked from the fact that diseases related to the physical environment even in twentieth century Gold Coast and Asante were quite related to the way the indigenous people managed their own environment. This argument rather opens

[21] Akyeampong , *Themes in West African History*,186

up the need to further investigate especially in twentieth century Asante and Kumase, specifically, the disease combating strategies employed by the indigenous people and the Colonial Administration to prevent diseases related to the physical environment.

Again, the argument of the presence of diseases in Asante in the nineteenth and twentieth centuries has been buttressed by Maier. Maier noted the presence of diseases in Asante such as malaria that were much related to the environment which were treated by indigenous healers. However, Maier argued that the frequency and types of diseases common in Asante especially in the nineteenth century, which in this stead persisted through the twentieth century, were most difficult to determine empirically. However, what Dupuis puts forward has widely been considered as impressionistic evidence. Dupuis seemed to have had an implicit understanding regarding the climate and atmosphere in the Gold Coast and places adjacent to the settlements of the coast- these were locations he noticed to be unhealthy. However, the observation made by Dupuis point to the fact that the place called Asante was healthier than the coast.[22] The account of Dupuis shows that climatic factors contributed to the relative health of the inhabitants of Asante and moreso to a greater variety of food crops, fruits and general diet in the forest.[23] With respect to the forest, Dupuis was significantly talking about remote Asante but not Kumase.[24] Irrespective of this observation, W. Hutton is noted to have observed that Kumase was bordered by an old swampy land, which the British captain Brackenbury thought to be unhealthy even though he recognized its redeeming feature of providing good water supply for the town.[25]

[22] Ibid
[23] Ibid
[24] *J.* Dupuis, *Journal of Residence in Asante* (London: H Colburn, 1824)
[25] D. Maier, Nineteenth-Century Asante Medical Practices, *Comparative Studies in Society and History*, Vol. 21, No. 1, (Jan., 1979) 63

The serenity of Kumase was adequately emphasized. It was argued that regular rainfall in Asante cleaned the air, soil and dwelling places frequently, which made regular bathing possible and eventually reduced the incidence of tick, louse and fecal-borne diseases in the nineteenth century.[26] Significantly, it was shown that there was a smaller percentage of relapsing fever, cerebro spinal meningitis, small pox, yellow fever, yaws, tuberculosis, onchocerciasis, schistosomiasis and leprosy than in other regions of the Gold Coast.[27] The diseases enumerated by these authors are an attestation to the fact that several of the diseases witnessed in the twentieth century existed in the centuries before. It is essential to note that this information is relevant especially in undertaking a study in the history of medicine on the people of Asante. Again, it is important to note that authors like Dupuis and Maier seem to have placed much emphasis on Asante; hence, it is significant to make reference to them especially when a study of the history of medicine in Asante is being undertaken.

The first European doctor, Tedlie, who visited Asante in 1817, has been extensively referred to by Addae (1997) and Maier (1979) to have vaguely recorded diseases such as syphilis, yaws, ulcers, scald-heads and gripping pains in the bowels. It has been noted that fevers were most prevalent countrywide after the periodical rains. Rheumatism was noted to be a common complaint as well as internal inflammation during the rainy season. Meredith is also noted to have listed leprosy and dysentery.[28] Maier has noted that in Asante, Tedlie treated single cases of

[26] Ibid
[27] Ibid
[28] Ibid

stricture of urethra, edematous feet and an ulcerated palate among some upper class Asante who came to him for help.[29]

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

Bosman (1967) writing in the eighteenth century also described the environment in the Gold Coast which he referred to as the Coast of Guinea. His description seems to fit the assertions and claims made by Dupuis, Beecham and others. He was particularly concerned about the way of life of the indigenous people and how this invariably affected Europeans living in such jurisdictions. Bosman noted that the available diet in the Coast besides fish was dry lean hen.[30] The best that the sick could get at the Coast was culinary vegetables and spoon-meats.[31] Again, he emphasized that the indigenous people suffered from diseases as a result of mismanagement that were present in their daily lives. Here, he postulated that they were supposed to avoid excess

[29] Ibid
[30] W., Bosman, *A new and Accurate Description of the Coast of Guinea* (UK: Frank Cass & Co. Ltd., 1967)106
[31] Ibid

eating and drinking.[32] The indigenous people were seized with dangerous and too often mortal diseases.[33] It is important to note that the argument of Bosman seem to fit much with the Coast rather than the interior including Asante, yet his writing does not create such delimitation since the people at the colony were not totally or wholly disconnected from Asante in terms of contact and communication. Bosman hinted that the indigenous people lavished it out with palm wine and brandy both when taken in excess are pernicious.[34] This was not the only inconvenience the indigenous people caused themselves. The drinking habit of the indigenous people did not allow them to have sufficient money to buy the required food; they were only left with the supply of bread, oil and salt or at best with fish and therefore in the European view point it was not expected that the indigenous people would be healthy.[35] Such drinking to stupor was accentuated especially when one had a large salary. With little strength left in them from falling, the ill air and the adieu health led them to the after life.[36] It is important to ascertain whether the writings of Bosman had a bearing on some of the developments on health education on the part of the Colonial Administration that would emerge at the Gold Coast and Asante in particular especially in the first half of the twentieth century.

The argument for the unhealthiness of the environment shared by Addae, Maier, Dupuis, Bosman and others need not be overemphasized. Although in certain instances Asante, and for that matter, Kumase, is given the credit for some environmental serenity, the contrasts drawn by Bosman in describing the environment at the Coast throw much light on the argument made by

[32] Ibid
[33] Ibid
[34] Bosman , *A new and Accurate Description of the Coast of Guinea*, 106
[35] Ibid
[36] Ibid

the school of thought that the environment of West Africa and particularly the Gold Coast was mostly unhealthy. Bosman distinguished one place at the coast from another. He argued that there were places where the wind blows continually and very fresh where the indigenous people had the least stench, these areas were considered to be undoubtedly the healthiest.[37] This notwithstanding, the Europeans including Bosman himself, was not surprised when they realized that the indigenous population did not easily succumb to death due to ill environment. This was attributable to the fact that the indigenous people were born into such air, hence, their ability to withstand such stench and were not easily infected with diseases.[38] In contrast, diseases with high prevalence in the country were noted to be small pox and worms and the former was devastating.[39] Significantly, there is a lacuna, Bosman's assertions and observations are not accurate description of what was happening in Asante and Kumase in particular. Again, much attention was not paid to the major prevention strategies that were put in place to forestall such environmental hazards and epidemics at the interior including Asante. It is important to also note that Bosman's work covered the eighteenth century.

Significantly, one of the writers who seemed to have paid close attention to Kumase in his writing was Anti (1996). His description of the physical environment of Kumase especially in the nineteenth century points to the fact that the environment of Kumase was appalling. He hinted that on the western part of the king's palace (Kofi Kakari's palace) was the "quarters of ghosts" where decapitated bodies were thrown. It was an open space where there were big tall

[37] Bosman, *A new and Accurate Description of the Coast of Guinea*, 107-108
[38] Ibid
[39] Ibid

shady trees under which dead bodies were left.[40] Some of the dead bodies have been described by Anti to be putrefied, bloated, swollen, discoloured and loathsome. There were others with worms upon which vultures roost, eating and feeding on them to make the sorrows of the dead everlasting and their pains eternal.[41] Anti does not argue that such occurrence was motivated by custom yet he gives a clue to the purpose such practice was intended to serve. The death described by Anti although horrific seemed to have a cataclysmic impact on the entire population, that is, the stench of the carcasses could have increased the health hazard of the people of Kumase.



The findings of Anti focused on the eighteenth and nineteenth centuries respectively, hence he did not give ample evidence to suggest that the quarters of ghosts was still operational in the twentieth century Asante especially from 1902 to 1957. Yet, it is understood that anything of such magnitude or similar to the description of the eighteenth and nineteenth centuries in the twentieth century could have created an alarming disease situation in Asante. Since Anti had no health argument in view with respect to the quarters of ghosts he makes a further assertion that the sanitation of Kumase was not as bad as one could imagine.[42] He hints that there were some private latrines dug deep under fairly big round hollow supporting pillars, and from time to time boiling water was poured into them to kill flies and other insects. This was an attestation of the observations made by Dupuis and his contemporaries. Anti buttresses the assertion that by the eighteenth century, there were not only private latrines but there were public ones to meet the needs of the entire community especially the poor in Kumase who could not construct their own.

[40] A.A, Anti, *Kumase in the Eighteenth and Nineteenth Centuries* (Accra: Graphic Corporations, 1996) 16
[41] Ibid
[42] Ibid

Another extensive effort made by the indigenous people as noted by Anti was the dumping of refuse at the outskirts of the township that was burnt every morning.[43] The observations made by Dupuis, the attestations made by Maier and Anti point towards the need to ask questions in the twentieth century Asante and Kumase on how the health of the indigenous people was managed or the process put in place to forestall the occurrences of diseases or epidemics. Although Kofi Kakari's quarters of ghosts is a variation, significantly, a retrospective analysis of the seventeenth and eighteenth century Kumase suggests a deliberate policy or plan among the indigenous population to keep their community free from filth.

Another remarkable work is *Health in Colonial Ghana, Disease, Medicine and Socio-Economic Change.* In this work Patterson focuses on the first half of the twentieth century. However, he shares a similar thought with earlier writers like Dupuis and with twentieth century contemporaries like Maier and Akyeampong. Patterson has argued that infectious diseases have accompanied human movement throughout history. He noted that explorers, merchants, soldiers, pilgrims, refugees and migrants have carried plagues, measles, small pox, typhus, tuberculosis, syphilis, malaria, yellow fever, cholera and a host of deadly afflictions around the world. This expressly buttresses the case of rampant transmission of diseases through human interaction and movement. He further elucidated that technological, economic, and political changes have encouraged contacts between pathogens, their vectors and susceptible populations for centuries. He said, long established diseases tend to be less deadly. [44]

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

Significantly, the area of present-day Ghana had been inhabited by village agriculturalists for at least a millennium and probably much longer. He said these farmers were in daily contact with hundreds of people who could readily exchange diseases spread by aerial droplets or by direct contact. In addition, the author touched on the fact that the people suffered diseases from water contaminated with human waste. Also, settlements, clearings for farms provided habitats for other diseases and their vectors. Patterson argued that Ghanaian societies especially in the early twentieth century were afflicted with microbial and multicellular parasites. Some of the infections were askaris, filarial, hookworms, tapeworms, guinea worm, schistosomiasis, yaws, leprosy, yellow fever, dengue, pneumonia, tropical ulcer, amebic and bacillary dysentery. Patterson argued that malaria was holo-endemic throughout Ghana. An increasing mobile population in the twentieth century brought about enhanced risks of disease transmission. People entered unfamiliar disease environments, where they encountered new pathogens or new strains of familiar ones. They carried pathogens and vectors to potential new hosts and habitats, thus helping to break down previous isolation and made the country into a more homogeneous epidemiological unit. The question of human interaction is an essential aspect of studying modes of diseases transmission amongst human population, but it is essential to point out that although human interactions have promoted the spread of different diseases in different regions, it is possible that through such interactions knowledge of different medicines was also imbibed by different groups of people especially the people of Asante.

Patterson's work leaves a gap to be filled. Just as he placed emphasis on the ubiquity of diseases due to movement, it is expected that transmission of knowledge about how to cure such diseases could also have been possible and the probable tests of the response of the indigenous people of

the Gold Coast towards such diseases and epidemics in the twentieth century could have been possible. Furthermore, Patterson stated that the concentration of hospitals, water supply systems and immunization efforts in urban areas helped to reduce the health menace of the cities but in Ghana, like elsewhere in historical periods, early urban growth exacted a high toll on human life and well being. This particular argument put forward by Patterson creates an impression that population growth in urban areas puts a lot of pressure on the available European medical posts hence reducing their efficiency. Firstly, it follows the argument that European medicine was predominantly urban based. This suggests that Indigenous medicine would thrive in such areas s European medicaments were not present. Secondly, it shows that by the overconcentration of human population in urban areas like Kumase, disease transmission could have been rampant.

Patterson has put forward that except for deforestation, there was relatively little environmental change in the period before 1955, which affected human health. Commercial lumbering began in the 1880s and has been an important industry ever since. Significantly, deforestation allows sunlight to reach pools of water creating favourable breeding conditions for *Anopheles gambiae*, the major vector for falciparum malaria. Water development projects such as dams, fish farms and irrigation schemes always have the potential to alter local disease environments. However, little work of such nature was done prior to 1955. It has been stated that the completion of the Akosombo Dam and the filling of Lake Volta have had important ecological effects on the country. Just as deforestation stimulated the breeding of certain disease vectors, Patterson has set the tone for the need to investigate the challenges this environmental change brought on some specific groups of people at the Gold Coast. Most importantly, concentration of health centres in urban areas like Kumase might have encouraged the use of indigenous techniques to combat

health challenges those at the hinterlands were faced with as a result of ecological change or deforestation. Moreso, Patterson does not look into details, the potential social cost in dealing with such ecological change that burdened the Colonial Administration, especially with issues pertaining to defense clearing in combating of trypanosomiasis in the north and most importantly the forest regions of Asante. Due to the presence of diseases in the environment of the indigenous people there were several concerns that emerged before and within the period under study. The need for existence or survival was a well-noted belief amongst the people of Asante.



Frierman and Janzen have also argued in their work *Social Basis of Health and Healing in Africa* that Africa's population remained comparatively stable under early colonial rule.[45] However, by the 1920s, malaria, small pox, sleeping sickness and the influenza pandemic contributed to a high death rate. Other scourges, such as sexually transmitted diseases and the effects of famine in lowering vitality and hence reproductive capacity, also contributed to population decline in Africa.[46]

As a result of the public health implications of this study, sections of Frierman and Janzen's book, specifically those dealing with small pox in Kenya and tuberculosis in South Africa authored respectively by Mark Pawson and Randall Packard, provide useful information. They argue that Population movement aided the spread of these two diseases, small pox and tuberculosis.[47] The argument that population movement caused the transfer of disease from one area to the other within Africa including the Gold Coast has been earlier made by D.K

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

Patterson.[48] Again, population movement as a result of drought in Kenya by the turn of the twentieth-century aided the spread of small pox.[49] The spread of tuberculosis in South Africa was attributed to the return of migrants who had been infected in the towns and were returning to their homes.[50] The spread of diseases due to population movement in communities in Africa including Asante has been confirmed by several writers.



## 2.2 Medicine as a form of Social Concern

The primary focus of indigenous Asante society is based on the philosophy of life which aims at the perpetuation of life, that is, life for the individual and for the group. Twumasi has argued that it is this quest for life, both for the individual, which bolsters magico-religious beliefs and practices.[51] Hence, these magico-religious beliefs caused the people of Asante to depend upon super-sensible powers with the goal and desire to increase their hold on life and to provide some kind of insurance against threats to life or disruption of the social unit.[52] These as it were, draw attention to witchcraft; those that the colonialists allude to as superstition but which is essentially a void to be filled in the study.

Twumasi asserts that in the traditional context of Asante cosmology, illness was not considered as just a pathological change hence, the supernatural was invoked as the main causal factor.[53] Within this framework, the etiology of health and illness were far more behavioral than biological. The Asante traditional cosmology, according to Twumasi, had no room for a purely

[48] Patterson, *Health in Colonial Ghana, disease, medicine and socio-economic change,* 40-45
[49] S. Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa*
[50]Ibid
[51] Twumasi, *Medical Systems in Ghana*,8
[52] Ibid
[53] Ibid

naturalistic notion of illness because there was, and still, no clear-cut conceptual separation of the natural or physical world on the one hand and the supernatural and the magico-religious world on the other whereas in the world of "scientific medicine" there is a conceptual separation between the natural and the supernatural.[54] This, as it were, explains the reason why in traditional Asante society treatment of diseases was not only limited to natural application of herbs, stems and roots but also through the consultation of spiritual beings or deities.



However, Akyeampong has argued that with the presence of Europeans at the Coast, the indigenous people closer to the European forts rather resorted to the treatment of the European barbers. Significantly, this might be as a result of European influence on the indigenous people or the need to meet a dire health need. These barbers who met the health needs of the people were noted to be the surgeons in the European settlements. Pieter De Marees wrote,

> They, the barbers often use sabaparille, which is brought to them by the Dutch ships against the pox and the clap. They boil the ointment in fresh water and drink it as a draught against the pox and similar diseases and also against the worms which they get in their legs.[55]

Indigenous patronage of European medicine as put forward by Akyeampong does not negate the fact that those that were not closer to European settlements still held on to their traditional world view because even to the "enlightened" the supernatural causation of disease becomes grimly clear when known and efficacious medicaments fail to solve their health challenges.

[54] Ibid
[55] Akyeampong, *Themes in West-African History*, 187

Akyeampong, McNeil and Patterson have already noted that the unhealthiness of the environment of the indigenous people invariably caused them to suffer from diseases that needed urgent attention. It was therefore the concern not only for the indigenous people to continuously meet their health needs but the situation was harsher for the Europeans who had come to settle at the Gold Coast and Asante. The response of the indigenous people closer to the forts and castles is an attestation to the fact that the indigenous people especially those at the coast, were not only inward looking especially in matters pertaining to health but rather were very much interested in making use or exploiting what was readily available to ameliorate or cure the diseases they suffered. Thus, it seems to contrast the view of strict supernatural adherence to the causes of diseases and the commensurate supernatural forces for treatment to the embrace of an admixture of two mutually exclusive world views or thoughts, that is, indigenous and modern therapies, as the quest of the indigenous people to find cures to their health challenges permitted with time. Writers like Bosman have argued that the Coastal regions of the Gold Coast, though closer to the forts and castles, were noted to have "corrupt medicine" (medicines which had no scientific explanation especially those that were considered unhygienic by European standards) and unskillful physicians.[56] The medicines that the Europeans had were also spoilt.[57] This could have been the result of the exposure of the drugs to wet conditions as they traversed the coast of other continents or the result of the fact that the expiry dates of such drugs were due.

For instance, Patterson has stated that health education was part of the Colonial Education curriculum and literates were able to read medical department posters and other publications. Most important was the role of education in changing old beliefs and making people more

[56] Bosman, *A New and Accurate Description of the Coast of Guinea*,106
[57] Ibid

receptive to western medical ideas. Significantly, it is important to ascertain whether there was medical education introduced by the Colonial Administration in Asante in the first half of the twentieth century to prevent epidemics. Patterson notes that rising living standards helped to improve health conditions. Better clothes kept people warmer. Additional garments meant that a person was more likely to be able to wear something clean and dry. Also, metal roofs that replaced thatch and concrete blocks that substituted mud and wattle provided warmer and drier homes with reduced habitats of domestic insects and rodent pests. Higher incomes could be used to buy more meat, vegetables and other nutritious foods. The arguments put forward by Patterson seem to suggest that socio-economic change in the Gold Coast enhanced the health of the people of the Gold Coast. This notwithstanding, Patterson does not throw more light on the argument in so far as Asante is concerned. Yet, it could be ascertained that the people living in urban centres like Kumase had better health conditions as a result of more controlled environmental policies initiated mostly by the Colonial Administration with the collaboration of native heads. It is important to state that Patterson does not focus on Asante and Kumase hence, it is important to ascertain particularly what was happening in Asante during the period under study. It is pertinent to note that the presence of diseases in Asante and the concerns of the indigenous people also meant that there was indigenous medicinal knowledge that was used to develop potions among other things to help combat the prevailing diseases at the time. This is what has been reviewed under the heading, Indigenous Knowledge and Indigenous Healing systems.

In the *Social Basis of Health and Healing in Africa*, Gloria Waite's contribution on public health in East and Central Africa is useful to this study.[58] The significance of Waite's contribution to

[58] . Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa*, iv-xii

this study is in her endorsement of Charles Hughes's definition of public health as 'All illnesses that affect the public as well as all activity it undertakes to influence its health status.'[59] This definition is broadened to include not only orthodox medicine pertaining to environmental sanitation and prevention of communicable diseases but also traditional health practices of rainmaking and the identification of sorcerers.[60] The definition underscores the fact that to ensure good health a great deal of concern and efforts must be shown. This corroborates Twumasi's argument that the Asante world view on health matters resisted anything that brought them bad health and would apply every available cure including both natural and supernatural.[61] The definition also emphasizes Patterson's discourse on European health education in the Gold Coast from the beginning of the twentieth century to 1955.

Philip Curtin introduced another dimension to the discussion in his examination of urban planning which highlighted the influence malaria and the plague had on health administration policy. Curtin observed it was this development that led to the separation of European and African living quarters as a means of protecting expatriates.[62] It is important to note that malaria remained one of the major causes of infant mortality in Africa. In several areas of Africa including the Gold Coast and Asante in particular, segregation became a tool for the Europeans. This notwithstanding, in certain peculiar instances, as for example, in the case of the Gold Coast where Health Boards were set up by the colonial as part of the health administration policies. During the twentieth century, Curtin reminds us of the conflicting views of Europeans on whether Africans should concentrate on the destruction of mosquitoes or "quininization" in the

[59] S. Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa*
[60] Ibid
[61] P.A, Twumasi, *Medical Systems in Ghana*, 23-24
[62] S. Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa*

control and prevention of malaria.[63] This is an attestation to the fact that within the colonial period, in Africa, there were several decisions and varieties of practices aimed at stamping out tropical diseases like malaria. This study seeks to bring out the pertinent details in Asante though there is the general notion of decisions and indecisions and different strategies used by the colonial administration to prevent or combat diseases in communities in Africa.



However, Terrance Ranger described both the success and shortcoming of European medical work in South-eastern Tanzania. He referred to the experience of treating the yaws-ridden population of the Masai district with arsenical and bismuth preparations in the early 1920s.[64] Such treatments served as a warning lesson regarding the need for a patient to complete his course of treatment, with the colonial administration following it up with effective surveillance. This seems to have been the general trend in communities in Africa during colonization. Through legislation and cooperation with chiefs as was the case in British West-Africa, people who were declared to be infected with contagious diseases underwent treatment without intermissions under the supervision of their respective chiefs until they were declared fit by the medical officers. In South-eastern Tanzania, it was realized that those who were inoculated but did not continue with the treatment had their lesions reappearing.

The work of Vaughan, *Curing their ills: Colonial Power and African Illness*, traces the history of encounters between European medicine and African societies in the nineteenth and twentieth centuries.[65] Vaughan's detailed work looked at the impact of European medicine on the continent. He seemed to suggest that the Europeans used medicine as a tool for imperial

[63] Ibid
[64] S. Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa*
[65] M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford University press, Oct.1, 1991)

domination on the African continent using the claims of scientific neutrality of European medicine to create a bad image for several of the indigenous medical practices which hitherto were accepted by the indigenous people.[66] This motive did not encourage the Europeans to easily accept indigenous medical practitioners, in the case of Ghana and elsewhere, the indigenous medical practitioners had to form different healing associations to pressure the colonial administration to enable them have free and unhindered practices.



## 2.3 Indigenous Knowledge and Indigenous Healing Systems

In an article written by Maier on nineteenth century medical practices in Asante, references were made to several pertinent issues that are relevant to the study of history of medicine in Asante. The article touched on what has been termed as the irrational such as the roles of priests and priestesses, shrines, magic, and religious rituals.[67] However, the reliance on such indigenous methods of treatment was debased by doctors from the United States of America who visited Ghana in 1960 claiming that traditional methods of treatment consists solely of ignorance and superstition. Admittedly, such conclusions as noted by Maier in essence distinguishes a recourse to shrines, faith healing services from home remedies, herbalists, *Asante Nkramo* physicians (The term refers to Asante Muslim converts), western trained nurses and doctors.[68] It was, however, the use of traditional priests and priestesses that was vehemently opposed by European writers and American doctors as being irrational because it lacked 'scientific' or biomedical explanations. Maier lays emphasis on the reconstruction of religious and non-religious techniques or methods used for controlling physical diseases in the West-African State of

[66]Ibid
[67] Maier, Nineteenth-Century Asante Medical Practices, 63
[68] Ibid

Asante. The roles of Indigenous Priest Healers seemed to have been identified by Bosman in eighteenth century when he hinted that the ministration of the *Okomfo* was as effectual as that of the Pope himself and by that you may observe what power the priest has over evil spirits.[69] Maier however, focused on some of the social implications of these methods. Some of these implications had earlier been spelt out by Bosman who articulates the view that the term "fetish" or *bosom* refers to a "false God".[70] However, he proceeds by stating that the indigenous people mostly made offerings to deities, performed religious worship and mostly paid a fee at a shrine to inquire of their fate.[71] In like manner if they were injured by another they made "fetishes" to destroy them in a similar manner.[72] However, the contrast is that if any person was caught throwing this "poison" he was severely punished, sometimes with death.[73] There is the need to find out whether in the first half of twentieth century Asante these practices were persistent and to identify some of the changes that were effected as a result of colonization.

Significantly, according to Bosman the IPH was traditionally never accused of falsehood.[74] If the whole land was ruined as a result of his ministration, his reputation remained secured and untouched and if by chance his predictions came to pass there was not in the world a wiser or holier man, and he was sure not to want his reward.[75] The claims made by Bosman that the priest was revered had future socio-economic ramifications. The study would find out some of the social ramifications concerning the way the IPHs exercised the inalienable powers traditions seemed to have bestowed upon them.

[69] Bosman , A *New and Accurate Description of the Coast of Guinea* ,106
[70] Ibid
[71] Ibid
[72] Ibid
[73] Ibid
[74] Bosman , A *New and Accurate Description of the Coast of Guinea* ,106
[75] Ibid

The term "fetishism" according to Bosman referred to all things the indigenous people made in honour of their "false gods".[76] Bosman does not suggest that the indigenous people accepted such European branding of their beliefs and practices with the term "false" and "fetish". Yet, what seemed not to have been much questioned by twentieth century writers is the fact that the world view of the indigenous people focused on the existence of deities who inspected their course of life, rewarded good men and punished the wicked ones. The most dangerous punishment the indigenous people could imagine was death and it was this which occasioned their abstinence from forbidden meats or drinks, fearing they would die if they but once tasted it.[77] The IPH was considered to be able to cure all manner of ailments. The period witnessed the existence of sacred groves where offerings were made for the public good. Persons presumed to have defiled them; pluck, cut or break off any branches of trees were regarded as deviants.[78] These viewpoints as it were have their own disease prevention significance of the physical environment, yet European writers have described them as unhealthy in uncertain terms.

The argument of Cruickshank is not different from what has been put forward by Bosman. He hinted that the ministration of the priest especially in the nineteenth century could not be questioned by European powers.[79] The victims of the severe laws of the priests in reference to debt, false accusation and pretended crimes of which they had no evidence but their superstitious fears which had a correlation with the oracular dictates of the "fetish man" and the entire beliefs of the indigenous people as referred to by Cruickshank was a path the governor did not make an

[76] Bosman , A *New and Accurate Description of the Coast of Guinea*, 106
[77] Ibid
[78] Ibid
[79] Cruickshank , *Eighteen years on the Gold Coast of Africa* , 152

effort to traverse.[80] It is as well essential that this nineteenth-century view of the governor still persisted in twentieth century Asante especially in matters pertaining to the operations of IPH. However, Cruickshank draws a contrast that within the nineteenth century it was only when the governor had noted the obnoxious nature of such custom that he cautiously led his attack against it.[81]



Significantly, Cruickshank buttresses the view about the authority that the priest exercised among the indigenous population. This is quite similar to some of the views shared by Bosman. Cruickshank argued that different kinds and degrees of power were attributed to different "fetishes".[82] One might be celebrated for his success in exorcism, another for the detection of a thief and the recovery of a stolen property and a third for the curing of diseases and the making of the barren fruitful.[83] It is important to note that the specialization of particular shrines as to what they are noted for is something which is well noted in Asante traditional society. However, it is an established fact that the afore-mentioned specializations are sometimes noted to be embodied mostly in one particular deity or shrine. This notwithstanding, Cruickshank made notes about the extensiveness of the field of impostors in indigenous priest healing who preyed on their victims.[84] There were also numerous hosts of intermediaries or secretaries (*abosomfo*) also referred to by Cruickshank as "simple conjurors who assumed the "fetish" character as a very efficient field for all kinds of roguery, and made large gains out of the credulity of the indigenous people."[85] Would the Colonial Administration not be concerned in Asante in the first

[80] Ibid
[81] Ibid
[82] Ibid
[83] Cruickshank B, *Eighteen years on the Gold Coast of Africa*, 152
[84] Ibid
[85] Ibid

half of the twentieth century in matters pertaining to this roguery especially when it is found out that it persisted during the twentieth century? The "Priest craft", that is the profession of the IPHs as referred to by Cruickshank was not only confined to the male portion of the indigenous community for there was also an established order of priestesses or "fetish women" who further swelled the ranks of what was described by Cruickshank as "religious harpies".[86]



The world view or the character of the Gold Coasters and for that matter Asante, the nature of their traditional governance, their ideas of justice and administration, domestic and social relations, crimes and virtues were all more or less influenced by and formed upon what has been described by Cruickshank as their peculiar superstitions.[87] Cruickshank argued that there is scarcely an occurrence of life into which this all-pervading element does not enter. It gives fruitfulness to marriage, it encircles the newly-born babe with its defensive charms, it preserves it from sickness by its votive offerings, it restores it to health by its bleeding sacrifices, it watches over its boyhood by its ceremonial rites, it gives strength and courage to its manhood by its warlike symbol, it tends its declining age with its consecrated potions, it stays the raging pestilence among other things.[88]

However, the views of the Europeans in relation to what has been stated in the preceding paragraph were quite different. They claim that no ingenuity of the "fetish man" (IPH) could conceal the multitude of their broken pledges or save from exposure the hollow tricks by which

[86] Ibid
[87] Cruickshank, *Eighteen years on the Gold Coast of Africa*, 153-154
[88] Ibid

according to Cruickshank they manage to prop up their tottering faith.[89] The Europeans considered especially in the nineteenth century that the indigenous people in the Gold Coast including Asante should have overcome and discontinued with what was referred to by them as childish infatuation. This, notwithstanding, it was found out that the situation was much related to "man's innate consciousness of the helpless nature of his being and his need for supernatural assistance, especially his need for faith in things unseen on which to rest the anxious burden of his hopes and fears".[90] Cruickshank contradicts himself by saying that this is "a humiliating proof of man's natural blindness, as well as of his vicious and corrupt tendencies summarily tainted as a fruitless confidence".[91] Cruickshank rather develops another argument that seems to suggest that the indigenous mindset was prejudiced but this assertion is not supported wholly by Dupuis, Bosman, Anti, Maier among others. Cruickshank argued that the more familiar relationship with Europeans by the indigenes and the freer interchange of ideas as well as the effect of missionary teachings gave an entirely new and vigorous impulse to the native mind; this was seen to have crumbled the cherished prejudices of the native mind.[92] Does this not rather denote that the indigenous people were open to different ideas and ways of doing things? It further brings to the fore the influence of Christianity and other religious influence in the way of life of the indigenous people of the Gold Coast including Asante especially in matters pertaining to health or the use of medicines.

Significantly, the Europeans saw the "fetish" as a police that enhanced the efforts of the Colonial Administration in the maintenance of the movement of persons, safe keeping of gold, items and

[89] Ibid, 155
[90] Ibid
[91] Ibid
[92] Cruickshank, B, *Eighteen years on the Gold Coast of Africa*, 153-157

the movement of Asante traders of these precious minerals to the coast.[93] However, according to Cruickshank the oppression of masters, the tyranny of chiefs and the extortion of "fetish men", having been exposed were punished, hence, their authority fell into contempt which necessitated instituting new checks by the Colonial Administration.[94] During the twentieth century, according to Cruickshank, the advanced natives saw the ancient landmarks of society disappearing and attributed much of it to the roguery of the fetish men who by their extortions have alienated the allegiance of the "fetish-worshippers" and have branded the whole system with the character of imposture. Did we see or witness the carry-over of these events especially into the first half of twentieth century Asante? And what were some of the major responses of both the indigenous people and the Colonial Administration?

In contrast, Maier postulated, though tentatively, that the Asante recognized the need for physical rather than spiritual what has been considered already as irrational therapies.[95] This claim made by Maier rather opens up another flood-gate to do a further investigation, here on twentieth century indigenous medical practices in Asante, to find out the prospects they made as well as counter reactions from the Colonial Administration. A further attestation by Maier that indigenous medical practitioners as distinct from priest healers were organized and given recognition by society according to their level of skill and were also considered as people who approached the expansion and development of their occupation with the care and rationality shown in all advancing societies is not an all encompassing statement.[96] In twentieth-century Asante, evidence by this study will show whether IPHs were organized and licensed by the

[93] Ibid
[94] Ibid
[95] Maier, Nineteenth-Century Asante Medical Practices, 64
[96] Ibid

Asante Confederacy Council. This view has already been buttressed by Maier especially when reference is made to the fact that the IPH is part of the *nsumankwaafieso*.

Rattray's works on the Asante, an Akan society, contrasts the assertion of outright disregard for IPH. In 1921, the then Gold Coast Government chose Rattray as the first head of the Department of Anthropology. In the capacity of British colonial anthropologist, he traveled to areas formerly under Asante control and documented aspects of socio-political organization and indigenous "religious" life. Rattray's work focused on the Asante and did not attempt to explore the indigenous medicinal system nor its conceptual underpinnings. Instead, he contended that religion was inseparable from other facets of life.[97] Again, based in the Bono town of Bonkwae-Takyiman, during his study of the Primary Health Training for Indigenous Healers (PRHETIH) project, Peter Ventevogel (1996) concluded that Akan medicine was not a "real system" because of its highly externalizing and diffuse character. "The issues of the existence (or denial) of indigenous African "medical systems," theories of natural and supernatural or personalistic disease causation and therapy, and the ubiquity of witchcraft, which undergird the foregoing, saturates the discourse on African therapeutics and culture".[98] Also, Fields in the 1930s concluded that "According to African dogma sickness and health are ultimately of supernatural origin" and "organic illness is almost always attributed to witchcraft, bad medicine or sin, seldom to worry and stress".[99] This cause was further advanced by Ventevogel (Ventevogel, 1996) who noted "the literature on Akan medicine lacks real consensus on the indigenous

[97] R. S, Rattray, *The Tribes of the Ashanti Hinterland* (Oxford: Claredon Press, 1937) 5-10, 72-87
[98] K., Konadu, "Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and encounters with (Medical) Anthropology", *African Studies Quarterly*, volume 10, Issues 2 and 3, 2008,
[99] Ibid

nomenclature of nutritional diseases and indigenous disease names cannot be substituted unproblematically by Western disease terms."[100]

This notwithstanding, Onyinah drew similar conclusions that the belief in witchcraft in the way of living of the indigenous psyche was strong. Witches were thought to feed on human flesh and drink human blood, inflict material loss on people, afflict people with diseases and made them ignoble through their misdeeds.[101] Here, the experts in dealing with such matters contrary to European views were the IPHs, but in the same vein claims are made to the effect that initial attempts to ameliorate the impact of witchcraft failed.[102] Hallucination, to the European, mindset was a probable cause. Cruickshank had earlier hinted that witchcraft in the Gold Coast was a crime which entailed, according to African laws, not only death upon the witch or wizard but death and bondage upon their relations also. This argument differs especially in Asante. The witch could be punished but his entire family is not noted to be equally guilty of the offence, which their relative is held accountable for. However, it is a well-proven argument by several authors and writers who have commented on witchcraft including Cruickshank that witchcraft is chiefly discovered by "fetish men". These so-called "fetish men" were noted by Cruickshank especially in the nineteenth-century as people who suited their own purposes in denouncing the guilty.[103] If sudden illness or death should overtake a person who happens to have quarreled with another, the sick or the dead was severally considered to have been bewitched and the witch rarely escaped punishment.[104] Appeals were also made by persons accused of witchcraft to prove

[100] Ibid
[101] O., Onyinah, "Deliverance as a way of Confronting witchcraft in Modern Africa: Ghana as a case History", *Cyber Journal for Pentecostal and Charismatic research*, 2009
[102] Ibid
[103] Cruickshank, *Eighteen years on the Gold Coast of Africa*, 157
[104] Ibid

their innocence and when they were innocent, heavy penalties were decreed against their accusers.[105] The studies of Nadel, Luckman and Debrunner share the view that witchcraft belief is the outcome of social instability such as famine, rapid change, oppression and economic distress. Other works such as Field's case studies and analyses of so called witches in Ghana reveal how witchcraft is rooted in the psychological reactions of those suffering from ill health, misfortunes and inability to control their destinies.[106] Evans-Anfom has commented that there is the need to find out how trainable indigenous healers are."[107] Significantly, Evans-Anfom neither considered nor questioned how "trainable" are biomedical practitioners, who appear to be hegemonic and the most hostile toward attempts aimed at cooperation between the indigenous and modern medical practitioners.[108]

We understand that Asante or Akan medical knowledge is not static or resistant to refinement, but has been one of continuity in medical practices aligned with spiritual-temporal convictions held over the centuries. Siginificantly, Konadu has argued that in reducing African medical systems to "witchcraft," global readers and Africans consume such colonial renderings of those systems and, invariably, fail to appreciate the layers of indigenous medical knowledge possessed by various members of a community and the ideational basis of the system's approach and

[105] Ibid

[106] S.F, Nadel, Witchcraft *in four African Societies: An Essay in Comparison*, 1952, ed. Max G. Marwick (London: Penguin Books, 1951) 286. H.W, Debrunner, *Witchcraft in Ghana: A Study on the Belief of Destructive Witches and its Effects on the Akan Tribes* (Accra: Presbyterian Book Depot, Lt.d., 1961), also see Gluckman, *Customs and Conflicts in Africa* (Oxford: Blackwell, 1959) 101. M. J. Field, *Religion and Medicine of the Ga people* (London: Oxford University Press, 1937). M. J. Field, *Search for Security: An Ethno-Psychiatry study of Rural Ghana* (London: Faber & Faber, 1900)

[107] K, Konadu, "Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and encounters with (Medical) Anthropology"

[108] Ibid

therapy.[109] Konadu splits Akan medical knowledge into three primary and overlapping spheres which include those at the level of core and basic knowledge, specialized and in-depth knowledge, and peripheral knowledge.[110] The first sphere corresponds to the core-basic knowledge shared by most, if not all, community members and the basis upon which those members plan and act. Here, "core-basic" refers to what is fundamental and widely known within the indigenous medicinal system, and at an essentially basic level of knowledge and aptitude, though there are those who are an exception to this general observation. For instance, he argued, a "majority of the population still prepare and use their own herbal mixtures," and thereby exhibit agency in the process of addressing their health needs.[111] The second sphere corresponds to specialized and in-depth knowledge that is associated with the specialists who function ultimately to maintain the coherency and expand the development of the community as it principally relates to holistic health and healing. Those specialists were the indigenous healers who represent the institutions of *abosomfo*, *akomfoo*, and *nnunsinfo* ("herbalists").[112] The third is not of direct relevance to the study.

The above spheres of indigenous medicinal knowledge all share an ideational basis that further questions the ubiquity of "witchcraft" proposition and the common anthropological understandings of African therapeutics. The ideational basis of indigenous African medicine suggests a holistic approach to balanced health and other human circumstances and this basis

[109] K, Konadu , "Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and encounters with (Medical) Anthropology"
[110] Ibid
[111] Ibid
[112] Konadu, "Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and encounters with (Medical) Anthropology"

considers the variables of family, way of making sense of the world, vocation, ecology, and cultural environment while placing a high value on the human being. Still, it is yet an unresolved matter that needs to be attended to. The ubiquity of witchcraft or superstition in the Akan or Asante medical thought or world view would find a place in this study to fill a persistent gap in this area of study in indigenous medical therapies and European influence.



It has been further attested that a *sine qua non* of traditional medicine is that the service is performed through the utilization of a magico-religious acts and concepts.[113] In spite of this, Twumasi argued, the magico-religious does not mean the practitioners of traditional medicine did not have any notion about physical cures, stressing the argument for a progressive medical thought of the indigenous healers in Asante, he argued, they have a reserve of remedies with which to treat the sick some of which have scientific validity.[114] Wounds were bandaged and broken bones set and bound. Stimulants and sedatives were also found in the traditional pharmacopoeia. However, most treatments were and are still regarded as aspects of a total treatment which include magico-religious ingredients.[115] Again, Beecham argued that it was noticeable even in the nineteenth century that the "fetish" men and women applied themselves assiduously to the study of the healing art and acquired such knowledge of the properties of herbs and plants as enabled them to effect the cure of many complaints.[116]

[113] R. A, Lystad, *The Ashanti: A proud people* (New Jersey: Rutgers, 1958)
[114] Twumasi, *Medical Systems in Ghana*, 9
[115] Ibid
[116] Beecham, J, *Ashantee and the Gold Coast* ,204

Another writer, Bosman, attested to the fact that local remedies were able to cure certain diseases and others such as viral diseases against which European remedies were helpless. He stressed that Africans on the Gold Coast were unfamiliar with surgery aside from the superficial cuts made on the skin for the rubbing in of medicinal herbs. Serious wounds and internal bleeding were definitely beyond the scope of African therapies in the Gold Coast. [117]



Bosman, notwithstanding, attested to the fact that there is a body of knowledge regarding the use of herbal and vegetable remedies. Bosman argued that the remedies worked because he saw his own countrymen cured by them. He noted that the Africans successfully treated dangerous wounds that the European doctors had given up hope and concluded that the green herbs, the major medicament used by the indigenous people was efficacious[118] Bosman made a list of medicaments used in Asante. The list included lemon, limejuice, malaget, which is also known as grains of paradise, the cardamom roots, branches and gums of trees and several sorts of green herbs which were noted to be impregnated with an extra ordinary sedative virtue.[119]

Again, Bosman shows in his writing, the efficacy or the subject matter of indigenous remedies yet, his conclusions in several instances are based on the fact that there are indigenous medicaments that are able to effect cures. However, he argued that the indigenous people were to be pitied for when they were shot, cut or otherwise wounded in their wars, they neither knew nor had any other ways of cure rather than by green plants which they boiled in water and smeared

[117] Bosman, *A new and adequate description of the Gold* Coast, 221-224
[118] Ibid
[119] Ibid

the ailing part of the body with that decoction which proved effectual in some cases.[120] However Bosman notes that those who did not know how to prepare the potions applied it in vain. This caused their wound to gangrene, and at best turned to a running, which continued the whole life.[121] The views put forward by Bosman raises the question about the fact that knowledge about the application of herbs or the preparation of decoctions among the indigenous people was learnt and in instances where an indigenous person did not imbibe such skills he was unable to put the medicine into effective use.



However, in *Our Days Dwindle*; Kyei argued that growing up in rural pre-colonial West-Africa entailed the acquisition of knowledge crucial for the reproduction of the community including herbal knowledge. Other writers like Frierman and Janzen accurately observed that the diagnosis of illness shapes cultural ideas on misfortune and evil. The power to name illness is the power to say which element in life lead to suffering.[122] To emphasize, it was a well-known fact that as one moved from village to village during colonialism and early part of the second half of the twentieth century Ghana, one could not help noticing herbariums at so many backyards or fences made especially of medicinal plants. Ampofo (1967) admits that in his village there was not a fence without say *newbouldia Levis* known in Akan as *osensrema* used for dysentery and eyelying the placenta, *spondias monbin* known in Akan as *atoaa* for post partum haemorrhage and *ocinum veride* known in Akan as *onunum* for "belly palavers".[123]

[120] Ibid
[121] Ibid
[122] S., Frierman, and M.J, Janzen, (Eds.), *The social bases of health and healing in Africa* (Berkly,CA: University of California press, 1992)
[123] O, Ampfo, "The Traditional Concept of Disease, Health and Healing, with which the church is confronted", *Ghana Bulletin of Theology* (June 1967) 8

Akyeampong argued that tropical medicine came to constitute the frontier of medical science in the second half of the nineteenth century as the European's desire to colonize the tropics created the impetus for medical discoveries. He further stated that the colonization of Africa might well have been impossible without the industrial and medical revolution of the nineteenth century. Conclusively, it is important to note the reference Konadu made from Sally-Anne Jackson when it was argued that nineteenth century imperialism and biomedicine, which was re-imagined as tropical medicine, were inseparable and the intimate relationship between disease and empire, in terms of ailing African bodies constructed as vectors of infection, allowed for African exploitation and colonial imposition. The diseased African body, cast as "other" or alien through the introduction of co-colonizing diseases such as tuberculosis, necessitated the denigration and suppression of "efficient indigenous healing systems in operation" and expedited the expendability of those from that "afflicted continent."[124] This seem to have been the case for European dominance in the Gold Coast and Asante specifically since European medicine or biomedicine was propagated to be the best form of treatment for diseases that infected both Europeans and indigenous people in the Gold Coast and Asante. The evidence pertaining to indigenous healers as well as European involvement in disease prevention and treatment in the Gold Coast and Asante as put forward by some of the books or articles reviewed in this chapter of the thesis would be buttressed, added to or contrasted by this study.

Writers like Frierman and Janzen dealt with the subject of traditional healing as the core of twentieth-century African medicine. In the *Social Basis of Health and Healing in Africa,* examples were drawn from societies in the northern, western, central and southern regions of the

[124] Konadu, K, "Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and encounters with (Medical) Anthropology", *African Studies Quarterly*

continent of Africa to demonstrate the point that the relationship between indigenous and western medicine are well portrayed. Although western medicine is popular with local populations, particularly urban dwellers, its limitations in dealing with non-organic illness are apparent.[125] This suggests that in the absence of certain indigenous medical knowledge the gaps or limitations in the western forms of medicine could not have been filled and vice versa. Twentieth century views recognize the complementary nature of traditional and western medicine.



In his discussions of "Female Circumcision and Genital Operations in Egypt and Sudan: A Dilemma for Medical Anthropology"[126], Gordon observed that the literature on the matter was scant despite such factors as longevity of the practice, its enduring prevalence, and its capacity to arouse emotional response.[127] The study suggested that there was a small accumulation of medical observations from the experience of British colonial surgeons and gynaecologists in the 1930s and 1940s and also in the 1990s from indigenous practitioners.[128] This in essence emphasizes the fact that the existing literature on some of the traditional medical practices in some communities in Africa including Asante is limited. As a result of this, there can be no overreliance on the information concerning the activities of the colonial health officers and officials on the continent especially during colonization, but rather, some indigenous medical practitioners could serve as key informants in writing and re-writing the history of traditional medical practices in Africa including Ghana.

[125] S. Frierman and J.M., Janzen (Eds.), *The Social Basis of Health and Healing in Africa*
[126] D., Gordon, "Female Circumcision and Genital Operations in Egypt and the Sudan: A Dilemma for Medical Anthropology" *Medical Anthropology Quarterly*, Vol.5, (1991) 3–14. doi: 10.1525/maq.1991.5.1.02a00010
[127] Ibid
[128] Ibid

In their work, *Tongnaab: The History of a West African God*, Allman and Parker deal with witchcraft and anti-witchcraft movements in Ghana from the 1870s. The authors suggest that the rise to witchcraft concerns was a response to colonial conquests and rule. The study suggests that deities from the north were more effective against witchcraft; hence people in the south resorted to consultations of northern deities. A notable example is the priest of Tongu and the Tongu shrines that were replicated in the south including Asante.[129]



[129] J. Allman and J. Parker, *Tongnaab: The History of a West African God* (Bloomington: Indiana University Press, 2005)141

## CHAPTER THREE

## INDIGENOUS MEDICINE IN ASANTE AND THE TRAINING OF INDIGENOUS HEALERS

This chapter focuses on Indigenous medicine in Asante. It deals with the aspects of medicine which are concerned with religion or beliefs of the people. However, it also deals with herbal practice which is connected to IPHs and specialized fields like bone-setting, circumcision surgery, and traditional midwifery.



### 3.1 Indigenous Priest Healers (IPH)

In ancient times and even today in many societies and cultures, every natural occurrence in man's environment, whether good or bad including natural calamities, pestilence and diseases of man were and still are attributed to either acts of God or deities and spiritual or mystical demons. According to Asante oral traditions, traditional priests or (IPH) were implored to intercede in such events. They cured diseases through incantations, spells, preparation of potions, exorcism, and mostly through the invocation of deities, which according to the indigenous people was the beginning of formal medicine.[130] For instance, an IPH was believed to have played a central part in the formation of the Asante Kingdom. The conception and the birth of Osei Tutu, the founder of the Asante Kingdom was due to the miraculous fertility medicine that *Okomfo* Anokye prepared for Osei Tutu's mother, Yaa Manu, who was also known as Manu Kotosii.[131] Significantly, a deity was a medium used by the IPH in the healing of diseases. The art of healing

[130] Twumasi, *Medical Systems in Ghana*, 24-39., Manhyia Archives of Ghana, Kumase, MAG1/1/102A, Correspondence between Ghana Psychic an Traditional Healing Association and the *Asantehene*, 1963

[131] K, Botwe-Asamoah, "The Romanticization of the Asante Kingdom: A critique" *African Journal*, vol.2, No. 1, 2008

through deities is an ancient practice that has persisted to the present time.[132] It was noted that the term *Obosom* or deity in Asante consisted of medicine concocted of various materials thought to have special powers, such as clay from the sacred River Tano, certain herbs and roots, ancient beads, cowry shells, and neolithic celts. These disparate objects were compounded together into a conglomerate mass, which was then placed in a brass basin. In certain instances it was only water.[133] This medicament was made potent by calling down a measure of the universal power, which was caught by a skilled practitioner in a number of ways and forms.[134] Again, a deity may be defined as any material object in which a spirit or spiritual power is present.[135] It was some natural substance, which by its appearance or peculiar properties appeared unusual.[136] It was a bone, stone or wood crudely carved into the likeness of some creature or brass bowl filled with gold dust, mystic herbs and sealed with wax or some ceremonial object or sacred relic.[137]

Mostly, a deity was composed of several magical or non-magical elements such as pebbles, feathers, hairs, bones, twigs and beads and has a special virtue because of certain rites performed in the assembling of its parts.[138] Sometimes it involved a particular pattern, which was carried on the head, worn on a person, or placed at where the person lived as a protection against evil

[132] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A , Correspondence between Ghana Psychic and Traditional Healing Association and the *Asantehene* 1963, Observations made at the Edweso Besease shrine, 20th June, 2008
[133] Discussion with Dr. W.J Donkoh, Department of History and Political Studies, KNUST, 5th October, 2009
[134] Swithenbank, M, *Ashanti Fetish Houses*, (Ghana University Press: Accra, 1969)10
[135] Ibid
[136] Ibid
[137] Ibid
[138] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Early Medication by Deities, A presentation from Dr. Kofie, J.E , Senior Technical and Research Officer, Ghana Psychic and Traditional Healing Association, Ashanti Region, 3rd August, 1963

forces. [139] By the 1900s the term *Suman* was used interchangeably to refer to a deity or an object of formulae, which could invoke supernatural help for the bearer.[140] *Suman* was an object or carving, stems of trees that were believed by the people of Asante to possess certain supernatural powers that could bring good fortune including health to good people and was inimical to those who did evil.[141]



"Medicines" made from small objects and from herbs were sometimes swallowed or were inserted under the skin to increase their efficacy.[142] Further enquiries have shown that herbs were originally used as "fetishes" only but as time passed they were chewed, boiled, brewed and drunk not for the sake of its medicinal properties but in order that its spirit might thus be captured and held.[143] Through trial and error, it was gradually discovered that some of these plants were more effective than others and some ailments responded to one herb and some to another.[144] Through trial and error, pharmacology was built up. Magic was the motive but medicine was the result. The existence of such forms of healing power is what was frowned upon in the twentieth century by the Colonial Administration especially when Asante had been fully placed under the control of the British.

[139] Ibid
[140] M, Swithenbank, *Ashanti Fetish Houses*, [Henceforth Ashanti Fetish Houses] (Accra: Ghana University Press, 1969) 11
[141] Interview with Nana Tenkorang Wade, at his residence, Dichemso, Kumase, 12th September, 2006
[142] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Early Medication by Deities, A presentation from Dr. Kofie, J.E, Senior Technical and Research Officer, Ghana Psychic and Traditional Healing Association, Ashanti Region, 3rd August, 1963
[143] Ibid
[144] Ibid

As the beliefs of the people were refined their beliefs in deities gradually changed into *amulet*. An *amulet* has been defined as small figure of gods, goddesses and sacred symbols cut from stones or molded from clay baked and glazed.[145] These figures were nicely shaped so that they could be hanged about the neck on a cord. The amulets became a charm of protection against various spirits. Any spirit or witch that attacked the wearer was confronted by the likeness and power of a protecting deity.[146] With the introduction of Christianity into the country and specifically Asante, the *amulet* was equated to the crucifix worn by many Christians. It has been argued by J.E Kofie that it is either an amulet or a symbol based on the motive of the bearer. He noted, if the bearer believes that the symbol offers him protection, then the cross becomes an *amulet*.[147]

Significantly, it was believed that the amulet evolved into what was known as the *talisman*, a magical charm decorated with cabalistic formula or mystical design calculated to protect the owner against physical or metaphysical hazards.[148] Talismans of one class, which were shaped to resemble parts and organs of the body were worn to ensure or to restore health to the parts which they represented.[149] Such talismans were hanged in the temples of churches as votive offerings or as appeals for help.[150] As society progressed, the people of Asante still found the need to offer themselves the necessary physical, social, and psychological protection. This, as it were made deities significant in indigenous Asante society such that sometimes deities were

[145] Ibid
[146] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A , Early Medication by Deities, A presentation by Dr. Kofie, J.E, Senior Technical and Research Officer, Ghana Psychic and Traditional Healing Association, Ashanti Region, 3rd August, 1963
[147] Ibid
[148] Ibid
[149] Ibid
[150] Ibid

brought from different regions into Asante. In most instances they protected the particular families that brought them and to a larger extent, the communities in which they were situated.[151]

Significantly, in spite of colonialism, the first half of twentieth century Asante saw a priestly caste who seriously engaged in indigenous medicine. Shrines and priests recorded a number of adherents.[152] The priests began to make profit as a result of the increasing population of their devotees. For instance, any person who wished to be a co-worshipper or subject to a said *Suman* had to slaughter a fowl and deposit a sum of one pound and six shillings and when it caught any witch or wizard the sum of one pound, three shillings was received.[153] It was also emphasized that in case of minor grievances the offender paid three pounds six shillings. In the case of witchcraft, the offender paid three pounds or the cost of a cow in the north.[154]

Witch finding significantly became a noticeable trait at some of the shrines that were dotted around Kumase. Much could be deduced from the words of Kwesi Abebrese, an IPH at Bokoso in Asante. He claimed that deities prohibited the evil practices of wicked persons, wrong invocation of supernatural or mystical powers or application of bad medicines and antisocial behaviour.[155] This invariably was to zero in on witches who were believed to be wicked persons who wrongly invoked supernatural or mystical powers to bring diseases and untold hardships on people.

[151]Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Application for a physician license file,1934-1940

[152]Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Correspondence between Kwame Fori and the *Asantehene*, 1926

[153] Ibid

[154] Ibid

[155]Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Application for a physician license file,1934-1940

Also, the need for priests and shrine devotees to increase the number of their adherents and to entrench themselves in the 1920s and 1930s in Asante urged them to trumpet the antidotes of their deities; this was the period European interest was against several forms of indigenous medical therapies. The priestly caste in Asante believed deities could cure certain infirmities including barrenness and impotence.[156] One of the priests, Kwadwo Num, who was resident in Kumase by 1940, attested that adherents or priests of deities were directed to efficacious remedies to treat ailments, which troubled the indigenous people of Asante.[157] It was also believed that the mystical powers of *Suman* could cure madness, "fainting fits" or convulsion, leprosy, blindness and also tell the fate of people.[158]

Mostly, the indigenous people of Asante testified to the efficacy of the "medicines" administered by the IPHs. In a testimony, it was noted that one John Mensah, a blind soldier consulted a priest of Krachi Denteh and was told to mix the blood of a white cock with honey and anoint his eyes with this "indigenous ointment" for three days. He recovered his sight and gave thanks to the deity, Denteh.[159] Again J. E Kofie attested that a certain Johnson who had hemorrhage of the lungs consulted the priest of Kobi and was told to take pine nuts, mix them with honey and eat it for three days. He was also cured.[160]

[156] Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Application for a physician license file,1934-1940
[157]Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Correspondence between Kwadwo Num and the Office of the *Asantehene*, 1940
[158] Ibid
[159] Ibid
[160]Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Early Medication by Deities and Herbs, a presentation by J.E Kofie to the *Asantehene*, 3rd August, 1963. J. E Kofie reported to the Asantehene events that persisted in Asante from the 1920s through to the 1960s. It was an attestation to the efficacy of the medicines of priest healers especially at the first half of twentieth century Asante and beyond.

Significantly, in the first half of the twentieth century, some of these beliefs invariably helped curb certain antisocial behaviours and negative lifestyles that had repercussions on the physical and psychological or mental health of the people.[161] Adversely, those who were falsely accused or branded as witches were mostly scorned and rejected by their families and communities at large.[162]



### 3.2 Organization of the Asante Healing Profession in the Early Twentieth Century

It is a well-noted fact that knowledge about herbs in Asante and the treatment of sickness was well known by the indigenous people. Also, practitioners in Asante were very organized. For instance, by the first half of the twentieth century in urban towns such as Dwaben and Kumase, physicians were organized and specialized. All physicians in Asante were under the jurisdiction of *Nsumankwaafieso* which the *Asantehene* Prempeh I described, in a letter of explanation to the District Commissioner of Kumase, as "the pharmacology" where we had well-trained and qualified physicians in charge, whose duty it was to attend to the sick and injured".[163]

In Asante, the *Nsumankwaahene* was noted as the chief medicine man. As the chief physician of the *Asantehene* he had every right to call the *Asantehene's* palace for consultation.[164] As the physician for the *Asantehene*, he was also obliged to prescribe medicine for others. Significantly, he was the indigenous doctor for the state. The *Nsumankwaa* stool was *mmaamadwa* (patrilineal)

[161] Ibid
[162] Interview with Nana Tenkorang Wade, at his residence, Dichemso, Kumase, 12th September, 2006
[163] PRAAD, Accra, Correspondence between Agyeman Prempeh I and the District Commissioner, 14th April, 1928
[164] Agyeman Duah, J., *Nsumankwaa Stool History*, Institute of African Studies, Legon, acc. No. Ass 22 (1962.) 8

to which sons succeeded. The *Asantehene* could place anyone he chose. Nevertheless, it was expected that potential candidates for the stool and elders were to be familiar with herbal matters.[165] An informant who grew up in the *Nsumankwaa* house in the latter part of the nineteenth century hinted that the *Nsumankwaahene* was responsible for preparing *Asantehene's* medicine so the *Asantehene* chose the one whom he believed was skilled in medicine.[166]



As the head of long settled Muslims and indigenous Asante Muslim converts the *Nsumankwaahene* dealt with matters relating to Muslim or Asante Nkramo physicians most importantly to ensure that administratively they were well positioned to continue or discontinue their practice based on reasons he deemed fit.[167] Mostly, it was the Muslims or the *Asante nkramo* who were noted to have introduced non-herbal medicaments into Asante even before the twentieth century.[168] Lancing, cupping, bleeding, cauterization and variolation are Muslim medicines mentioned in the Koran that were introduced into Asante by Muslim physicians.[169]

Similarly, the *Nsumankwaahene* was the head of all migrant practitioners who settled and plied their vocation in Kumase and other villages in Asante. Some of the practitioners came from Togo, Nigeria, Burkina Faso and other West African countries and with the permission of the head of all indigenous physicians, that is, the *Nsumankwaahene*, they were able to join the traditional healing environment to engage in indigenous medical practice. Several of these

[165] Ibid
[166] J., Agyeman Duah, *Nsumankwaa Stool History*, Institute of African Studies, Legon, acc. No. Ass 22 (1962.) 8
[167] Interview with Samuel Kwaku Anane, a former Asante Nkramo, at his residence, Krofrom Abodwese, Kumase, 20th August, 2009. I received several responses from Muslims who attested to the fact that Asante Nkramo refers to the group of Asante who became Muslims through marriage or Asante Muslim converts.
[168] Maier, Nineteenth-Century Asante Medical Practices,73
[169] Ibid

migrant practitioners who come to Asante in the first half of the twentieth century claimed they had the antidote to diseases like epilepsy, stomach ache, cough, piles and rheumatism. In 1954, a migrant Native Doctor from Burkina Faso, Sidi Sakoh, who settled in Asante, claimed he had the antidote to diseases such as acute blindness, fevers, and stomach troubles that were prevalent in Asante.[170]



Another migrant, Yusufu Alufa, a physician who settled in Kumase claimed he had the antidote to cure headache, stomach ache, leprosy, and epilepsy. It is important to state that most of the migrants cured similar diseases and this shows the persistence of such diseases in Asante and for that matter, Kumase. For example, in the same period one Henri Bocco, a herbal practitioner claimed that he could cure stomach ache, headache, rheumatism, toothache and yaws. In 1954, one S.O. B. Adebayo, a Nigerian who settled in Asante New Town, Kumase, and practised as a herbalist claimed that he could cure impotence in men, gonorrhea, and barrenness in women, nettle rash and rheumatism.[171]

Also, one area which the migrants touched was infant mental health care. One migrant practitioner, Usman Bin Suleman describes it as "Infantile in children".[172] He claimed he could cure rheumatism, piles, headache, and dysentery.[173] Again, some of the migrants engaged in general practice clearly pointing out that their claims to cure diseases was limitless, especially

[150] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Correspondence between Sidi Sakoh and Office of the *Asantehene*, 1954

[151] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Correspondence between S.O.B Adebayo and the Office of the *Asantehene*, 1954

[152] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Correspondence between Usman Bin Suleman and the Office of the *Asantehene*, 1954

with claims that their antidotes had no ill effects. This is exemplified by the claims of Deasi Abra, a native of Afoega Akukome in the then French Togoland that he was able to cure diverse sicknesses without any side effects.[174]

Amongst the male migrants who joined the indigenous health system in Asante in the first half of the twentieth century were their female counterparts who were also skilled in the art of healing maladies. A notable example is Aysatu Ajoke who was a resident of Aboabo, Kumase, but a native of Lagos. She claimed she could cure impotence, rheumatism, piles and problems related to the eyes. [175] It is essential to stress that present in the indigenous healing milieu were circumcision surgeons, traditional bone-setters and traditional birth attendants.

### 3.3 Circumcision Surgeons (*Wanzams*) and Muslim Influence in Asante

In a broader context, it is understood that non-herbal medicine is severally a Muslim practice that was introduced into Asante by Muslim physicians even before the first half of the twentieth century. Bonnat recorded a Muslim from Buna who stated that Kumase contained Muslims who performed the functions of physicians to the *Asantehene* who held them in high regard. Among the class of Muslims who came to practise in Asante especially by the first half of the twentieth century were Wanzams or circumcision surgeons. It is already explained that the Asante Nkramo and Muslims generally introduced many of the non-herbal medicaments in the twentieth century including circumcision. This notwithstanding, before the twentieth century, circumcision was an

[153]Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Correspondence between Usman Bin Suleman and the Office of the *Asantehene*, 1954

[154] Manhyia Archives of Ghana, Kumase, MAG 1/1/102, Correspondence between Aysatu Ajoke and the office of the *Asantehene*, 1954

unacceptable practice in Asante and Kumase specifically because it had a negative connotation. The Asante *Odehyee* (royal) could not subject himself to mutilation. Donkoh adequately expounds that:

> Often first generation slaves were stigmatized by reference to their linguistic difference expressed in their halting or inflected twi. Often too, they were distinguished by cicatrisation. Ordinarily, the freeborn avoided body marks and scarification including circumcision, all of which were regarded as mutilation.[176]



Ordinarily, it could be inferred from Donkoh's argument that it was non-Asante residents in Asante who indulged in circumcision. Maier has also noted intermarriages between Muslims and Asante. It was this group of people who made circumcision gain deeper roots in the Asante community by the turn of the twentieth century.[177]

According to Dupuis, the Asantes without knowing the content of the Koran, were equally persuaded to believe that it is a volume of a divine creation, and consequently that it contains ordinances and prohibitions that were most congenial to the happiness of mankind in general. Further enquiries have shown that circumcision is part of Muslim medicine, which is duly prescribed by the Koran.[178]

[155] Maier, Nineteenth-Century Asante Medical Practices,74

[156] Donkoh, W.J "Legacies of the Transatlantic Slave Trade in Ghana: Definitions, understanding and Perceptions" in Anquandah, J. K, (Ed.), *The Trans Atlantic Slave Trade: Landmarks, Legacies, Expectations* (Accra: Sub-Saharan Publishers, 2007), 308-309

[159] Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, Kumase, 19th February, 2008

By the first half of the twentieth century an *Odehyee* in Asante was not permitted to opt for circumcision; such an indulgence amounted to a violation of an age-old taboo of circumcision.[179] Growing up as a young Asante boy in Kumase by the first half of the twentieth century demanded that one looked upon circumcision with contempt.[180] However, within the same period, that is, the first half of the twentieth century, intermarriages and influence of Islamic culture in Asante made several of the indigenous people to engage in circumcision. Significantly, there was a rising chorus from young girls in Adum a suburb of Kumase demanding a change in the status quo. Girls in Adum sang what has been described as profane songs calling for their male counterparts to be circumcised:

> "An uncircumcised penis is detestable, and those who have not circumcised should come for money from us so that they can get circumcised. We shall never marry the uncircumcised."[181]

Circumcision was invariably becoming the order of the first half of twentieth-century Asante primarily because the mass exodus of Hausa Muslims to the south in 1898 brought the practice to Asante. However, in the first half of the twentieth century, Muslims became integrated into northern chiefdoms structures but maintained their distinctiveness even in the 1920s in the south keeping to the Zongos such as Asawase, Aboabo and Mossi Zongo all in Kumase. The Muslim medicine which gained prominence in the nineteenth century was still practised in these Zongo communities in the first half of the twentieth century. The influx of the indigenous communities to these settler communities as noted earlier was persistent even in the 1920s.[182] Young women were ready to foot the bill of their male counterparts to ensure that they were circumcised. An uncircumcised penis was unattractive to them. This, as it were, pushes forward the fact that

[160]J. Appiah, *The Autobiography of an African Patriot* (Accra: Asempa Publishers, 1996) 22
[161]Ibid
[162] Ibid
[163]Interview with Mohammed Fuseini and Mustapha Fuseini, Aboabo, 19th February, 2008

circumcision was not demanded by the young women on medical grounds but a circumcised penis by the first half of the twentieth century looked more decent to women. It also buttresses the fact that the people of Asante were receptive to other cultures and practices. Patronage of circumcision by Asante boys was done secretly. The clandestine nature of indigenous patronage was much to be desired. The Wanzams mostly carried out their operations between the hours of six in the morning and five and six in the evening either in the middle of farms or places outside the settlements.[183] The time for the operation was to prevent excessive pain but the location adds to the fact that it was a practice unaccustomed to the indigenous people.[184]

Though, the expertise of the *Wanzam* became highly recommended in the first half of the twentieth-century Asante, the practitioners mostly dwelt on supernatural strength in the performance of their surgical operations.[185] Chants and recitations including talismans were used by practitioners to prevent hemorrhaging. It was believed by the practitioners that hemorrhaging during circumcision was either caused by a competitor or sometimes by evil forces resident in the person being circumcised or the family.[186] With sharp knives produced by special blacksmiths especially during the first half of the twentieth century, the circumcision surgeon pulls the foreskin a couple of times, implants the long nail of his left thumb into the point of the foreskin, and makes a mark thereon and finally uses the sharp knife to circumcise. The operation

[183] Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, Kumase, 19th February, 2008., J, Allman, "Rounding Up Spinsters: Gender Chaos and Unmarried Women in Colonial Asante." in Cornwall, A, (Ed). *Readings in Gender in Africa.* (Indiana/Oxford: Indiana University Press, 2005) 201-210

[184] Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, Kumase, 19th February 2008

[185] Ibid

[186] Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, Kumase, 19th February, 2008., Dupuis, *Journal of Residence in Asante* , 142

was dexterously executed in six minutes or so without anesthetics.[187] After circumcision, a herbal preparation which was mostly a combination of herbs and roots was spewed by the practitioner on the fresh wound to stem the flow of blood after which the wound was dressed.[188] It must be noted, however, that by 1950 as a result of modernity and European influence there was recourse to the use of antibiotics.



It is not known that the British trained medical practitioners of modern medicine in Asante had no knowledge in circumcision. However, at the government hospital in Kumase where such circumcision could be done under anaesthetics, the English doctors in charge did not perform circumcision operation because it was not a medical necessity.[189] For instance, in 1949, Britain, the colonizing country withdrew free medical service cost in infant circumcision in its newly formed National Health Service and made it an out-of pocket cost to parents and the proportion of newborns circumcised in England and Wales fell to less than one percent. Significantly, the Colonial Administration did not pay much attention to circumcision in the Gold Coast and Asante for that matter. This as it were increased indigenous interest in *Wanzams*. It is significant to note that Asante boys who were circumcised received approbation from their female counterparts but were scorned and felt contemptuous in the presence of the elderly, both male and female.[190] They were to lose their rights by becoming "half-alive" and "half buried" through their circumcision.[191] Appiah writing in 1996 argued, "We had eaten of the forbidden fruit and

[187] Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, Kumase, 19th February, 2008
[188] Ibid
[189] Appiah, *The Autobiography of an African Patriot* , 22
[190] Ibid
[191] Ibid

were to pay the penalty for doing so. It was the fast traditional rule that no man could occupy a stool once he was circumcised"[192]

As early as the late 1920s there was a dispute between fathers and their sons at Adeebeba, a village near Kumase, because their sons followed the new fashion of male circumcision, disrespected Asante custom and insisted on their personal autonomy.[193] With the presence of Sunni group of Muslims in Kumase, the arrival of the Ahmadiya Movement in Asante in 1921 and the establishment of the Ahlis Sunna *Wal-Jama'a* in the 1950s, Muslim influence gained roots in the Gold Coast. With an admixture of influence, external contacts and ego-enhancement, visits from both far and near, most of which centred in Kumase, Muslims in Kumase by 1950 had a strong foundation and influence in the city.[194] Significantly, by the middle of the twentieth century, as a result of persistent influence of Europeans, traditional usages, beliefs, customs or rules such as panyaring, human sacrifice, the rule on circumcision became relaxed and it is suspected that occupants of stools in Asante became comrades of circumcision.[195] Over the period, with the introduction of midwifery schools in Asante, midwives engaged the services of *Wanzams* to train students in circumcision skills.[196] However, according to Mohammed Fuseini, in Asante, it was an unequal relationship between the modern health care practitioners and the *Wanzams*. The relationship was one of exploitation, which left the *Wanzams* unappreciated.[197]

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[192] Ibid
[193] T.C , McCaskey , *Asante Identities, History of Modernity in an African Village, 1850-1950* (Edinburgh: Edinburgh University Press) For the International African institute, London (Bloomington and Indianapolis: Indianapolis University Press /International African Library,25, 2000), 277
[194]N, Samwini, *The Muslim Resurgence in Ghana since 1950: Its effects upon Muslims and Muslim-Christian Relations*, 2006, 38-39
[195] Ibid
[196] Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, Kumase, 19th February, 2008
[197] Ibid

Prior to the 1940s and 1950s circumcision surgeons received gifts which included fowl, clothes and other merchandise but from the 1940s and 1950s, emphasis was shifted from the offer of gifts to payments in cash. However, the reward that came to *Wazams* was based on the request the practitioners made and how much their clients could offer.[198] In spite of the income circumcision surgery provided for practitioners in Asante, efforts to come together to form an association proved futile. The reason for this failure was largely personal interest on the part of individual potential members as well as lack of interest of stakeholders and the medical authorities at the time.[199] Forson has reported of the carry-over of such disregard in the twenty-first century by observing that,

> The work of *Wanzams* has not been appreciated through any means of certification… But as the fact remains that more village folks cannot have easy access to doctors to perform "A-Septic Technique" (i.e. The free bacteria or germs) surgery on circumcision, the services of these traditional men would be needed by the village folks. So the need to train and equip them with modern hygienic ways and methods of circumcision[200]

Further enquiries revealed that by 1950, in Asante, *Wanzams* still carried out their operations without administering local or general anesthetics and that they used home- made and unsterilized surgical instruments and bandages that were literally pieces of old rags.[201] This

[198] Ibid
[199] Ibid
[200] J. P, Forson, "Male Circumcision and HIV/AIDS", *The Ghanaian Times*, 13th October, 2006
[201] Appiah, *The Autobiography of an African Patriot*, 22. Interview with Mohammed Fuseini and Mustapha Fuseini, Aboabo, 19th February, 2008. Mohammed Fuseini attests to the fact that as late as the 1950s his comrades in circumcision did not pay close attention to hygiene, however with time as a result of the higher standards of their clientele, especially the literate ones, they have been compelled to upgrade standards in terms of ensuring prevention of disease transfer from one child to the other and infections due to unhygienic conditions. He claims there is still much to be done since with time if standards were not raised they would only be left with little or no patronage from the cities except with rural dwellers.

situation indicates that in Asante and specifically Kumase diseases and infections became transferable through circumcision.

### 3.4 Traditional Bone-Setters (TBS)

Bone-setting is one of the ancient medical practices which is done through the art of bone manipulation. The practice of bone-setting or manipulation has been attested to by visitors to Asante in the nineteenth century.[202] A Muslim physician in Asante in reporting to Tedlie some of the corrective medicines in nineteenth century Asante noted that a fracture of an arm or leg was bound with splints and if God does not take the patient he recovers in four months.[203] This form of surgery practised by Muslim physicians was attested to by Rattray. A Freeman that it was crude and inefficient compared with European methods of 1898.[204]

Most of the people in Asante who took to bone-setting even in the first half of the twentieth century did not have formal education. It was the sole preserve of indigenous healers, especially those in the rural areas.[205] It has been noted that the practice served as the basis upon which modern manipulative therapies such as Chiropractic and Osteopathy evolved in the late nineteenth century.[206] Further enquiries have shown that in Asante, the practice was not subject

[202] Maier, "Nineteenth-Century Asante Medical Practices",73
[203] Ibid
[204] Ibid
[205] Interview with Adamu Allah Bar, at his bone setting centre, Allah Bar, Kumase, 9th February, 2008
[206] http://gartoninghana.blogspot.com/2007/12/bone-setter.html

to any scientific study.[207] Bone-setters commanded a great deal of respect for their treatment of fractures. Prior to the introduction of modern methods from the first half of the twentieth century, it was an established fact that bone-setting was almost the sole preserve of TBS. Traditionally, the practice was used to serve the needs of the people in the community.[208] Amongst chiefs and their subjects were people who were gifted. Noticeable amongst the gifts used in meeting the needs of the community was bone-setting. Practitioners in this field mostly hoped for the blessings of God in serving their community and patients who were healed gratefully presented gifts in the form of fowls, sheep, and goat and during monetization practitioners received money.[209]

Two principal issues accounted for the thriving of traditional bone-setting in Asante in the face of colonialism especially in the first half of the twentieth century. Firstly, the entrenched belief by some TBS in Asante that modern health care practitioners do not set bones, the belief which stressed that doctors engaged in a different form of surgical operation rather than bone-setting.[210] The second view was based on testimonies recorded in the first half of twentieth-century Asante. Patients who suffered from fractured and broken bones returned from hospitals to seek treatment from TBS because they healed faster and considered their treatment efficacious.[211]

[207] Interview with Adamu Allah Bar, at his bone setting centre, Allah Bar, Kumase, 9th February, 2008, H. M Hemmila, M.S, Keina, Nen-Kiukaanniemi, S, Levoska, and P Puska, (Ed.), "Long Term effectiveness of Bone-Setting, Light Exercise Therapy and Physiotherapy for Prolonged Back Pain", *Journal of Manipulative and Physiological Therapeutics*, February, 2002, 99-100

[208] Interview with Adamu Allah Bar, at his bone setting centre, Allah Bar, Kumase, 9th February, 2008

[209] Ibid

[210] Ibid

[211] Interview with Adamu Allah Bar, at his residence, Allah Bar, Kumase, 9th February, 2008, Interview of those who patronized bone-setting at Adamu's residence. The practice of bone-setting has been with the family for over hundred years. There are scores of people in Kumase and Asante at large who patronized the family practice in the first half of the twentieth century and beyond.

There was a general notion in the first half of the twentieth century that Bone-Setters in Ghana including Asante diagnosed and treated fractures in more or less general way and used the same methods for all patients.[212] The bone-setter commenced by examining the affected area thoroughly.[213] Subsequently, the bonesetter usually pulled and tried to reposition the affected body part. The affected area was mostly massaged with cow fat or shea butter to improve blood flow and afterwards dried herbs were applied. The cow fat and the shea butter were also used to prepare herbal cream or paste to massage the affected part. However, Adamu has argued that both the cow fat and shea butter have no medicinal properties.[214] The principal and the common mode of holding fractured bones together was the application of a tight splint at the fracture site. These traditional fracture splints are made from sticks, bamboo, rattan cane, also known as *Oncocalamus yrightiana* and palm leaf axis also known as *Elaeis guineensis*. These materials are knitted together to form mat-like splints that are usually wrapped round the fractured site tightly.[215] Either a bandage was made with a mat of small wooden sticks or plantain leaves. Irrespective of the type of fracture, the limbs were preferably bandaged in an extended position.[216]

With the passage of time, some bonesetters in Asante and Kumase specifically started using rags or *Adikidon* and bamboo sticks to dress the fractured area. As modern medical influence increased in Asante in the first half of the twentieth century and beyond, TBS used gauze

[212] Ibid, M.J.H Aries et al, "Fracture Treatment by Bone-setters in Ghana", *Tropical Medicine and International Health*, vol. 12 No.4, pp564-574
[213] Ibid
[214] Adamu Allah Bar recounted the story on 9th February 2008 at Allah Bar in Kumase. He said that his great grand father started the practice during the era of Okomfo Anokye a traditional priest who lived in *Asante* and helped Nana Osei Tutu during his reign as the King of *Asante*.
[215] J. D, Ogunlusi, C. I Okem, Oginni, "Why Patients Patronize Traditional Bone Setters", *The Internet Journal of Orthopedic Surgery*. 2007. Volume 4 Number 2.
[216] Interview with Adamu Allah Bar, at his bone setting centre, Allah Bar, Kumase, 9th February, 2008.

bandages, cotton bandages and plaster as well as sticks.[217] It is important to note that the traditional methods of manipulation are still persistent in the practice of bone setting in Asante and Kumase.[218]

By the mid twentieth-century and beyond, bonesetters in Asante offered a more extensive treatment. Besides applying a kind of Plaster of Paris (POP), they also added medicinal herbs in the treatment of fractured bones. In addition, patients who had opened fractures visited hospitals for treatment to heal their wounds and then returned to bonesetters to cure their fractures.[219] This was premised on the belief that surgeons repair bones, whereas bonesetters strengthen them.[220] Bonesetters did not and still do not use X-ray machines. This made it and still does make it difficult for a bonesetter to detect what goes on inside the body. With the introduction of x-ray machines, cases of patients who had visited hospital before going to bonesetters had additional information about their fractures.[221]

Again, only a few patients received splints or clutches, occasionally they received a massage of the skin or had to drink a kind of herbal mixture. Adamu Allah Bar in Kumase supports this assertion. He attests that "We prepare concoctions from roots, leaves, and stems for the patient to drink whilst he undergoes treatment" [222] An example of the activities of a bonesetter is the

[217] Ibid
[218] Ibid
[219] Interview with Adamu Allah Bar, at his bone setting, Allah Bar, Kumase, 9th February, 2008
[220] Ibid
[221] Ibid
[222] Ibid, Aries et al, "Fracture Treatment by Bone-setters in Ghana", *Tropical Medicine and International Health*, vol. 12 No.4, 564-574

observation made by Nathan and others at Asante Mampong where twenty-seven year old Kaakyire assists the mother in setting bones:

> Nathan and I watched him work on a four year old boy who had been pushed down in the school yard and snapped clean the wrist in his bone. The boy's father cradled him between his legs while Kaakyire gently examined the bone with his fingers, making sure it was still joined the way he had set it - as kids often rattle it out of it's puzzle piece fit again - and then rubbed his arm with herbs, wrapping it in a banana leaf, then a strip of rubber to trap the heat of the herbs which are to meld the bone and finally, wrapping it with gauze and setting it with wooden sticks.[223]



It is important to note that bonesetters in Akan areas of Ghana and for that matter, Asante, held different views about whether patients and bonesetters were to perform rituals to deities to hasten the healing process. Whereas some believed that rituals ought to be performed, others believed that the activities of bonesetters were not connected to the roles of traditional priests.[224] What accounted for this school of thought was that we had new breed of bonesetters who were either influenced by European education or influenced by Christian missionaries.[225]

Treatment took several weeks to months and every three days, on an average, the bonesetter inspected the fracture mainly to renew the applications. Irrespective of the kind of fracture, patients were sometimes advised to fully use and carry weight on the body part after three to four weeks even if they felt pain.[226] This notwithstanding, the setting of a fractured bone was done most of the time without basic knowledge of anatomy, physiology or radiography which made

[223] Ibid
[224] Ogunlusi, Okem, Oginni, "Why Patients Patronize Traditional Bone Setters", *The Internet Journal of Orthopedic Surgery.* 2007. Volume 4 Number 2., Interview with Adamu Allah Bar, Allah Bar, Kumase, 9th February, 2008
[225] ., Interview with Adamu Allah Bar, Allah Bar, Kumase, 9th February, 2008
[226] Ibid
[202] Ibid

limb and life threatening complications inevitable. These complications vary from tetanus, deformities and amputation to death.[227] However, fracture treatment in Asante, and for that matter Kumase, could serve as a model for respectful and efficient co-existence of indigenous and biomedical medicine in Ghana.

### 3.5 Traditional Birth Attendants (TBAs)

In Asante, conception was considered a happy phenomenon. This is because procreation was seen as part of the continuation of the genealogy of one's family. Therefore, to be childless was disastrous.[228] However, the social impact of the childless woman was mitigated when it was found out that the childless woman once carried a fetus but could not carry it to full term as a result of miscarriage or child death.[229] Child birth was therefore closely watched and here the experts in the community were the TBAs. The TBAs who were mostly old women were part of the kin group who were noticeable experts in caring for people and had knowledge of herbal application.[230] These older women were the sole providers of midwifery care prior to the introduction of European forms of medicine.

The support which was given to women during childbirth was purely indigenous, especially during the period 1902 when the British had fully taken over Asante. European influence was then not dominant. Hence, it was believed by both practitioners and adherents that all children

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[228]P, Sarpong, *Ghana in Retrospect; Some aspects of Ghanaian Culture* x(Accra: Ghana Publishing Corporation, 1974) 85

[229] Ibid

[230] Interview with Kwaku Gyewahom, Alias Papa Nkramo, at his residence, Krofrom Abodwese, Kumase, 10th December 2007

were to be born through natural means.[231] Disregard for surgical operation to aid child birth persisted in traditional Asante society even until the 1920s and 30s. It needs to be pointed out that even if they had been in favour of surgery, they did not have the skills to carry out surgical operations. However, the argument in the 1940s and 50s to defend the stand against such operations was based on the belief that a woman was likely to be operated upon during subsequent deliveries if she was operated upon during the first time of delivery, stressing that it could deteriorate the health of the woman and create deleterious future consequences and even death.[232]

In Asante, pregnancy was termed as warfare, this was not because they did not want the unborn child but because child birth could result in death.[233] They were noted to be one of the avenues through which witches work out havoc on their helpless victims.[234] It was therefore the responsibility of the pregnant woman and the TBA from the stage of conception to do everything possible to ward-off any disaster and to have easy childbirth. These were found in the use of herbs, bark of trees, seeds and special foods as anti-natal drugs. Such practices were repeated in post-natal care.[235]

[231] Ibid
[232] Interview with Kwaku Gyewahom, Alias Papa Nkramo, at his residence, Krofrom Abodwese, Kumase, 10th December, 2007
[233] Sarpong, *Ghana in Retrospect, Some aspects of Ghanaian Culture* , 85
[234] Ibid
[235] Interview with Kwaku Gyewahom, Alias Papa Nkramo, at his residence, Krofrom Abodwese, Kumase, 10th December, 2007

It was with tact and an old indigenous expertise that the TBA worked. Firstly, it was generally accepted that the term of a pregnant woman could exceed the normal term of nine months.[236] However, complications in child birth were severally attributable to a misdemeanor on the part of the expectant mother or a breach of the advice given by the TBA. For example, pregnant women were not to eat proteins in excess since it could cause the fetus to overgrow in the womb.[237] Over time, they were advised not to take alcoholic beverages or drinks. It was also a belief that if the expectant mother saw a monster it could influence the events of the child's birth. Significantly, until the TBA saw the pregnant woman going through *nteteho*, (an uneasy feeling in the womb showing the preparedness of the unborn baby to enter the world), it was unnatural and therefore unacceptable to aid the pregnant woman through delivery. This, as it were, was mostly accompanied with a secretion of liquid and potentially a show of blood.[238] Significantly, the TBA believed that the unborn baby could be born from the seventh month onwards.[239] The apparent lack of appreciation of surgery by an expectant mother and the TBAs who aided delivery even during the first half of the twentieth century vaguely showed a lack of in-depth knowledge in physiology and anatomy.[240] There is an attestation that in instances where there was hemorrhaging during child birth, leaves were made into decoction and applied at the cervix to stem the flow.[241] In instances where the baby did not present with the head but rather with the feet, safe delivery was ensured through the application of a slippery herbal decoction at the cervix to ensure that the baby's head rather presented or the extent of danger was minimized.[242]

[236]Ibid
[237] Ibid
[238] Ibid
[239] Ibid
[240] Ibid, Response from mothers who visited Kwaku Gyewahom during the time of the interview
[241] Ibid
[242] Ibid, during a field interview with Kwaku Gyewahom, Krofrom-Kumase (2007), he attested that the application of decoction at the cervix is an old practice which is tried and tested. As a practitioner he had several of such cases and could successfully aid the delivery of such babies.

Being aware of the looming danger in child birth, some TBAs posed as spiritualists and aided delivery with the use of charms and amulets worn around the arms, waist, or hanged around the door post of the house of the pregnant woman basically to prevent witches, magicians, sorcerers and other evil powers from attacking both the pregnant woman and her unborn child.[243]

As traditional midwives, TBAs in Asante over the period served also as paediatricians. They were well respected in Asante as those who had expertise in meeting the health needs of children or infants in the community. They were believed to be supernaturally endowed with the gift of finding out what was wrong with infants and were able to choose suitable treatment for cases that were presented to them.[244] Further enquiries have shown that from 1902 to 1957 TBAs received complaints of feverishness, hotness, *asabra* which was vaguely described as malaria, convulsion, babies with bloated stomach or abnormal head and boils.[245] These conditions were treated with herbal preparations. Over the period, to determine what disease a baby had been infected with was based on observation and the handling of similar cases over a period of time.[246]

The first half of the twentieth century saw an upsurge in colonial influence in Asante. In 1931, the colonial administration introduced the Midwives Ordinance. The intent of this Ordinance was to enforce the training and control of midwives in Ghana and Asante specifically as enshrined in

[243] Sarpong, *Ghana in Retrospect; Some aspects of Ghanaian culture,* 85
[244] Interview with Kwaku Gyewahom, Alias Papa Nkramo, 10th December 2007, Krofrom Abodwese-Kumase
[245] Responds from elderly women who either patronized the services of TBAs or those whose parents patronized their services, Interview with Kwaku Gyewahom, Alias Papa Nkramo, , Krofrom Abodwese-Kumase, 10th December 2007
[246] Ibid

Gazette number 85 of 1931.[247] Purposefully, the ordinance ensured that no person other than a duly qualified medical practitioner, a registered midwife or a person whose name was on the list of unqualified midwife (Here, reference is made to TBAs who have been noted or listed by the Colonial Administration) was permitted to habitually attend to women in child birth within the limits of Kumase or any place within which the governor by order declared.[248] Punitive actions were taken to enforce the Midwives Ordinance. For instance, anyone who contravened the Midwives Ordinance was made to pay a fine not less than ten pounds.[249]



The Colonial Administration was very much concerned with the operations of unqualified midwives; here reference is being made to TBAs. Applications from TBAs within the jurisdiction of Kumase and its environs were submitted for registration before 1st September, 1932.[250] Notices were sent round to chiefs and sub-chiefs and they were accordingly asked to advertise the need for unqualified midwives and women who took fees for midwifery care to report at the Senior Health Officer's Office, Kumase, and apply to be registered.[251] These notwithstanding remote villages were neglected, thus, it increased the number of child birth complications in the remote areas of Asante and further deepened the woes of families who lost their loved ones through painful ordeals and complications in child birth.[252]

[247] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, The Midwives Ordinance, 1931, ratified in Asante in Gazzette number 85 of 1931
[248] Ibid
[249] Ibid
[250] Ibid
[251] Ibid
[252] Ibid

In spite of increasing colonial influence on Asante, midwifery outside Kumase was mostly in the hands of TBAs.[253] The reason was that villages beyond the reach of health posts of the colonial administration had only one option, to stick to the forthcoming services of TBAs. The vast distances between colonial health posts did not allow the pregnant women to easily access the health posts. The situation was worsened by certain entrenched traditional beliefs that affected the choice of European medical therapies by the pregnant women. As late as 1945, that is, over forty-three years of strong colonial influence, most pregnant women in Asante were not seen patronizing modern midwifery care.[254] On 6th April, 1945, the Lady Medical Officer, Dr. Chapell complained that many women in the hinterlands of Asante who visited the child welfare clinic in Kumase had serious complications in their pregnant conditions.[255] Pregnant women with complications who visited the child welfare clinic in Kumase and were told to return for further investigations and treatment refused to turn up. The colonial administration gave directives to chiefs to search and find those women and furnish the medical officer with the necessary information concerning their plight.[256] The reason was noted to be based on fatigue involved in travelling long distances from hinterlands to Kumase and also the fear of being operated upon.[257]

One of the adjunct efforts by the Colonial Administration was to train nurses and midwives that would help meet the health needs of both mothers and their children. By 30th November, 1949, the Medical Department in Kumase set off with two major objectives, firstly, to recruit for training pupil nurses at the General Hospital and secondly, to train pupil midwives at the

[253] Response from elderly women who either patronized the services of TBAs or those whose parents patronized their services, Interview with Kwaku Gyewahom, Alias Papa Nkramo, 10th December 2007, Krofrom Abodwese-Kumase
[254] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Medical Hospital file 1928-1947
[255] Ibid
[256] Ibid
[257] , Interview with Kwaku Gyewahom, , at his Healing Centre, Krofrom Abodwese-Kumase, 10th December 2007

Midwife Training School.[258] The intention was to train female nurses within the age groups of seventeen to twenty. Response from the people in an earlier request made by the Medical Department was disappointing. In the whole of the Asante Confederacy, thirty-seven people responded.[259] This notwithstanding, on 8th December 1949, the Ashanti Confederacy Council made dispatches offering scholarship for students to be recruited into nursing training. However, students who were recruited were bonded for five years after training. This policy increased the number of trained nurses and midwives who invariably augmented the efforts of TBAs and gradually took over the field especially in Kumase after 1957.[260]

Another significant development was the fact that by 1948 midwives who had been trained by the Colonial Administration were not happy about their salaries. The Assistant Director of Medical Service encouraged the native jurisdictions to improve the allowances of midwives and the Native Authorities were obligated to subsidize the cost of midwifery services in their communities. This was adhered to as it bolstered the confidence of practitioners and helped to meet the health needs of mothers and children in the Asante Confederacy.[261] In contrast, midwifery care was not very extensive in Asante. Kumase was farther advanced in midwifery care than places like Bekwai and Offinso. For example, in a letter from the *Offinsohene* on 29th June, 1948, through the *Asantehene* to the Assistant Director of Medical Services, Kumase, the *Offinsohene* noted:

[258] Manhyia Archives of Ghana, Kumase, MAG 21/1/72, Correspondence between the Medical Department Ashanti and the Ashanti Confederacy
[259] Ibid
[260] Ibid
[261] Manhyia Archives of Ghana, Kumase, MAG 21/1/71, Correspondence between the Commissioner Ashanti and District Commissioners of Kumase, Sunyani, Bekwai, Mampong, 1948

> The Offinso Division is a large one extending to about seventy miles from Kumase. It has about seventy villages and towns with a female population of about twelve thousand. Since my enstoolment, April, 1946, I have watched with keen interest and noticed that so many expectant mothers died through lack of scientific medical aid at the time of labour. This is mainly due to the fact that the poor village women find it very expensive to travel to from seventy miles (Akomadan and Afrantwo) to Kumase for medical treatment when pregnant and particularly at the time of labour.[262]



It became a regular practice in 1948 and 1950s that midwives who were dispatched to certain divisions in Asante were responsible for touring villages in the particular divisions to see to educating expectant mothers and mothers on how to take care of themselves and their babies during pregnancy and after child birth.[263] To emphasize, midwives who were dispatched to respective divisions in Asante were supported by those divisions. The midwife who was stationed at Offinso toured the township and places that had no road transportation like Kyekyewere, Tetrem, Kwapanin and Kyebi to administer treatment to the sick and took care of pregnant women, mothers and their babies.[264]

### 3.6 Training of Indigenous Healers in Asante

This section focuses on the training of priest healers, herbalists, *Wanzams,* Bone-Setters and Traditional Birth Attendants.

In traditional Asante society, to become a healer of disease required a spiritual rebirth, which called for an initiation. The healer was from a priestly class, which believed that disease and

[262] Manhyia Archives of Ghana, Kumase, MAG 1/21/71, Correspondence between *Offinsohene* and The Assistant Director of Medical Services, 29th June, 1948
[263] Ibid
[264] Manhyia Archives of Ghana, Kumase, MAG 1/21/71, Correspondence between *Offinsohene* and The Assistant Director of Medical Services 29th June, 1948

pestilence were the acts of the deities. In Asante, for one to become an IPH, he had to be possessed by a deity but such a possession had to be ascertained by a qualified traditional healer. Akesson referring to Christiansen stated, "The primary requisite to become an IPH of a particular deity or shrine was a possession by a deity."[265] Also, the final decision to permit an individual to enter into the training traditionally was left to his relations. Both men and women were accepted as traditional medical practitioners and were trained at separate shrines.[266] According to Geoffrey Tooth:



> In the institution, the new entry was taken to the cemetery for a ritual bath in order to get into contact with the *nsamanfo*, the spirits of his ancestors. This was a complex supernatural organization that centred on ancestor worship in which the institution is a part. The essential fact is that intimate objects-deities, shrines and things become invested with magico-religious powers. These ancillary beliefs played a great part in the everyday life of the traditional society.[267]

The training of the IPH took a period of three years. The trainee left his house to live in the house of the trainer on the compound of the shrine. He or she trained under the constant observation of the trainer. According to William Good, during the first year of training, the trainee was not given any form of remuneration but was expected to perform any task that was given him by his trainer. Although he was not out of the village community, he had to observe many restrictions and fulfill many obligations. In essence, he was in a new community within a community. [268] In the second year of his training, the trainee was taught the names of trees, plants and ferns and the spiritual properties of each. The construction and the use of charms were

[265]S.K, Akesson , "The Secret of Akom", *African Affairs*, LX (December, 1936) 339
[266] Ibid
[267] Twumasi , *Medical Systems in Ghana*, 24-39
[268] Ibid

also emphasized in this part of the training. In the third year, the trainee was taught water gazing and the art of divination. At the end of this training, he attained the status of a fully-trained IPH.[269] Having completed his apprenticeship, the new IPH was called upon to exercise his gift of spirit possession at certain specific events or times when he acts as a mouth piece to his deity in order to offer advice to those who seek help and to prophesy future events. In his dissociated state he evinced knowledge seemingly beyond his normal capacity, and this combined with the authority with which his position is invested, made him a person of considerable power in the community.[270]

In the same environment of the IPHs were other healers whose training was essential to meet the medical needs of the people of Asante. It has already been observed that the IPHs applied themselves assiduously to the study of the healing art and acquired such knowledge of the properties of herbs and plants which enabled them to effect the cure of many complaints.[271] Herbal knowledge enabled the ordinary people in Asante to meet their health needs whereas the *Asantehene* in the nineteenth century benefited from European medicine, herbal medicine was cheap and served the needs of the poor including slaves.[272] Generally, in Asante, herbal knowledge was not acquired in a formal structured learning environment. By the turn of the twentieth century, herbal knowledge was still with the kin group. Information about the efficacy and the use of what type of herbs or leaves, roots, stems, fruits and seeds of trees or plants

[269] Ibid
[270] Swithenbank, *Ashanti Fetish Houses*,11
[271] Beecham, *Ashantee and the Gold Coast* , 204
[272] Maier, *Nineteenth-Century Asante Medical Practices*,73

relevant to cure specific kinds of diseases was with the kin group.[273] Mostly, it was the elderly women and men who had such knowledge since it was passed on to them from their parents and grand parents. The mode of acquisition of such knowledge was basically through connection and relationship between the young and the elderly whose storehouse of indigenous herbal knowledge could sometimes not be easily opened at the bidding of people they did not have trust and close relationship with.[274] This class of herbal practitioners or physicians was not necessarily hewn out of the priestly class but was born into a worldview that is quite dissimilar from what was seen in the latter part of the twentieth century. Amongst the indigenous practitioners was the belief that the blessing of the Supreme Being *Onyankopon* or Creator known in Akan as *Oboadee* should be invoked at every opportune time and mostly in instances when one received visitors.[275] Growing up in the court of the *Asantehene*, in the 1950s, Daniel Amponsah learnt that in several of the villages of Asante, *Nyamedua* "Tree of God", was planted in front of several houses. Pots that had collected rainwater, which dripped from the *Nyamedua*, are fetched and sprinkled on visitors to such households especially when they were leaving as a sign of invocation of the blessing of *Onyankopon*. Significantly, the chief medicaments were only considered potent when the indigenous healer who might not be from the priestly class or an *Obosomfo,* that is subject of a deity, acknowledged the Supreme Being, *Aduro a mereye yi se Onyankopon hyira so a ebegye wo*, meaning, "if God blesses this medicine I am giving you, it shall cure your sickness".[276]

[273] Interview with Daniel Amponsah, Alias Koo Nimo, Edwase-New Site, Kumase, 10th June, 2009. Daniel Amponsah is a court musician in Asante. He grew up at the palace of the *Asantehene* Opoku Ware II in the second half of the first half of the twentieth century.
[274] Ibid
[275] Ibid
[276] Ibid

Knowledge about healthy diets was accrued directly or indirectly by observing what the elderly advised them to eat and not to eat; it was also based on the lifestyle of the people. Mostly, what was considered as *dee Onyame anoa*, meaning what God has cooked was the best form of diet. For instance, in the first half of twentieth-century Asante, honey was preferred to sugar. Honey was considered to be medicinal whereas sugar was noted to have certain defects or ill effects on people.[277] *Abemuduro*, that is a combination of herbs and palm nuts to prepare soup was considered medicinal and was able to keep the body healthy and prevented diseases.[278] There are a lot of noticeable examples in Asante where, for instance, the decoction of the stem of *ekyem* also known as *Adenia cissampeloides* is mixed with palm soup and eaten by a woman who had given birth recently to heal the internal sores and enhanced the woman's ability to produce breast milk.[279]

Again, one of the medical practices introduced into Asante, which is circumcision surgery, became well entrenched in Asante in the first half of the twentieth century. As a result of strong migrant and Islamic influence there was continuity in the activities of Wanzams in Asante. The art of circumcision since its inception in Asante before the twentieth century remained a family business. Knowledge was passed on from one generation to the other.[280] One Mohammed Fuseini, a *Wanzam* who resides at Aboabo, Kumase, attested that his father who was a Nigerian from Katsina settled at Aboabo to start the practice of circumcision. As a young boy his father passed on the knowledge and the art of circumcision to him and since the 1930s he has been

[277] Ibid
[278] Ibid
[279] O.B, Dokosu, *Herbs of Ghana* (Accra: Ghana Universities Press, 1998) 94
[280] Interview with Mustapha Fuseini , at his residence, Aboabo, Kumase, 19th February 2008

involved in circumcision as a full time job and has passed on the knowledge and the art to his children.[281]

The pristine aspects of circumcision were passed on from the latter part of the nineteenth century to the first half of twentieth century Asante and beyond. The Muslim ritual of the washing of hands was considered a valuable accompaniment on the road to becoming a professional *Wanzam*. Over the period the washing of hands was done in accompaniment with an Islamic recitation.[282] But to judge the success of a trainee was truly based on whether he was humble and most importantly, spiritually gifted. This is exemplified by the fact that out of twelve children of Mohammed Fuseini, only two, Mustapha Fuseini and one of his brothers were able to master the art.[283] To emphasize, it was predominantly a male field until the introduction of midwifery schools, especially in the first half of the twentieth-century when several women got into the field.[284]

Similarly, in Asante, the training of bone-setters was based on transfer of knowledge from one generation to the other, that is, the transfer of knowledge from within a kin group in succession. Adamu Allah Bar, earlier referred to, attests that bone-setting has been with the family for centuries. His great-grand parents started the practice at Kona, a village near Kumase, and transferred the knowledge through his grand parents until he also had the privilege of acquiring the knowledge and the art from his father.[285] Further enquiry has shown that one Kaakyire,

[281] Ibid, at the time of my interview with Mohammed he claimed that he was eighty years.
[282] Ibid
[283] Ibid
[284] Ibid
[285] Interview with Adamu Allah Bar, at his bone setting centre, Allah Bar, Kumase, 9th February, 2008.

which means last born, who learnt bone-setting from his eighty-two year old mother has shown that the art was naturally learnt through careful observation among other things. This is summed up in the attestation of Kaakyire:

> The knowledge he gained from keenly watching his mother and assisting her started to work its way into his gentle fingers, sapped his muscles with acute sensitivity and poured into his heart patience from beyond.[286]



Similarly, Adamu has pointed out that knowledge of bone-setting was passed on from father to son as early as the age of seven since children were perceived to learn faster through observation. As a student of bone-setting, Adamu observed the methods and skills employed by his father. He keenly observed the ingredients and the content of every herb that went into the making of various concoctions and decoctions for the healing of patients.[287]

Just like circumcision surgeons, discipline was required from the trainee but acquisition of knowledge in bone-setting did not make the trainee a healer. The one who went through the training ought to have been divinely gifted. Before the twentieth century Asante some practitioners in certain parts of Asante took their trainees through a "Divine gift test".[288] This test was done to ascertain who amongst the children in the family was supernaturally endowed by God to continue with the family tradition of setting bones. Potential trainees were sent to the forest by the healer who broke the stem of plants and instructed the potential trainees to tie.

[286] http://gartoninghana.blogspot.com/2007/12/bone-setter.html
[287] Interview with Adamu Allah Bar, at his bone setting centre, Allah Bar, Kumase, 9th February, 2008.
[288] Ibid

Upon returning after a week to the forest the healer recruited those whose plant stem had joined into the traditional school of bone-setting.[289]

Graduating from the traditional school of bone-setting meant that the trainee had imbibed all that was to be learnt and had obtained the blessings of his trainer. The business of bone-setting will never be truly owned by the newly graduated bone-setter unless his trainer blessed it to be so. The absence of the blessing meant that the trainee had to continue to tread in the domain of his master abiding by his rules until the day comes when it will be passed on – heart, soul and history to him. The spiritual blessing was strictly adhered to even in the first half of twentieth century Asante and beyond.[290]

Similar to the practice of Wanzams in Asante during the first half of the twentieth-century, bone-setting was highly influenced by Muslim culture. Arabic recitations were learnt and administered especially before and after treating a patient.[291] The recitation was merely to ask for the hand of God but mostly, in the first half of the twentieth-century Asante colonial influence had shifted emphasis to the practical. Unless a bone is practically set through manipulation, the recitation did not attain its desired objective.[292]

Traditionally, the TBA in Asante learnt midwifery care through observation, which was not concerned with any clinical or laboratory training. Recruitment into the art was mostly from

[289] Ibid
[290] Interview with Adamu Allah Bar, at his bone setting centre, Allah Bar, Kumase, 9th February, 2008.
[291] Ibid
[292] Ibid

members within the kin group but at certain times people within the community who were closer to the group and were privileged were recruited into the training.[293] The trainee observed her trainer whilst she aided pregnant women during child birth. He did so for a period not less than three years. The trainee went on errands and by so doing he was able to familiarize himself/herself with the tenets of the practice.[294] The TBAs believed that the finest Traditional Birth Attendants were those who were naturally gifted or were supernaturally endowed. Trainees who were supernaturally endowed were faster learners than those who learnt the art for the sake of employment.[295]

To emphasize, trainees were advised to stay on for an additional year to render voluntary service to their trainer. This increased the period from three to four years. Such voluntary services added to the knowledge and skill of the young practitioner. During this period he was able to relearn what he missed during the three year period and to unlearn some of the misconceptions, that is the pain of the rigorousness of the study among other things, which he haboured during the period of his apprenticeship.[296] During this period the trainer looked out for certain virtues that would necessitate a successful practice. These included obedience, faithfulness and hard work.[297] Again, it was the responsibility of the trainer to school the trainee to enhance his appreciation of the fact that he was being inducted into an honourable institution which demanded diligence, a vocation which was quite rewarding.[298]

[293] Interview with Kwaku Gyewahom, Krofrom-Abodwese, Kumase, 10th December,2007
[294] Ibid
[295] Ibid
[296] Interview with Kwaku Gyewahom, at his residence, Krofrom-Abodwese, Kumase, 10th December, 2007
[297] Ibid
[298] Ibid

It is generally believed that British interest in Asante was not to train indigenous medical practitioners to continue to dominate the healing profession amongst the indigenous people. It is as a result of this that training of some indigenous people in modern therapeutics, that is nursing and Midwifery care were primarily focused on modern or biomedical therapeutics rather than retraining of indigenous healers in modern hygienic methods or techniques especially in the first half of the twentieth century.[299] Yet, it is understood that with time there has been several changes in spite of the continuity in the indigenous medical practices. Circumcision surgeons for instance from the 1950s started using gauze bandages and plasters. Since the 1950s it was noted that circumcision surgeons mixed palm kernel oil with some modern medicines to dress the wound of the newly circumcised. Also, bonesetters began accepting X-ray reports to help them determine the course of the treatment or the angle from which the bone is being set. Modern gauze bandages and plasters were also used by bonesetters in the 1950s. Practitioners in the class of Adamu Allah Bar also administered some paracitamol and other modern drugs to help ease the pain their patients went through. Islamic recitation or religious connections with respect to the ministration of the Bonesetter became disputable in the 1950s as a result of Christian missionary and modern medical influences. The TBA did not only see herself as the custodian in aiding women during delivery but was also quick to advice her clientele to visit colonial medical posts to receive certain medical attention which she deemed fit. It is also understood that there were practitioners like Sam Quainoo who had had some form of modern midwifery training which they incorporated into their practice. However few they were, their practices had the potential to reduce the life threatening conditions some of the women went through during the period under study. Again, the general belief of spiritual

[299] Ibid

influence in the cause of diseases and their treatment was not entirely assailed since the world view of the Asante pertaining to spirit or supernatural forces is still not changed.



## CHAPTER FOUR

## COLONIAL INFLUENCE ON INDIGENOUS MEDICAL PRACTICES IN ASANTE

This chapter focuses on the influence of the Colonial Administration on Indigenous Medical Practices, which include the formation of herbalist unions and associations, registration of indigenous healers, and Colonial Administration's clamp down on witch finding fetishes in Asante.

### 4.1 Reform of Indigenous Medical Practices

The major challenge that confronted the indigenous healers and the colonial administration at large in the first half of the twentieth century was the attempt to modernize indigenous therapies

or remedies, validate them by modern procedures and the attempt by the practitioners to persuade the Colonial Administration to license qualified indigenous healers.

The quest for recognition and the need for indigenous healers to improve upon their service delivery as demanded by the Colonial Administration necessitated the formation of traditional healers associations like the Society of African Herbalists, which was formed at Sekondi on 12th December, 1931 with its president being Kwesi Aaba. Their quest was to raise the local practice of "Medical Herbalism" to a high and refined standard and to seek for a free and unhindered practice for its members.[300] It has been noted that the Colonial Administration although came to terms with this fact they denied them the official recognition they wanted but made no attempt to suppress herbalist or any other indigenous healers.[301]

In 1934, efforts were made by the Society of African Herbalists to rid the indigenous medical system of what has been described by the Colonial Administration as charlatanry, fraud and superstition. This was attributable to the fact that several of the practitioners in Asante engaged in some form of religious practices, either in the form of propitiation of deities or the making of incantations. According to the Colonial Administration, it was the ignorance of the indigenous people couched in a belief in magic and witchcraft that cannot be explained by reason which resulted into a state of fear. Specifically, members of The Society of African Herbalists were required to report all contagious diseases to government doctors. In spite of these efforts, the indigenous healers were refused an official license of recognition because the Colonial

[300] Patterson , *Health in Colonial Ghana, Disease, Medicine and Socio-economic change, 1900-1955* , 27
[301] Patterson , *Health in Colonial Ghana, Disease, Medicine and Socio-economic change, 1900-1955* , 27

Administration hinted that there were verifiable heap of quack remedies in their practice.[302] Also, it was considered unnecessary at that stage of the society's development. In addition, a colonial office circular dispatch, citing a suggestion made by Lord Hailey in an African survey that raised questions on studying native medicine, was rebuffed because the Medical Department lacked the resources to do so.[303]



Again, Kwesi Aaba proposed a herbalist school where he will teach subjects like African dietetics, material medica, diagnosis, modern hygiene and sanitation. The others included African Herbal Massage or manipulative therapy, Astro-Herbalism and Organic Chemistry. [304] However, this was to no avail. In his booklet, *African Herbalism: a mine of Health*, Aaba wrote and predicted that future African chemists will find useful medicines in local herbs. This was indirectly rejected on the premise that a study in African herbs was expensive. It was noted that any screening programme would be expensive and moreover, it had to be done in Britain because there were no local laboratories with the necessary facilities. The Department of Medical Service doubted that anything useful enough to enter into pharmacopoeia would be found, clearly a sign of disregard by the Colonial Administration for what the indigenous medical practitioners could provide for the indigenous people.[305] Although the indigenous healers were not given firm recognition, the Medical Department was fairly tolerant. They conceded that a minority, primarily among the herbalists, were honest and were able to help some patients. Customary

[302] Ibid
[303] Ibid
[304] Ibid
[305] Ibid

rulers, as are found on the Asante Confederacy Council, were given the power to license traditional medical practitioners who were determined to be honest and capable.[306]

By 1952, indigenous medical practice continued to be closely associated with deities and the role of their intermediaries who are also known as *Akomfo*. Again, there was an attempt by indigenous medical practitioners themselves to streamline their activities.[307] After the Association of African Herbalist, was another healing Association that took off in the 1950s. This was the Ghana Psychic and Traditional Healing Association. At its embryonic stage, according to Kwaku Gyewahom, what is known to have become part of the Ghana Psychic and Traditional Healing Association formed with a grand opening in Lateh Akuapem in 1962 included members with no formal education.[308] However, the literates amongst them did not understand what went into the indigenous healing practices. They joined the Association for their personal gains. However, prior to the coming together of various practitioners in Kumase and for that matter Asante, individuals practised in their enclaves and sometimes chose to do what pleased them.[309]

Unlike the Association of African Herbalists that sought to take out religious underpinnings in indigenous medical practice, the Association of Ghana psychic and Traditional Healers Association was formed under presidential directives to uphold, protect and promote the best in the traditions invested by the ancestors in the IPHs including priestesses and herbalists in Ghana.

[306] Ibid, Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Applications for physician licenses 1934-1947
[307] An Interview with Kwaku Gyewahom , at his residence, Krofrom Abodwese, Kumase, 10th December, 2007
[308] Ibid
[309] Ibid

The membership of the Association included herbalists, priests and priestesses.[310] The Indigenous Priests and Priestesses who were admitted into the Association were those who had successfully undergone training at a reputable shrine and possessed an unquestionable knowledge of Ghanaian herbs. Such practising priests or priestesses were licensed. All the traditional priests and priestesses who had undergone intensive training in the herbal milieu were clearly classified as priest-physicians. Also, a person who possessed unquestionable knowledge about Ghanaian herbs acquired through a period of training at a reputable shrine or under a competent herbalist and was licensed also qualified to be a member of the Association. [311]

Members were required to pay a membership fee of four shillings a year. The executive members of the branch in Asante paid one pound four shillings a year. This was divided as follows: ten shillings was kept in the District Treasury, ten shillings in the Regional Treasury and four shillings in the National Treasury. This was to ensure the smooth running of the Association, which was manned by a Chairman, Secretary, Organizing Secretary and the executives all year round. [312]

In spite of the goodwill of the members of the Association, it was found out that since its inception, the association suffered from several internal unrests. The following precipitated the

[310] Ibid
[292] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Correspondence between the Ghana Psychic and Traditional Healing Association, Ashanti Regional Secretariat and the *Asantehene*, 3rd August, 1963

unrest: extortion of money by officers, unpopular officers, disrespect shown to District Commissioners or Chiefs by officers of the Association. The others included questions on the Local, Urban and City Councils especially in connection with the issuing and renewal of licenses as well as tensions brewed by the interference of Medical Authorities and Foreign Agents. [313] In spite of its setbacks, the Association had regulations which would guide it and the entire indigenous medical practice in Ghana and Asante in particular into future prospects.



**4.1a Regulations for the Psychic and Traditional Healing Association**

The Association aimed at upholding, protecting, and promoting the best in Psychic and Traditional Healing in Ghana, and collectively to cooperate with the Ghana Medical Association and the Ghana Academy of Sciences in the promotion of the Science of Herbalism, as well as Psychiatric and Psychosomatic treatment.[314]Membership was opened to any person actively engaged or interested in psychic and traditional healing in Ghana, for example, herbalists, priests and priestesses as well as those associated with shrines. Membership carried with it the obligation to accept and abide by the aims of the association and refrain from acts that could bring the Association's name into disrepute. In addition, members were to refrain from any practices, which could in any way endanger public health and morality.[315] Such a regulation was essential because it had the tendency to prevent quackery and also ensure public safety.

[293] Ibid
[294] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Correspondence between the Ghana Psychic and Traditional Healing Association, Ashanti Regional Secretariat and the *Asantehene*, 3rd August, 1963
[295] Ibid

[296]Ibid

The constitution of the Association placed it under three functional headships in terms of organization and administration. They were the National, Regional, and District levels. The activities of the Association were formulated and supervised by a National Committee comprising a National Chairman, National Vice Chairman, National Secretary, National Treasurer and National Organizing Secretary. Not more than one of these officers was to be from one region.[316] The National Committee was required to meet at least once every quarter. The National Chairman, in consultation with the National Vice Chairman, and the Regional Chairman, convened meetings. Two-thirds of the recognized members formed a quorum. The National Committee consisted of selected people from the various districts. The names of the proposed officers were to be submitted two months in advance. These were voted on by the outgoing members of the Committee. Officers were elected annually.[317]

Again, regions were determined by the National Committee in accordance with the political and administrative regions of the Nation. Each region had the following officers: The Regional Chairman, Regional Vice Chairman, Regional Secretary, Regional Treasurer and Regional Organizing Secretary. The officers at the Regional Level were elected annually by popular votes on candidates by candidates nominated by the districts. Two thirds of the recognized members formed a quorum.[318] Also, the District Branch formed the unit of the Association. It comprised all indigenous priests and priestesses as well as herbalists who formed the membership in a district. There was an Indigenous Head-Priest or Priestess who was chosen in consultation with

[297] Ibid
[298] Ibid
[299] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A,Correspondence between the Ghana Psychic and Traditional Healing Association, Ashanti Regional Secretariat and the *Asantehene*, 3rd August, 1963

the District Commissioner and the chiefs concerned. The Executives at the District Level were made up of competent indigenous healers in the district, at least one from each town or village. The District Branch was required to meet periodically, and its deliberations communicated to the Regional Branch, whose responsibility was to discuss and inform the National Committee where necessary. During the deliberations of the District Branch, two-thirds of members present formed a quorum. In addition, a General Executive meeting of the District was to be determined by the Executive. It is significant to emphasize that the District Branch was the Foundation stone of the Association.[319] To emphasize, such devolution of power was to ensure that the Association was able to operate effectively at the local level since it had the propensity to bring together competent practitioners at the district level and expose those whose charlatanry made the practice unpopular during the colonial period.

Again, the Association's Constitution or any part of it could be amended, rescinded or altered by a resolution carried by three-fourths majority votes of a National Committee meeting. The mandate for such changes was first to be obtained from the General Meeting at the District Levels. A proposal regarding any such changes was to be submitted to the National Committee, two months in advance.[320] Significantly, these rules and guidelines for operations ensured that there was advancement in the indigenous medical practices in Ghana and for that matter, Asante. It also suggests that the period of the first half of the twentieth century and beyond ensured the transition from a hitherto disorganized group of practitioners into a seemingly formidable group whose role in the healing of the sick persisted before the advent of the Europeans into Asante.

[300] Manhyia Archives of Ghana, Kumase, MAG 1/1/102A,Correspondence between the Ghana Psychic and Traditional Healing Association, Ashanti Regional Secretariat and the *Asantehene*, 3rd August, 1963
[301] Ibid

### 4.1b Registration of Indigenous Healers in Asante

From the period 1934 to 1955, the Asante Confederacy Council began to issue licenses to honest and capable indigenous medical practitioners. The licenses were intended to separate the genuine practitioners from the quack ones (Here, quackery referred to those whose claims to cure were proven not to be so and those whose medicines according to the Colonial Administration were harmful to the individual's health and well-being). This was so because of the belief that the references upon which such registration could be granted to persons who applied would come from chiefs and people well respected in the respective communities in Asante where such practitioners engaged in their healing practices. Primarily, it was based on the bye-laws made by the Asante Confederacy Council relative to the need for Native Physicians within the Confederacy to procure licenses to validate their practices and to eliminate quack physicians.[321] The office of the *Nsumankwaahene* played a significant role in the issuance of the licenses. Most of the applicants applied through the office of the *Nsumankwaahene* whose office objects such as the use of *Suman*, amulets, rituals and indigenous medicine mattered in Asante customary practices. Significantly, applicants of the physician license had to obtain a testimonial or references from prominent persons in the area where they practised. The referee was preferably a chief or an *Odikro* and any person who could attest to the efficacy of the practitioner's therapy or remedies.[322]

[302] Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Applications for physician licenses 1934-1947
[303] Ibid

Four categories of practitioners applied for the physicians' license. There were those who sought for the license to operate as herbalists, that is, they used purely herbs, stems and roots of plants for the preparation of concoctions and decoctions for the treatment of diseases. There were also Indigenous Priest Healers who employed both the supernatural powers and herbs in curing diseases. They resorted to the use of customs, rituals and propitiations or employing the powers of the deities in the healing process. There were "Spiritual healers" like *akomfo* and those from spiritual churches like the Twelve Apostles Churches.[323] Some of these spiritual healers engaged in fortune telling, full life reading and exorcism. They believed that diseases were caused by contrary spiritual forces that have to be annihilated through "spiritism". "Spiritism" in this sense means employing supernatural forces to counter contrary spiritual disease spirits that cause the medical predicaments of the presumed innocent.[324]

The fourth category, were those who sought for the license to sell herbal potions either on the streets of Kumase or specified areas in Asante. Most of these people were not necessarily experts in the preparation of herbal potions but they were into retailing and marketing. Those who procured the license in order to offer herbal remedies were charged not to administer or prescribe any poisonous medicine or perform any act that is dangerous to life or contravened Cap 57 sections 15, 16 and 17 of the laws of the Gold Coast, 1936.[325]

[304]Ibid
[305]Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Correspondence between the Spiritual Head of Cherubim and Seraphim and the *Asantehene*, 4th April, 1955
[306]Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Correspondence between the Spiritual Head of Cherubim and Seraphim and *Asantehene* , 4th April, 1955

Again, the bearer of the Medical Herbalists licence could not pose as a witch or wizard finder. Exposing people as witches or wizards was contrary to Order in Council number 28 of 1930. This notwithstanding, the practitioner could cure anyone who felt that his infirmities were caused by disease demons or witches. Also on 31st January 1936, practitioners were told not to charge more than thirteen shillings.[326]



**4.2 Rules and Regulations for holders of the Physician Licence Certificate in Asante**

Holders of the physician Licence were charged to renew their license every year. They paid a maximum of four pounds three shillings for the renewal of their license. The certificate bore the signature of the Financial Secretary of the Kumase Division Native Authority and the name of the native physician to whom the licence was granted. The holder of the certificate also had a serial number prefixed with an alphabet, which made his certificate distinct from other holders of the physician licence.[327]

The bearer of a physician licence was required to adhere to several rules, which were paramount so far as the practice of indigenous medicine in the first half of twentieth-century Asante was concerned. They were required to adhere to the following:

[326] Ibid

[308]Manhyia Archives of Ghana, Kumase, MAG 1/1/22 Rules and Regulations For Holders of the Physician license, a sample Certificate issued to Kofi Mensah of Nkawkaw on 31st December 1953

Every native physician was to hold a licence in the form and manner as explained in paragraphs one and two. Anyone who breached this order was punished with a fine not exceeding twenty-five pounds or was imprisoned with or without hard labour not exceeding three months. In certain instances, the offender was required to pay a fine of twenty-five pounds and in addition to that serve three months imprisonment with or without hard labour.[328] Also, every holder of a physician licence who was found to be guilty of practicing harmful medicine with the intent to endanger human life was punished with a fine not exceeding twenty-five pounds or to imprisonment with or without hard labour not exceeding three months.[329]

Again, any licencee who attempted to defraud, extort or charge unreasonable fee was guilty of an offence and based on summary conviction was punished with a fine not exceeding twenty-five pounds or to imprisonment with or without hard labour not exceeding three months or both. Upon demand by an accredited person who was duly authorized by the *Asantehene* to inspect a physician licence, any holder was under obligation to produce his licence for inspection.[330] The native physician licence was subject to renewal in January every year provided the 3d license was handed in for such renewal or upon affidavit that the previous license issued got missing before the period of renewal of licence. All particulars of endorsements in the old licence were to be entered in the new license for the necessary references. Lastly, annual fee payable on this licence was four pounds, thirteen shillings.[331] Significantly, holders of the physician licence were

[309]Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, Native Physician License, 1933
[310] Ibid
[311] Ibid
[312] Manhyia Archives of Ghana, Kumase, MAG 1/1/22 , Rules and Regulations For Holders of the Physician license, a sample Certificate issued to Kofi Mensah of Nkawkaw on 31st December 1953

by inference to live above reproach in their practice. Their ability to do so did not only encourage them to operate freely in the indigenous medical milieu but it also had the capacity to allay the fears of the Colonial Administration insofar as the practice of harmful medicine was concerned.

The rigidity with which the rules were applied in Asante resonated in the Colony. In 1948, as a result of the seeming success of the herbalists' licence in Asante, request came from the Colony to the Asante Confederacy Council to enable them access the documentation in reference to the herbalist licence in Asante and to further replicate it at Cape Coast.[332] The Acting Secretary of the Confederacy further forwarded a specimen of the licence granted by the Kumase division and minutes of Asante Confederacy Council meeting held in 1942, which dealt with the question of granting of physician licence and fees charged.[333] These records proved invaluable and amply met the expectations and needs of the Colony.[334]

In 1948, as a result of a conviction obtained in Accra against a quack doctor, J.S. Prince Agbojan for practising surgery and medicine, receiving payments for practising medicine, importing dangerous drugs and poisons and for dealing in poisons, the Commissioner of Police drew the attention of native authorities to the fact that Agbojan possessed a medical herbalist-practising licence purported to have been signed by a chief whom he had no connection with.[335] It was further recommended that, though the practice the culprit engaged in did not directly fall under indigenous medicine, based on his experience it would be necessary that before herbalist licences

[332] Manhyia Archives of Ghana , Kumase, MAG 21/1/77, Correspondence between The Acting Secretary, Asante Confederacy Council and The Secretary, Joint Provincial Council- Cape Coast, 30th October, 1948
[333] Ibid
[334] Ibid
[335] Manhyia Archives of Ghana, Kumase, MAG 21/1/77, Correspondence between Chief Commissioner, Asante and the Asantehene, 29th October, 1948

were issued by the native authorities, the applicants were to be referred to the nearest police officer, who after enquiries, would be able to advise whether or not the licences should be issued.[336] Upon further correspondence between the District Commissioner and the *Asantehene,* in 1949, the Asante Confederacy Council granted permission that information about applicants of herbalist licenses be seen by the police before such licenses were issued.[337] Such efforts did not only lessen the burden on both the Colonial Administration and the Native Authorities but rather it improved quality and efficiency in the indigenous healing



### 4.3 Colonial Administration's Clamp down on Witch finding Shrines

From 1907, as a result of gradual infiltration of new ideas and progressive trend of European rule, the IPH in Asante began to experience a diminution of power. This made the healers determined to make every effort to retain their practice and continue to have some form of control in the indigenous healing therapies.[338] The IPH strategy to maintain the status quo was mostly couched in false accusation against their skeptics. For example, E.C Fuller the Chief Commissioner of Asante in 1907 upon investigating a false triple murder accusation brought upon one Cudjoe by an IPH, ensured that the chiefs who instigated this were severely dealt with and the fine imposed on the supposed offender was refunded including compensation. The chiefs were publicly censured for getting involved.[339]

[336] Ibid
[337] Manhyia Archives of Ghana, Kumase, MAG 21/1/77, Correspondence between Chief Commissioner, Asante and the Asantehene, 24th February, 1949
[338] PRAAD, Accra, ADM 11/1/10, Correspondence between the Chief Commissioner of Asante and Acting Colonial Secretary, 1907
[339] PRAAD, Accra, ADM 11/1/10, Correspondence between the Chief Commissioner of Asante and Acting Colonial Secretary-1907

The Asante Confederacy Council found out that some IPHs in Asante engaged in witch- finding and the so-called curing of witches. According to the Colonial Administration, the practitioners used these claims to extort money from people. Countrywide, in the 1930s, the Colonial Administration paid close attention to the activities of the IPHs. Attempt on the part of the Colonial Administration to clamp down witch finding shrines dotted within and near Asante caused IPHs to defend their practices on account that they have throughout the period of their practice gained considerable experience in the practice of witchcraft and moreso they had officially gained the recognition of the respective chiefs or native heads.[340] Priests of witch-finding shrines argued for the need to counter the perception of an overwhelming force of sorcerers and witches in their respective communities in Asante and elsewhere. Witchcraft was believed to be dangerous to lives and property, so in instances where the Colonial Administration barred the witch- finding shrines from operating, according to the IPH, it meant that any believer in such shrines or deities of witch finding could not find a better place to sooth his sorrows especially when bewitched.[341]

Earlier, in 1929 witch-finding shrines dotted across the Gold Coast including Asante were believed to be engaged in giving of medicinal relief and cure to those bewitched or suffering from other ill effects of the practice of witchcraft and also the practice of giving facilities for those accused or suspected of witchcraft to confess or be given the facility to prove themselves innocent or otherwise.[342] The IPHs claimed that the circumstances or rituals connected with their practices were voluntary. They argued that no one was compelled to make a confession unless of

[340] PRAAD, Accra, ADM11/1/886,Witchcraft- Persecution of persons accused of, 1932
[341] Ibid
[342] PRAAD, Accra, ADM11/1/886,Witchcraft- Persecution of persons accused of, 1932

his or her own free will and no one was asked to drink the medicine against witchcraft except of his or her own free will and so far as the votaries of their beliefs were concerned, they did not indulge in practices harmful to persons or property or did what was contrary to the enactments of the Colony.[343] Witchcraft, according to the IPH, was a fundamental article of belief in the faith of a majority of the people of the Gold Coast and specifically Asante.[344]



In the 1930s, complaint of witch-finding shrines flooded the office of the Secretary of Natives Affairs at Victoriasborg, Accra. Several enquiries were made and this resulted in the closure of such witch finding shrines. Several shrine tours were made by the Colonial Administration in the Gold Coast and particularly Asante. For instance, on 2nd January, 1931, at 10 am, the Provincial Commissioner, accompanied by Captain J.C Warrington as part of their inquisitorial tours paid a visit to Nana Tongo at Suhum but, to their utter surprise, they suffered sudden black ants' invasion at the shrine. This did not permit the Colonial Officers to prolong their enquiries at the shrine.[345] However, shrines which were considered harmless were not closed down especially those that did not arrogate themselves the right to pass judgment on matters that were pending before a Tribunal relating to witchcraft.[346] It is quite revealing to point out that within the same period Tribunals faced with witchcraft related issues sent persons accused of witchcraft to medicine men or IPHs to be tested and judged. It was a seeming contravention on the part of the hand that was instilling the discontinuance of witch finding to be seen not only patronizing but

[343] Ibid
[344] Ibid
[345] PRAAD, Accra, ADM 11/1/886, Correspondence between Kwabena Asifu and His Excellency Sir Ransford Slater, Governor and Commander in Chief of the Gold Coast Colony, 1932
[346] PRAAD, Accra, ADM 11/1/886, Correspondence between Kwabena Asifu and His Excellency Sir Ransford Slater, Governor and Commander in Chief of the Gold Coast Colony, 1932

collaborating with the IPHs to satisfy their ends.[347] The extortionate demands from witches who had been proven guilty by the Tribunals were not emphasized but the indigenous remedy for witchcraft was considered worse by the Colonial Administration. According to J. de Hart, the Attorney General, in the native mind witchcraft could not be defined and since there was no definition for it, it could not be proven at the Native Courts.[348] The witch is eventually deluded by incantations offered by the IPH(s) and she comes forward to confess her guilt. According to J. de Hart she is always of mentally unbalanced type, and has suffered for years from a form of delusionary insanity hence she was more suitable for a mental institution than to a Native Tribunal or prison.[349] Moreso, J. de Hart concluded that there could be danger of miscarriage of justice in a trial for witchcraft before a local tribunal soaked with superstition and there could be no reason to suppose that a charge of practising witchcraft could not be fraught with the gravest danger of superstition hence, the amendment of the Order in Council of 1906 which gave recognition to witch finding.[350]

One noticeable development in 1932 at the Gold Coast and for that matter Asante was that the subsequent amendment of the Native Administration Ordinance, followed by the Order in Council No. 28 of 1930 prohibited the practice of witch or wizard finding and any ceremony connected with it with a penalty of twenty-five pounds against those taking part or instigating others to take part in such practice. This notwithstanding, prior to 1930, operators of witch-finding shrines were already in practice and were supported by the Native Administration

[347] Ibid
[348] PRAAD, Accra, ADM 11/1/886, Correspondence between the Commissioner Eastern Province and The Secretary for Native Affairs ,1932
[349] Ibid
[350] PRAAD, Accra, ADM 11/1/886, Correspondence between the Commissioner Eastern Province and The Secretary for Native Affairs, 1932

Ordinance which gave recognition to the fact that witchcraft was a practice indulged in by the inhabitants of the Gold Coast, and the belief that the practice was harmful to human life and to property was not publicly assailed.[351]

Again, on 26th September, 1931, Hon. W.J.A. Jones, Secretary for Native Affairs, stated on the floor of the Legislative Council that;

> The Africans in this Colony do hold a very strong belief in the power of witchcraft, and that it was not for the members of government (i.e. Europeans) who had cast aside or outgrown the belief in witchcraft to ridicule those who believe in it and still maintain that belief.[352]

It was the opinion of the Secretary for Native Affairs that the belief in witchcraft was left alone for in the course of time it would die a natural death. It was however based on the explanation of the Secretary for Native Affairs to the Provincial Members of Council, encouraging them that the amendment did not seek to break down their belief in the powers of witchcraft. It was based on this explanation that the Provincial Members of Council refrained on behalf of the indigenous people from opposing the amendment of Section 46 of the Principal Ordinance (Order in Council 1906) in its reference to the practice of witchcraft.[353]

The IPHs were unsettled especially when they wanted to hold on to their positions in the face of incessant colonial action against some of the practitioners in the indigenous healing milieu in

[351] PRAAD, Accra, ADM 11/1/886, Correspondence between Kwabena Asifu and His Excellency Sir Ransford Slater, Governor and Commander in Chief of the Gold Coast Colony, 1932
[352] Ibid
[353] PRAAD, Accra, ADM 11/1/886, Correspondence between Kwabena Asifu and His Excellency Sir Ransford Slater, Governor and Commander in Chief of the Gold Coast Colony, 1932

Asante. Firstly, they sought for the relaxation or the liberal interpretation of the Order in Council to give them a legitimate scope to operate since according to the IPHs it was impossible for a people (i.e. Asante) to maintain a religious belief or any other belief without seeking to propitiate the evil practices associated with that belief. Secondly there was also the need to seek remedies for themselves from those harmful influence created in their minds by the existent belief which they believed were exercised around them and against the safety of their lives and property.[354] Again, the IPHs requested from the Colonial Administration that the interpretation of the Order in Council should not be stretched to include those cases in which persons who believed they were witches or were possessed by evil spirits voluntarily appeared before an acknowledged medicine man or IPHs for such evil spirits to be exorcised or driven out of their bodies.[355] There was also the call for a distinction between legitimate practice of witch medicine and the illegitimate or prohibited practice of witch-finding.[356] The distinction sought was based on those who voluntarily sought to be relieved from their pains and those who were compelled by some superior authority, such as a family, a Tribunal or some other community to have themselves declared innocent or guilty of witchcraft.[357]

In addition, the IPH both in Asante and elsewhere in the Gold Coast noted that strict interpretation of the Order in Council could result in people being made to fear for their lives as to the influence that witches or wizards have upon them without having the right under the Order in Council to consult a legitimate IPH or medicine man or a native doctor versed in the practices

[354] Ibid
[355] PRAAD, Accra, ADM 11/1/886, Correspondence between Kwabena Asifu and His Excellency Sir Ransford Slater, Governor and Commander in Chief of the Gold Coast Colony, 1932
[356] Ibid
[357] Ibid

of witchcraft to analyze the cause of a person's troubles by a process of psycho-analyses, and to find remedies for the belief, whether baseless, hallucinatory or not, which that person entertains with regard to his own health and well being.[358] Of essence is a general anthropological view that in most non-western societies, including Ghana, traditional healers are the first resort in mental health problems and they continue to be used even after psychiatric systems are enlisted.[359] In mental health situations in developing countries there is not one that refuses to mention the role of the family or the kin group. It is noted that IPHs seemed to have in most cases been able to win the support and the involvement of the family or the kin group.[360] Significantly, the arguments put forward by IPHs in Asante and other practitioners at the Gold Coast were to enhance their position and also avoid being prosecuted for engaging in what they deemed legitimate.

Still, the persistence with which the Colonial Administration saw to the closure of witch and wizard finding shrines put the healers out of business. Witch finding became a lucrative business and as a result of increasing adherents at such shrines the practice became widespread. Significantly, amongst the indigenous people witchcraft was a crime, which did not bring death upon the witch or wizard but also death and bondage upon their relations.[361] Cruickshank argued that witchcraft was chiefly discovered by "fetish men" who in this study are also referred to as IPHs. They suited their own purposes in denouncing the guilty.[362] If sudden sickness or death overtook a person, who coincidentally quarrelled with another, this other person was considered

[358] PRAAD, Accra, ADM 11/1/886 ,Correspondence between Kwabena Asifu and His Excellency Sir Ransford Slater, Governor and Commander in Chief of the Gold Coast Colony, 1932
[359] Adler, L. L, Gielen, P. U, *Cross-Cultural topics in Psychology*, (USA: Greenwood Publishing Group) sites (Jilek, 1993)
[360] Ibid
[361] Cruickshank, Eighteen years on the Gold Coast of Africa, 179
[362] Ibid

to have bewitched him and rarely escapes punishment.[363] Appeals were also made by persons accused of witchcraft to be relieved of possible false accusation, and if declared innocent heavy penalties were decreed against the accuser.[364] It must be noted that the collaboration between Native Tribunals and these shrines made it gain foothold in 1932. Native Tribunals dispatched under duress, all suspected witches and wizards for treatment at shrines after which the cured parties were milked of considerable proportion of their income.[365] So great was the witch finding business, and so remunerative to both tribunals and Priests, that it is no wonder that it came to the notice of the Colonial Administration, and eventually led to the suppression of the practice.[366] However, in April 1932, Hugh Thomas, the acting Colonial Secretary, permitted that IPHs could continue with the practice of exorcising people who voluntarily came for treatment.[367]

The late 1930s and 1940s saw an overwhelming growth of Christian influence countrywide. As an effort to evangelize and civilize the indigenous people, the missionaries taught that the belief in the spirit forces such as the gods, "fetishism", dwarf and witchcraft was superstitious.[368] The reason for the growth of Christianity within this period was also partly due to the way the indigenous people attempted to deal with their threats and fears, especially witchcraft.[369] The emphasis was that an enlightened religion, education, medicine, and better social and racial conditions would help to dispel witchcraft beliefs.[370] The archival records have shown that some

[363] Ibid
[364] Ibid
[365] PRAAD, Accra, ADM 11/1/886 , Correspondence between the Commissioner Eastern Province and The Secretary for Native Affairs, 1932
[366] Ibid
[367] Ibid
[368] Onyinah, "Deliverance as a way of Confronting witchcraft in Modern Africa: Ghana as a case History", *Cyber Journal for Pentecostal and Charismatic research*, 2009
[369] Ibid
[370] Ibid

of the complaints made to the Secretary of State and the Secretary for Native Affairs concerning witch-finding shrines came from some Christian Priests.[371] Reports from the Subcommittee appointed by the Gold Coast Christian Council to enquire into common beliefs in witchcraft and the subsequent recommendations made included a strong case against IPHs who were into witch finding:

> It is our conviction that unscrupulous persons often take advantage of the prevailing belief, to acquire notoriety and importance by pretending to possess power which in fact they do not possess. We recommend to the Christian Council that, with a view of unmasking some at least of these designing persons, a reward of money be offered to any person who in the presence of two or three of the members of the Council can perform a feat, which it is often claimed can be performed- the feat, namely of "eating" a material object, a pawpaw for example without physical contact with it, at a distance of five yards.[372]

The committee emphasized the general beliefs of the power witches possessed in the Gold Coast and Asante. It was believed that the powers possessed by witchcraft included self-transformation into a beast or a bird sometimes known by scientist as *zoanthropy*.[373] The belief that witches had power to inflict diseases and death upon human victim without physical contact or physical mediums among other things was emphasized. Generally, it was believed that witches are organized in non-material groups, thus, it was during such meetings the witch finder intervened to rescue a victim.[374] Even with this, the church suspected extortions on the part of the IPHs and

[371] PRAAD, Accra, ADM11/1/886, Witchcraft- Persecution of persons accused of, 1932
[372] PRAAD, Accra, ADM 11/1/886, Report of the Subcommittee appointed by the Gold Coast Christian Council, 1930
[373] Ibid
[374]PRAAD, Accra, ADM 11/1/886, Report of the Subcommittee appointed by the Gold Coast Christian Council, 1930

doubted their integrity and moreover decided to trumpet the Order in Council No.28 of 1930.[375] It was the conviction of the sub-committee of the Gold Coast Christian Council that:

> Whatever be the truth about witchcraft, the person who stands to gain most by the continuance of the belief is the witch-doctor. In one sense we hold that in the present sense of public opinion the witch-doctor is more dangerous than the witch. His power to terrorize the weak minded; his power to suggest to unbalanced persons that they are witches, when as a matter of fact they are as innocent in this respect as the members of this Council; his power to create or intensify an atmosphere of suspicion and malice, these are powers which make him a grave danger to society.[376]

In 1934, the Chief Commissioner of Asante resident in Kumase continued to receive reports against various shrines in Asante concerning witch finding. It was realized that as a result of the passage of the Order in Council No. 28 of 1930, several witch finding shrines were proscribed under the Native Customs Ordinance in Asante.[377] These shrines reappeared with different names which made it difficult for the Chief Commissioner and any such officer of inspection to identify them.[378] On 6th July 1934, the acting Chief Commissioner of Asante in collaboration with the acting Governor of the Gold Coast on 14th July, 1934, passed the Native Customs Witch and Wizard Finding Order, 1934.[379] This sought to give a final blow to the practice of witch-finding shrines. The practice of witch or wizard finding and any ceremony connected with it was prohibited and any person who took part or instigated any person to take part in such practice in Asante was liable to a term of imprisonment with or without hard labour not exceeding three

[375] Ibid
[376] Ibid
[377] PRAAD, Accra, ADM 11/1/886, Correspondence between Chief Commissioner of Asante and the Colonial Secretary of State. 1934
[378] Ibid
[379] Ibid

months or with a fine not exceeding twenty-five pounds.[380] This notwithstanding, in 1938, it came to the notice of the District Commissioner, Asante, that the practice of "fetishism" was still being abused and that witchcraft formed a large part of the programme of the priests' healers.[381]

### 4.4 Glimmer of Hope in the Indigenous Medical Practices

Although the activities of quack practitioners had become alarming in the 1940s, there were other positive developments amongst herbal practitioners in Asante. One of the success stories amongst the herbal practitioners was Kofi Kyeremanten who was a bearer of the *Asantehene's* Native Physicians license (vide C/E No. 47). Kyeremanten and other practitioners advertised their herbal potions by means of leaflets or "handbills" by telling people the diseases their herbal potions could cure. Some of the diseases that appeared in the advertisement were menstrual pains, stomach pains, pains in thigh and chronic waste pains due to gonorrhea. The others included leanness due to chronic illness, loss of appetite, debility and stoutness due to sickness, rheumatism, pains in bones, impotence and miscarriage. Significantly, literates and non-literates attested to the efficacy of Kyeremanten's medicine.[382]

By 1940, due to the steady growth of modern medicine there were people who had knowledge in herbal medicine and some training in modern medicine. These people mostly applied their knowledge in both areas to the benefit of their communities. For example, on 16th September, 1940, Sam Cobina Quainoo, a registered native physician and midwife at Offinso who had been

[380] Ibid

[362] Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Correspondence between Kofi Kyeremanten and the *Asantehene*'s Secretariat, 1940

[363] Ibid

registered by the Senior Health Officer-Kumase, stated that he had healed eight hundred people of various diseases. It was attested by John Forson, an Offinso Royal on 8th August, 1940, that he had witnessed Quainoo heal over six hundred of his relatives and several people at Offinso who suffered from diseases like gonorrhea, asthma and coughs.[383] The others included rheumatism, piles and fits, sterility in men and barrenness in women and babies' body disorders. The attester further wrote, "He has the true ability to declare whether a particular disease is curable or incurable. He mercifully treats people with no deceit."[384]



An attestor, A. C Dateh wrote:

> I came under Mr. Sam Cobina Quainoo's treatment in July 1938. For many months, I suffered from dysentery. In the desperate hour of my suffering, Mr. Sam Cobina Quainoo came to my aid, and by a diligent application of his herbal medicine, my sickness was overcome. Efficacious as his medicine is, I shall not hesitate in commending him as an efficient herbalist.[385]

A story is told of one Robert K. Asiamah, a native of Asante resident of Kumase. By 1954, it was attested that he was able to make "African-made drugs" which were used to treat specified diseases. He made "Face Soaps' for the treatment of skin diseases. He also made drugs for the treatment of scabies, craw craw, lice and ringworm, among others. [386]

[364] Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Correspondence between Sam Cobina Quainoo and the *Asantehene*, 16th September, 1940
[365]Ibid
[366] Ibid
[367] Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Application for a Physician License, 1934-1947

The above historical facts could be surmised in the words of Patterson: "In any case for the foreseeable future, medical care in Ghana, as in all countries will be based on traditional and neo-traditional beliefs and self treatment, as well as on orthodox scientific medicine." [387]



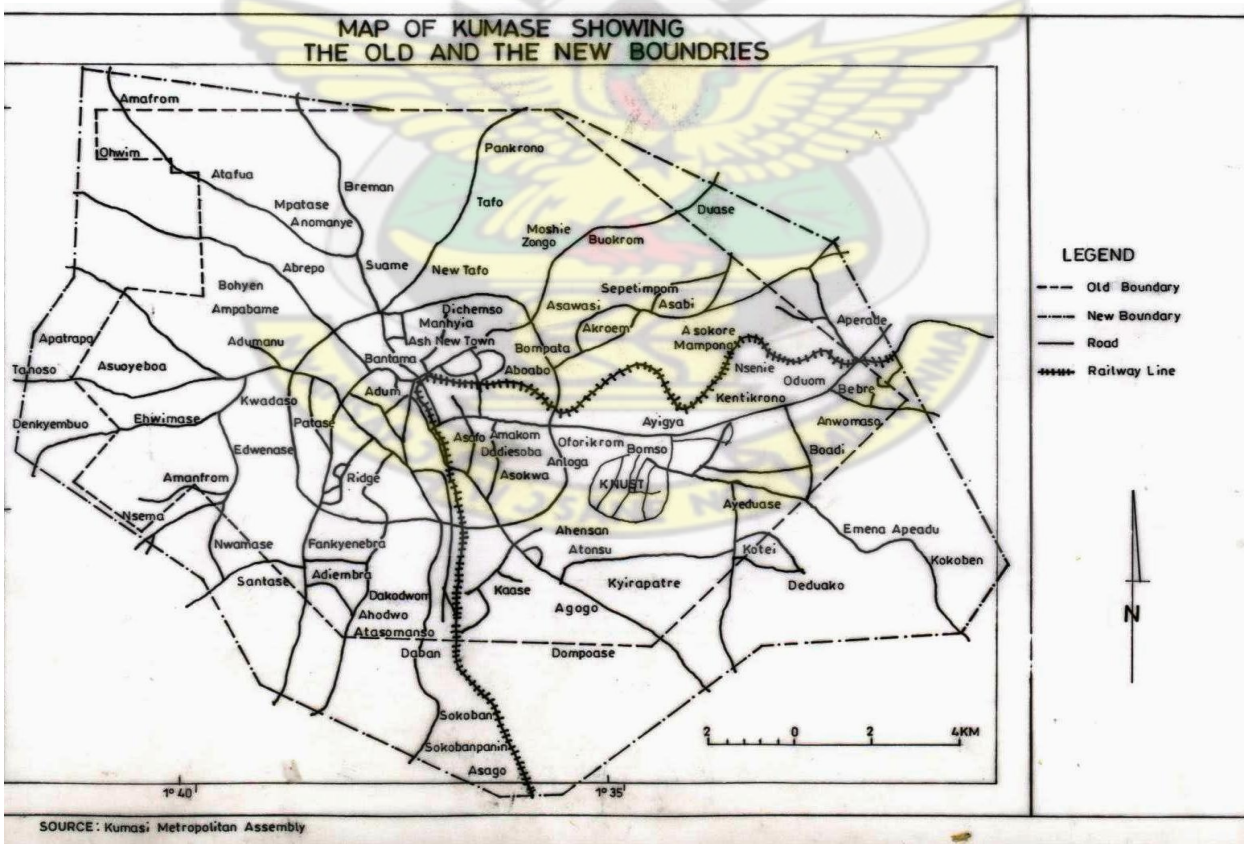



[368] Patterson, *Health in Colonial Ghana, Disease, Medicine and Socio-economic change, 1900-1955* , 27-28

## CHAPTER FIVE

## COLONIAL ADMINISTRATION AND INDIGENIOUS DISEASE COMBAT AND PREVENTION STRATEGIES IN KUMASE AND ITS ENVIRONS

This chapter focuses on the Colonial Administration using modern medicine, rules and health education to cure and prevent diseases respectively as well as the usage of colonial institutions like the hospitals, KPHB, Native Authorities like chiefs and headmen with the cooperation of the indigenous population including the efforts of indigenous medical practitioners to cure and forestall the occurrence of epidemics. Below is Map Two showing the area of Kumase and its environs which formed part of Asante within the period under study. Some of the areas shown on the map, benefited from health campaigns and surveys embarked upon by the colonial administration.




**Map Two**

## 5.1 Disease Combat in Asante: Colonial and Indigenous Response

Present in Asante from 1902 to 1957 were different medical therapies. This was based on the fact that both the indigenous people and the Colonial Administration in Asante were confronted with several health challenges. Like elsewhere in Africa the general health of the indigenous people was lowered by the constant toll of such diseases as malaria, yaws, dysentery, bronchial infections, the bubonic plague among others.[388]



In 1908 and 1924, bubonic plague occurred in Ghana including Asante. The disease is known to have been caused by bacteria that normally infect wild rodents. The plague was introduced into Ghana on two separate occasions. It was brought to Accra in 1908 by infected rats that landed in cargos at the port. In 1924, infected rats at the port of Sekondi introduced the plague. In all Sekondi had 120 cases and 92 deaths. Rats conveyed plagues up to the railway to Kumase. At the end of March 1924, Dr. Selwyn Clarke, the able Medical Officer of Health who led an anti-rat drive, began a massive slum clearance and re-housing efforts and had over hundred thousand of Haffkin's vaccines administered in Kumase and nearby towns.[389] Admittedly, the scourge of the plague seemed to have overpowered indigenous medicaments and the efforts of indigenous healers.[390]

The disease was largely confined to the poor, overcrowded Zongo areas and nearly all the cases and death were among migrants from the north or from Nigeria. The Kumase epidemic was over by September but sporadic cases were discovered for several months afterward. One hundred and sixty-five cases were reported in Kumase with 146 deaths. In Kumase, the disease was

[388] PRAAD, Accra, ADM 11/1/156, Human Trypanosomiasis Committee and best means of combating, 1935.
[389] Patterson, *Health in Colonial Ghana: Disease, Medicine and socio-economic change,1900-1955*, 47
[390] Interview with Nana Tenkorang Wadie, Dichemso, December 2006.

transmitted along the lines of communication. The major measure that was employed in fighting this disease was through the destruction of the rats that were the major carriers of the plague. At this stage, it was not only based on colonial drive but the indigenous people in Kumase saw the need to prevent rats from invading their compounds[391] Again, by September 1947, in Kumase and its environs, 1008 rats were caught and destroyed. This practice became widespread in Asante in the twentieth century. For example, from 1942 to 1947, 1012 rats were caught and destroyed in Kumase and its environs[392]. To emphasize, the number of rats the indigenous people destroyed were countless once it was handed down to them by the Colonial Administration the need to destroy rats, they had the occasion to assiduously do so.[393] The danger rats posed at the time rather served as a major motivating factor for the indigenous people to respond efficiently to the call of the British Colonial Administration to kill rats. Again, during the outbreak of the plague in 1924,the then Senior Medical Officer of Health, Dr. Selwyn-Clarke in conjunction with the Kumase Public Health Board (KPHB), advised keepers of animals especially those who kept horses at the Zongos to desist from it because keeping horses within the township was noted to be unhealthy. According to Dr. Clarke, they contributed to the spread of the plague in case the rats and the mice fed on the refuse of the horses. Keepers of animals, especially horses were made to situate their pens at the outskirt of the Kumase Township.[394]

Significantly, the period 1933 to 1935 was noted not to have had widespread epidemics. As compared with previous years, the general health of the indigenous people of the Gold Coast and

[391] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Report of the medical Officer of Health, Kumase, September 1942., Interview with Maame Akua Nsiah (84 years), resident in Kumase, 15th January, 2008
[392]Manhyia Archives of Ghana, Kumase, MAG 1/1/35 Report of the medical Officer of Health, Kumase, September 1947
[393] Interview with Maame Akua Nsiah (84 years), resident in Kumase, 15th January, 2008
[394] PRAAD, Accra, ADM 1/2/1/66, Correspondence between Katsina and the District Commissioner, Ashanti, April 1934

specifically Asante was unsatisfactory.[395] The invaliding and death rate figures for African officials attested to that, although the figure for the number of deaths per thousand of patients treated in hospitals, dispensaries, among others, remained the same as in 1933-1934.[396] This record was noted to be partly due to the efforts of the Medical Department and all its branches in the Colony including Asante and Kumase specifically.



**Table 5.1** House Visits by Health Inspectorate

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

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

The records of the hospitals and dispensaries showed an increase over the previous year of nearly two percent in the total of in-and-out patients treated, while the number of house to house visits carried out by the inspectorate of the Health Branch rose from 1,590,647 in 1932 and 1,735,501 in 1933 to 1,929,507 in 1934.[397] It is noteworthy that within the same period, as elsewhere in Africa, the general health of the indigenous people was greatly lowered by the consistent toll of such diseases as malaria, yaws and dysentery especially amongst the infant population.[398] Again, within the period malaria was noted to be the number one killer disease in Africa.[399] Amongst the Akan, and for that matter Asante, the disease was known as *Atiridi* in adults but *Asabera* in

[395] PRAAD, Kumase, ADM 11/1/1560, Human Trypanosomiasis Committee and the best means of combating
[396] Ibid
[397] Ibid
[398] Ibid
[399] Ibid

children. Learmouth has argued that one of the causative agents of malaria; plasmodium falciparum is the malaria parasite with widespread distribution in the tropics especially in Africa. The blood and tissue of men are invaded by certain species of plasmodium.[400]

During epidemic seasons in Asante there were temporary increase in abortions a reduction in conception and a consequential reduction in birth rates among the indigenous people.[401] From 1936 several symptoms in children including hot skin, high fever, or cold and shivering, and vomiting were diagnosed to be malaria.[402] Children of indigenous Asante who died out of the disease passed out in the form of fit of convulsion, which was attributed to witchcraft. [403] Here, the experts that were consulted for treatment were herbalists and TBAs. There was the reliance on the use of concoctions and decoctions made of stems, roots and leaves of trees. Some were efficacious to the extent that those who reported their cases to these indigenous healers were healed. Others also used enemas especially when it was believed that the disease was intestinal.[404] In the twentieth century, every discovery of new case in malaria was treated with seriousness. For example, the discovery of two cases of oval malaria in Kumase in 1933 was considered worthy of special notice. Every annual report noted the severity and ubiquity of malaria. There were surveys showing high parasitemia in school children in urban areas like, Accra, Kumase, Sekondi, Cape Coast and Koforidua. [405]

In 1943, the Director of Medical Service noted that malaria occurred everywhere yet there was

[400] Howe, M. G, Ed., *A world Geography of Human Diseases* (London: Academic press, 1977) 68
[401] Ibid
[402] Manhyia Archives of Ghana, Kumase, MAG 1/1/35: A short talk to African Mothers Broadcast, Accra by Dr. Duff, Director of Medical Service 1st July, 1936
[403] A short talk to African Mothers Broadcast, Accra 1st July 1936, 8pm by Dr. Duff, Director of Medical Service. Interview with Maame Akua Nsiah (84 years), resident in Kumase, 15th January, 2008
[404] Interview with Kwaku Gyewahom, New-Tafo, Kumase, 10th December, 2007
[405] Akyeampong, K.E, (Ed.), *Selected Themes in West-African History*, 2000, 193-194

little evidence that any sustained work was undertaken by the Colonial Administration amongst the population."[406] Two factors might have worsened the malaria burden during the colonial period. The major vectors, *A Gambiae* and *A Funestus*, were common everywhere except in dense forests. However, when the forest was cleared these insects especially *A Gambiae* established themselves.[407] Also, logging, food production, the extension of cocoa farms and road and railway construction all created clearing where vectors could breed. Borrow pits where earth was removed for roads, railroad also served as breeding grounds for mosquitoes that caused malaria. Malaria was one of the major causes of infant death in Asante. Although the figures were low in urban Asante, the unreported cases could have been very alarming in the 1940s.[408]

In Asante, the Colonial Administration controlled malaria through the use of insecticides against the anopheles and better housing. Deliberate malaria eradication was mainly through the use of residual insecticides against adult anopheles. An example was the use of DDT, and other anti-laval measures, prophylactic and curative drugs.[409] Also, general standards of hygiene including the separation of cattle shed from houses especially when it was believed that the vectors are *zoophilic.*

In a colonial broadcast made by Dr. Duff, the Director of Medical Service on 1st July, 1936, the people of the Gold Coast including Asante were charged to kill mosquitoes at sight because they were the enemies of both parents and their children. The indigenous response especially in Asante was quite sporadic. It became a common phenomenon in Asante among the indigenous

[406] PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935
[407] Ibid
[408] Manhyia Archives of Ghana, Kumase, MAG1/1/35, Report of the medical Officer of Health, Kumase, September 1942
[409] G. Melvyn Howe Ed., *A world Geography of Human Diseases*, 77

people, that both the young and old found the cause to kill mosquitoes at sight.[410] Hannah Adei has hinted that growing up in a village called Hweremoase in the 1940s she saw her peers kill mosquitoes at sight. The reason for killing mosquitoes was not necessarily based on medical reasons but because of the pains they felt when bitten.[411]

The Colonial government made efforts to drain swamps, fill up pits and holes in the big towns including Kumase. Also, in 1936, what was regarded as a powerful remedy to the disease was introduced by the Colonial Administration to the indigenous people.[412] Quinine was believed to hold the antidote to the disease without any ill effect on either children or adults. A massive educational campaign was employed through radio broadcast and through opinion leaders to educate mothers, the young and the old on the correct usage of quinine[413].

Further enquiries among the indigenous people of Asante have shown that one of the noticeable drugs in use in Asante in the late 1930s and beyond to cure malaria was quinine.[414] One of my interviewees hinted that she has used quinine before and has never used any indigenous medicine for treatment. The response of 84 year old Akua Nsiah, attests to the lifestyle of a group of citizens, Asante, who were caught up in the full tide of social and cultural change due to western influence.

The Colonial Administration made quinine available in all dispensaries, hospitals, clinics and

[410] Interview with Hannah Adei, at her residence, Dichemso, Kumase, 11th June 2008
[411] Ibid
[412] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, African Mothers Broadcast, Accra, by Dr. Duff, Director of Medical Service, 1st July, 1936
[413] Ibid
[414] Interview with Maame Akua Nsiah (84 years), at her residence, Krofrom, Kumase, 15th January, 2008

drug stores. Provision was made for mothers who could not visit doctors or any health posts. Every Post Office and postal agency in the country sold government quinine tablets at especially cheap rate. In addition, to ensure that people bought the quinine then considered to be the right for the treatment of malaria, graphic details as to the nature of the drug and how it was packaged were made known to the general public. Significantly, instructions or inscriptions pertaining to the correct usage of the drug was translated into various local dialects including, Ga, Fanti, Twi, Ewe and Hausa.[415] From 1902 to 1957, inhabitants of Asante villages were highly non-literates. Therefore, it became a paramount role for the few educated kin groups to help to translate or better still, read what was translated in Twi to the sick to ensure proper usage of quinine or any other drug that was introduced by the Colonial Administration into Asante.

Pregnant women were advised by the Colonial government to take quinine under strict instruction of a Medical Officer. It was strongly recommended by the Colonial government that expectant mothers took a tablet of government quinine daily or half a tablet morning and evening for three or four weeks before and after the birth of a child. Dr. Duff advised that quinine was good for the womb and it ensured that the mother recovered fast after her delivery. Also, Dr. Duff argued that if malaria attacked a pregnant woman it could cause miscarriage and perhaps death.[416] Such educational awareness from the Colonial Administration was mostly communicated through interpreters to non-literate dwellers in Kumase and its environs.

Again, the Colonial Administration introduced the use of mosquito nets. Pregnant women and

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

parents including their children were admonished to sleep in their own mosquito nets to prevent mosquito bites and eventual infection with the malaria parasite.[417] Available information does not allude to the fact that there was a free distribution of mosquito nets by the Colonial Administration. However, oral evidence suggests that there was widespread use of mosquito nets by European or expatriate communities both in Asante and elsewhere and indigenous people who could afford had access to them.[418]



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

> Segregation which is the greatest efficacy in preventing the spread of malaria is now carried out in building residence for European Officials in nearly every station in the colony, and the remarkable fall in the death rate speaks for itself.[419]

Segregation as an European mechanism to curtail malaria in itself meant little or nothing to the indigenous people of Asante. In determining the sick role in Asante, it has been found out that the sick were precluded from taking part in the recurrent social activity, they were quarantined.[420] Although prevention of transmission of an infected person to another was not the motive, the derived benefits included that. Twumasi emphasizes that:

> The characteristics of the sick role in the society are that in so far as he is legitimately recognized as a sick person, he is temporarily relieved of

[417] Ibid
[418] Interview with Maame Akua Nsiah (84 years), at her residence, Krofrom, Kumase, 15th January, 2008. Interview with Hannah Adei, at her residence, Dichemso, Kumasi, 11th June 2008
[419] Akyeampong, (Ed.), *Selected Themes in West-African History*, 2000, 197-198
[420] Twumasi, Medical Systems in Ghana, 34

> his obligations of his work activities. If he is a father he is not obliged to attend work to support his family or take part in the decision making process of his various social groups. This role is legitimated by the elders of the family and it is reinforced by the traditional medicine man, when the case comes to him at his medicinal shrine.[421]

In Asante, several measures were employed to curb the malaria surge. Sanitary workers were charged by the Colonial Authorities to inspect houses. From 1941 to 1942, 18,068 houses were inspected in Kumase. Significantly, within this period only thirteen houses were found to have the mosquito larvae.[422] Towns were divided into sanitary districts by the Colonial Administration under the control of special Sanitary Inspectors. These inspectors or their subordinates entered and searched every home at least once every week with or without a prior notice. Rainwater in discarded containers, hollows of trees and puddles as well as water stored for household use were checked.[423] Offenders escaped with a caution but were usually taken to magistrate courts and fined. At certain instances, the Colonial Administration passed ordinances to ensure that people in Asante kept their environment clean. There was the Mosquito Ordinance, which became the guiding principle for sanitary conditions and those who breached it were liable to a fine. From 1946 to 1947, seven people were fined a total of three pounds in Kumase for having mosquito larvae in their houses. [424] Similarly, traditionally, it was the role of chiefs in Asante to call for clean up in their communities. In emphasis, the role of the chief included both the physical and social well being of his subjects.

[421] Ibid
[422] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Report of the medical Officer of Health, Kumase, September 1942
[423] Ibid
[424] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Report of the medical Officer of Health, Kumase, September 1947

Again, in Asante and for that matter Kumase, the Colonial Administration formed the anti-mosquito brigade. The brigade filled marshy and lowly areas with indestructible refuse with top dressing of earth, oiled such water bodies as swamps, drains, and ponds. This prevented the growth of mosquito larvae.[425] Significantly, it was the indigenous hand that worked to achieve this end. But by far we understand that it was under the strict supervision of the Colonial Administration who also had their own medical interests to take care of.



By 1903, the case and vector of human trypanosomiasis, which is also known as sleeping sickness, were known. Though the disease is an ancient one, since the nineteenth and twentieth centuries, its basic behaviour has been the same.[426] Beginning in 1909, Dr. Alan Kinghorn spent a year surveying central Asante and portions of Brong Ahafo. He found only 106 cases out of 1800 people examined. In 1912, Dr. W.M Wad completed a thorough survey of Western Asante. In this area, people were aware of sleeping sickness and attempted to treat it. Out of 39,742 people examined in 196 villages, 102 were infected. Most of the victims were migrants from the northern territories. Vegetation that harboured the fly which caused sleeping sickness was cleared.[427] Trypanosomiasis was virtually eliminated in Lawra, Wa and Tumu districts. However, despite a small outbreak in the 1950s was largely confined to few areas in the south, Mamprusi and other scattered locations in the north. Control of the northern epidemic reduced the incidence in Asante because fewer of the labourers going south were infected with trypanosomiasis.[428]

[425] Manhyia Archives of Ghana, Kumase, MAG 1/1/4A, Kumase Public Health Board Gold Coast Colony, Estimates of revenue and Expenditure, 1927-1928
[426] PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935. Patterson, D. K, Health *in Colonial Ghana, Disease, Medicine and Socio-economic change, 1900-1955*, 1881, 44
[427] Ibid
[428] Ibid

In Districts like Damango, which had very little sleeping sickness, many cases were imported from Asante by returning migrant workers. While the spread of the disease was associated with rivers in the north, in Asante its distribution was linked to the road network. By September 1942, there were forty-one reported cases resulting in two deaths in Asante. However, by December 1947, there were two reported cases; both victims did not survive the scourge of the disease. [429]



With regard to the forest regions including Asante, an imminent danger was pointed out by one entomologist, Dr. Morris who concluded that the vectors that cause sleeping sickness, *G. longipalpis* was probably second to *G. palpalis* in the distribution of the disease at the Gold Coast.[430] It was known that the forest of the Gold Coast was receding from both north and south. This recession was due principally to the practice of shifting cultivation, assisted by the mining communities, induced a secondary type of scrub, which was very difficult to deal with, but eminently suited the colonization of *G. longipalpis*.[431]

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

[429] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Reports of the Medical Officer of health Kumase, 1942
[430] PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935. Morris, *On the Biomedics and the importance of G. Longipalpis Wied, in the Gold Coast*, Bulletin of Enthomological Research , Vol. 25 Part 3, September, 1934., *G. Palpalis and G. longipalpis*
[431] Ibid

the spread of the disease. [432]

One of the propositions put forward for the eradication of the menace of the human trypanosomiasis was the need for an improved system of indigenous farming, that is, the reduction in shifting cultivation to control *G. longipalpis*. Such a system was not only intended to ward off the vector, as put forward by Dr. Morris, it was at the same time to serve as a means of improving the food value of the crops of the farmers, thus, raising the general standard of health of the indigenous people.[433] The Acting Director of Agriculture giving evidence before the Trypanosomiasis Committee stated that the problem of shifting cultivation was not to be noted as insoluble but rather there was the need to learn from the success of green manuring in Nigeria.[434]

Again, by 1940, there were proposed rules to help curb the spread of the disease but it was not obligatory for any person to undergo a course of treatment for Trypanosomiasis. Significantly, the rules applied to only the indigenous people who, of their own free will, started treatment. The rule ensured that those who offered themselves for treatment continued until the Medical Officer discharged them.[435] These rules were applied in places like Kumase, Mampon, Dwaben, Esumeja, Kokofu, Nsuta, Adanse, Kumawu, Offinso, Edweso, Agona, Banda and Wenkyi in the Bono Ahafo region which formed part of northern Asante. The others included Mo, Abeasi, Nkoranza, Gyaman, Berekum, Techiman and Dormaa or Wampamu in the Brong Ahafo.

[432] Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Correspondence between the Assistant Director of Medical Service, Kumase and the District Commissioner, *Asante*,
[433] PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935.
[434] Ibid
[435]Manhyia Archives of Ghana, Kumase, MAG 1/1/162A, Rule 27 of 1940 published in Gazette 71 of 2nd November 1940

The proposed rules were made by the Native Authority in the Asante Confederacy Council with the approval of the governor under sub-section 15 of the Native Authority Ordinance, Cap 79. It was enshrined that the rules would apply to the whole Native Authority area. Again, it was stated, here to emphasize, that whoever began the treatment of human trypanosomiasis had to continue the treatment without intermission until discharged as cured by the medical authority. In addition, any person who contravened the rules was liable on conviction to imprisonment with or without hard labour for a term not exceeding three months.[436]

After taking into consideration the immense difficulties involved in clearing the territories of Asante especially when it was noted that the cutting down of economic crops such as cocoa could double the cost of clearing in Asante which was already five times higher than the northern territories, the Committee for trypanosomiasis still proposed the formation of paid gangs assisted with communal labour organized by the indigenous people. However, colonial action over a wider area was to be deferred until an expert survey of Asante threw further light on the extent to which the various districts in Asante were infected.[437]

On 15th October, 1941, Dr. Saunders proposed to make a preliminary survey at some of the suburbs of Kumase namely, Patasi, Dakodwom, Kwadaso, Amakom, Aboabo, Dichemso and New Tafo, Tafo, Suame, and Kaase to investigate cases of sleeping sickness. The team started work on Monday, 20th October, 1941. The sleeping sickness survey team took blood tests of the inhabitants. They were charged not to take any fee or render any tests or engage in any other

[436]Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Section 15 of the Native Authority Ordinance, Cap 79. Regulations made by the Governor in Council under Section 18 of the Infectious diseases Ordinance, Gazetted in 1935.
[437] Manhyia Archives of Ghana, PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating – Recommendations as to clearing in Asante.

medical service apart from running of tests on sleeping sickness patients. [438] A comprehensive report was obtained at the end of the survey. At Patasi, ninety-five people were examined but only two people were infected. Also, at Kwadaso one hundred and forty-five people were examined, seven people were infected. One of the infected persons was an *Odikro* who has been described by the archival document as an old and feeble man. Another report which came in on 23rd October 1941 stated that at Dakodwom, seventy-three people were examined but two were infected. At Asokwa one hundred and twenty people were examined, eight were infected.[439]

Again, in spite of the good work done by the medical team, they were not successful at some of the places they went because of the attitude of the indigenous people. Dr. Saunders is noted to have reported in 1941 that he had trouble at the village called Aboabo. He said the inhabitants did not come for treatment. Dr. Saunders further proposed that as the place is by a railroad to Accra, it was important that the people were examined. At Mo, Dr. Saunders encountered a similar problem. He also suggested a further survey at Adiebeba, Ahodwo, Tuase, Nhyiaeso and Adiembra.[440] Nevertheless, it was noted by the Colonial Administration that the indigenous people were ignorant of the true nature of the disease and that became their greatest obstacle in dealing with it. Superstition and semi-religious accounts of the origin of trypanosomiasis and of the process by which an individual could be infected abound. The Colonial Administration called for a gradual enlightenment of the indigenous people by means of persistent although not blatant propaganda.[441]Significantly, rule number 27 of 1940 of the Gold Coast empowered a chief to compel a trypanosomiasis patient undergoing treatment at the hospital to complete the course of

[438] Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Report of Dr. Saunders, 21st October, 1941
[439] Ibid
[440] Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Report of Dr. Saunders, 21st October, 1941
[441] PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935.

treatment. For example, in Bekwai trypanosomiasis patients were compelled by the authorities at the Bekwai Hospital to report to the *Bekwaihene* to guarantee that such patients will report at the hospital until they were cured. [442]

Patients were mostly quarantined. Also, in cases where people were examined in villages, they were referred to hospitals for further treatment. By 26th February 1943, it came to the notice of the Chief Commissioner that the *Asantehene* and the Confederacy Council were unhappy about the scourge of trypanosomiasis in Asante.[443] As a result of this, the Chief Commissioner was asked by the Asante Confederacy Council to recommend an amendment under Native Law and Custom Order making it an offence to refuse to report to the Native Authority the occurrence of any infectious or contagious disease. Again, all District Commissioners in Asante were charged to make it known in their districts especially to persons or Officers in charge of Infectious Disease Regulation to report cases of sleeping sickness or any other infectious disease and to also make known to the people the penalties attached to the failure to report such cases. [444]

On 21st September, 1943, Captain Holden R.A.M.C made a trypanosomiasis survey at Kwadaso, Owhimasi, Adumanu, Kokoso, Abase, Apatrapa, Bokankye, Tanoso, and Esuyeboa all in Kumase and its environs. The others included Ampabame, Abrepo, Boanim and Yankomase. In this survey, reported cases were treated at the African Hospital. [445]Also, the Military Authorities at the 52nd General Hospital carried out a survey of sleeping sickness in old soldiers' settlements

[442] Manhyia Archives of Ghana, Kumase, MAG 1/1/162A, Rule 27 of 1940 published in Gazette 71 of 2nd November 1940, page 24. Regulations made by the Governor in Council under Section 18 of the Infectious diseases Ordinance, Gazetted in 1935.
[443] Ibid
[444] Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Correspondence between the Office of the *Asantehene* and the Chief Commissioner, 1945
[445] Manhyia Archives of Ghana, Kumase, MAG 1/1/85, Correspondence between Captain R.A.M.C Holden and the Native Administration, 1945

like Esuyeboa, Tanoso, Abuakwa, Asonomaso, Manhyia, Akropon, Afrofrom, Dadiase, Bokankye, Apatrapa, Abase, Adumanu and Owhim. Again, on 7th September, 1945, it was proposed that Kumase villages should be re-surveyed. A centre was opened by the Colonial Administration at Abrepo in 1945 to cater for cases that came from areas within five miles radius of Kumase and places that were not surveyed. Significantly, the survey of villages for trypanosomiasis persisted up to the 1950s.[446]



**Table 5.2** Human Trypanosomiasis Cases Treated at the Various Hospitals set up by the Colonial Administration in Asante, 1928-1934

| Date | In-Patient | Outpatient |
|---|---|---|
| 1928-1929 | 15 | 13 |
| 1929-1930 | 40 | 28 |
| 1930-1931 | 35 | 1 |
| 1931-1932 | 76 | 46 |
| 1932-1933 | 167 | 113 |
| 1934 | 206 | 164 |

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

Significantly, table 5.2 represents the toll of human trypanosomiasis within the period under study. The table might not be considered as a definite proof of the alleged large increase of the disease but when it was found out by the Colonial Administration that the indigenous people looked upon the disease as a curse and consequently refrained from reporting it or obtaining

[446]Ibid

treatment from modern health care facilities but rather patronizing the services of indigenous practitioners, it was certain to conclude that trypanosomiasis was certainly on the increase.[447] In the northern territories where chiefs refrained from reporting deaths to the Colonial Authorities based on the fact that the indigenous people considered such deaths as abominable, hence, those who died by the disease were not given befitting burial.[448] In 1934, four Europeans and two hundred and fifty-two indigenous people were treated in Kumase.[449]



Records have shown that the majority of the cases appeared to be amongst the labourers from the north, however, from available information it was certain that a considerable number of Asante were treated and further, the disease was well known amongst the indigenous population of Asante for years.[450] This notwithstanding, it was noted that many cases were reported from Sunyani and Kintampo areas but only very few from Bekwai and Obuasi.[451] This is because the infection rates in these towns were high.

Another disease which is known to have infected the people of Asante within the first half of the twentieth century is Cerebro Spinal Meningitis (CSM). Its symptoms included fever, stiffness of neck, pains in the head, ears and the spinal column. These pains were severe during the night.[452] Traces of cases of CSM were found in some villages and towns in Asante including Kumase. On 15th May, 1950, according to the report of Dr. A Brack, a Medical Officer of Health at the Basel

[447] PRAAD, Accra, ADM 11/1/1560, Report of Meeting of Local Committee on Anti—Trypanosomiasis Measures held at Kumase in June 1935.
[448] PRAAD, Accra, ADM 11/1/1560, Human Trypanosomiasis Committee and best means of combating, 1935.
[449] PRAAD, Accra, ADM 11/1/1560, Report of Meeting of Local Committee on Anti Trypanosomiasis Measures held at Kumase in June 1935.
[450] Ibid
[451] Ibid
[452] PRAAD, Kumase, ADM 3/2/5, Correspondence from the Health Department Juaso to the Medical Officer of Health, Kumase, 1950

Mission Hospital, Agogo in Asante, there were cases of CSM in Dwaso. Again, on 9th May, 1950, there was a reported case of CSM at Dompoase, a village in Adanse. In the same year, there were several reports from the General Hospital in Kumase on cases of CSM. In the same period, the South Wing Hospital at Kumase also reported several CSM cases. [453]

The disease affected both the young and the old with the average age ranging from fifteen to thirty-five. However, infants and toddlers were also infected. Some of the patients survived, especially in cases where patients reported at the hospital before the symptoms took a dramatic turn, significantly attesting to the fact that indigenous remedies were not very effective in dealing with the disease.[454] The disease was found among migrants in Asante and Kumase in particular. For example, on 26th February 1950, it was reported by the Medical Officer that two migrants from the north, Yakubu Kotokoli, and Basana Grushie who were resident in Adanse suffered from CSM, twelve year old Yakubu succumbed to CSM on 3rd March 1950. Also in the same period, Seidu Busanga and Amadu Kanjaga migrants from the north but residents of Kumase were both reported to have suffered from CSM. Again, on 19th February 1950, a twenty-eight year old migrant resident in Kumase died of CSM on admission at the South Wing General Hospital in Kumase. Also, on 28th January, 1952, the Medical Officer of Health of the South Wing General Hospital Kumase reported two cases of twenty-one year olds, one Efua Nsohwo, and Satima Kanjaga. Both were admitted on 17th January 1952, but Satima succumbed to CSM on the day of admission. [455]

[453] PRAAD, Kumase, ADM 3/2/5, Report of Dr. A Brack, a Medical Officer of Health at the Basel Mission Hospital, Agogo in Asante, 1950
[454] PRAAD, Kumase, ADM 3/2/5, Report of the Medical Officer of Health, General Hospital Kumase, 1950
[455] PRAAD, Kumase, ADM 3/2/5, Report from the Medical Officer of Health, South Wing Hospital, Kumase, 28th January, 1952

In addition, on 28th February 1952, the Medical Officer of Health, Kumase reported that, Amadu Kanjaga, a prisoner at the *Asantehene's* prison had contracted CSM on 24th February, 1952. The reported case at the prison was something to be worried about because of the probability that the disease could be communicated amongst prisoners in the same cell and the entire prison community including the prison officers. [456]



CSM was not only devastating but it had the potential to wipe out the youth who had energy to help in the developmental process of their respective communities in Asante. Within the period under study, several measures were employed by the Colonial Administration either to prevent, curtail or to cure people of CSM and its debilitating effects. In an instance where there was a reported case of an outbreak of CSM in an area or community, the Sanitary Overseer was charged by the Colonial Administration to conduct daily inspection of all contacts for a week and reported any case of symptoms amongst the indigenous people with the least possible delay. On 26th February, 1952, as a result of a reported case of Yaa Afre a native of Twedie in Asante, the Sanitary Overseer of the station was instructed to conduct daily inspection of the station for a week and reported any case of fever among the population. The chief of Twedie and the school teachers were advised to cooperate with the Sanitary Officer whilst he duly discharged his duties.[457] People who were infected with the disease were properly quarantined to avoid infecting other people in the community.[458] This in essence ensured that several people did not contract the disease through daily contact with the infected. Also, patients were given tablets by the Medical Authorities to help cure the disease. The Colonial Administration introduced the use

[456] Ibid
[457] PRAAD, Kumase, ADM 3/2/5, Measures that were adopted by the Medical Officers of Health to control CSM., 1952
[458] Ibid

of sulphanilamide tabs, which were given to infected persons to treat the disease. In addition, the temperatures of patients were checked at regular intervals to find out the progress they were making in their treatment. Mostly, temperatures of CSM patients were beyond hundred degrees Celsius. On 11th February 1951, there were seventeen reported cases at Afrantwo near Kumase. The patients were isolated and were discharged on 10th February 1951 after discovering that their temperatures had come to the normal level.[459]



Chiefs, elders and the inhabitants of Asante, and for that matter Kumase, were advised by the Medical Officer of Health, that they should open their doors and windows to ensure free flow of air. It was to ensure that rooms were well ventilated to prevent infection.[460] In contrast, it was observed that Cerebro Spinal Meningitis reported from out-stations was not shown in the Weekly Infectious Disease Returns. These omissions could have had serious repercussions on the Consolidated Weekly Epidemiological Information.[461]

Earlier, on 18th December, 1945, based on the Infectious Disease Ordinance, Cap 59, codified by the Colonial Administration, travel restrictions were imposed on the indigenous people of Asante to prevent the spread of CSM. However, persons whose duties required that they travel extensively along the road especially from Bamboi northwards were to apply for passes at the office of the Medical Officer of Health, Kumase. In 1930s, several restrictions were placed on labourers moving from the north to Asante and the ban was removed only when the Medical

[459] PRAAD, Kumase, ADM 3/2/5, Correspondence between the Health Department Dwaso to the Medical Officer of Health Kumase, 1952
[460] PRAAD, Kumase, ADM 3/2/5, Medical Directives from the Medical Officer of Health, Kumase to the people of *Asante*, 1952
[461] PRAAD, Kumase, ADM 3/2/5, Correspondence between Medical Department, Accra and Assistant Director of Medical Service, Kumase, 20th March 1952

Authorities in Asante found out that the northern epidemic had reduced drastically. For example, in 1939, Zongo headmen in Asante received reports that the outbreak of CSM had reduced in the northern territories and no restrictions were further placed on labourers returning to their homes. [462]

Smallpox is also one of the diseases, which infected the indigenous people of Asante. Howe refers to Christie that fewer diseases have been dreaded throughout the world than small pox.[463] It was observed that if the disease was suspected in the patient before he gets his rash then successful steps could be quickly taken to protect those around him. Also, patients who do not develop the skin rash were considered not infectious.[464] Virus escapes from the body of the smallpox patient mainly from his mouth and throat served as the main way in which smallpox spreads. Similarly, it was noted that when skin spots break down or scabs are shed virus escapes and contaminates the environment, bed, clothes, and floor dust. Viruses were also known to be excreted in a patient's urine.[465]

Infected laundry could be dangerous to those who handle it, a patient's room could also be contaminated with virus and remain so for several days. Although, small pox normally spreads by face to face contact of one patient to an uninfected person, there are rare occasions when the virus could be wafted in a current of air, smuggled around in a bundle of clothes or inhaled in the dust of a patient's bedroom.[466] Christie argued that smallpox smoulders inside a mud-hut or house and passes slowly from one unvaccinated member of the family to another and sometimes

[462] PRAAD, Kumase, ADM 3/2/5, Infectious Disease Ordinance, Cap 59, 18th December, 1945
[463] Howe, (Ed.), *A world Geography of Human Diseases*,255
[464]Ibid
[465] Ibid
[466] Ibid

to some other person in a neighbouring hut.[467] A vaccination or a previous attack is the major likelihood of preventing infection.

In the early days of The Smallpox Eradication Scheme, pockets of infection persisted in remote African villages including those in Asante. Field vaccinators were unwilling to travel to a vaccination assembly point and were also unwilling, to at first, penetrate the interior.[468] When there was communication between villages or when infected traders journeyed with their produce to the neighbouring market townships, smallpox was spread.[469] In 1942, the Medical Officer of Health in Asante noted that several cases of smallpox were noted in Kumase. The populace was notified of the outbreak of the disease through the beating of gong-gong by court criers in the suburbs.[470] A unit was set for the administration of vaccines at market places and anybody with any trace of spots on his body and in particular, on the face, reported himself or through a messenger at once to the medical authorities.[471] This was significant because smallpox spreads almost exactly the same way everywhere. The virus passes from a respiratory mucous membrane to its close contacts; there is an incubation period of 12 days and if contacts could be traced, vaccinated and kept under surveillance, the medical team could eventually catch up with the slow-spreading virus which must then die out in its new environment.[472]

On 21st February, 1942, a notice was sent to the *Asantehene* from the Chief Commissioner's Office with the notice that passengers who intended to travel on any of the passenger trains

[467] Ibid
[468] Ibid
[469] Ibid
[470] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Correspondence between the District Commissioner's office and the *Asantehene*, March 1944
[471] Ibid
[472] Howe (Ed.), *A world Geography of Human Diseases*, 264

leaving Kumase were to be vaccinated or to produce satisfactory proof of vaccination. Again, as a result of a suspected outbreak of smallpox at Abofuo in the Offinso division the Medical Officer of Health in Asante moved teams to carry out vaccination in some villages including Abofuo, Brofoyedru, Akomadan, Nkenkansu and Kobreso, all in the Offinso Division. Vaccinators were also sent to Anyinasu at the Edweso Division. The others were sent to Afrantwo, Sekyeredumase and Kyekyewere.[473] The efforts undertaken by the Colonial Administration to curb smallpox was essential because there was always the need to throw a ring of vaccinated contacts around each possible infected person and community. When the vaccination is done the virus cannot break the cycle in a fully vaccinated person. In contrast, mass vaccination was not necessary since vaccination and surveillance were only necessary for those who have been exposed to the virus.[474]

However, on 25th February, 1946, the Senior Health Officer proposed to have an extra vaccinator available. He was sent to the villages in and around Kumase to protect any person who had not been vaccinated. The villages noted for these operations were Bremang, Aboabo, Old and New Amakom, Suame, New Tafo, Kaneanko, Asunkwa, Patase, Abrepo and Toase. The chiefs in these villages were encouraged by the Colonial Administration to give their support to the vaccinator whilst he dispensed his duty.[475]

Furthermore, as a result of insanitary conditions prevalent in some of the villages in and around Kumase, several people including children suffered from bronchial infections. The disease was

[473] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Correspondence between District Commissioner's Office, Kumase and the *Asantehene* with copies to *Offinsohene* and Chief of Sekodumase.
[474] Howe, (Ed.), *A world Geography of Human Diseases*, 264
[475] Manhyia Archives of Ghana, Kumase, MAG 1/17/6 , Correspondence between the District Commissioner' office and the *Asantehene*, March 1944

however prevalent during the cold and wet seasons. According to W.M Howells, Senior Health Officer of the Gold Coast, during the year 1937, out of every thousand deaths registered in the Gold Coast, 165 were due to non-tuberculous diseases of the respiratory system and 94 were due to pulmonary tuberculosis. [476]

On 24th August, 1941, the Senior Health Officer identified the outbreak of whooping cough at Anwomase. He said almost all the children at the village had bronchial colds complicated by malaria. The condition was due to abnormal cold and wet weather aggravated by the local sanitary conditions, which were most unsatisfactory. [477] The disease was transmitted from person to person commonly by what is known as droplet infection. Although the non-tuberculous diseases of the respiratory system are not infectious like smallpox, they may by means of droplet infection, become epidemic, strike down a large percentage of the population and cause many deaths. This situation normally happened during the rainy season in Ghana including Asante. It is during this period that the people crowded together for warmth and closed all the ventilation openings in their rooms.[478]

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

[476] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer
[477] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, Whooping Cough Outbreak at Anwomase, 1941
[478] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer, 1941

and as the captain of the men of death. Infection of man with human *tubercle bacilli* is principally by the inhalation of a bacillus coughed up by patients with pulmonary tuberculosis.[479] As a result, pulmonary tuberculosis is the commonest form of the disease. According to the Senior Medical Officer, Dr. Howells, such sputum from a person suffering from a tuberculous infection of the lungs might contain hundreds or thousands of the *Baccillus tuberculosis*, the germ that causes the disease. These minute fragments of germs could float in the air of a room for a long time and might bring infections to many people.[480]In 1940s, it was advised by the Senior Medical Officer Dr. W.M Howells that if a mass of sputum is exposed to the direct rays of the sun, the drying process is rapid, and the life of the germs of infection is comparatively short. However, in a dark, poorly ventilated room, the process is gradual and a mass of sputum or expectoration may give off germ-carrying fragments for a prolonged period. [481]

Again, it was re-iterated by the Colonial Administration that promiscuous spitting by a person suffering from pulmonary tuberculosis meant infection of many other persons and, as a direct result, increased numbers of deaths.[482] In the "highly civilized" countries, it was found out that as soon as a person was found to be suffering from pulmonary tuberculosis, he was given a pocket spitting-flask. This is a small bottle containing a little disinfectant fluid and provided with a tightly fitting cap. Significantly, it is not good for a person suffering from pulmonary tuberculosis to swallow his sputum; hence, the patient was advised to bring out the flask, remove the cap, spit into the bottle, replace the cap and return the flask to his pocket. Daily, the flask was

[479] Howe (Ed.), *A world Geography of Human Diseases*, 175
[480] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer
[481] Manhyia Archives of Ghana, Kumase, MAG 1/17/6, A presentation on the Spitting Habit, presented by W.M. Howells, Senior Health Officer, 1941
[482] Ibid

emptied, the contents were burnt and the flask was disinfected. [483]

For the purpose of wiping his mouth, an infected person was advised to carry about with him a supply of paper handkerchiefs sufficient for the day. When one was used, it was not thrown away, but it was placed in a container carried in the pocket, and at night, all the used paper handkerchiefs were burnt and the container was disinfected. These measures were promoted by the Colonial Administration amongst the indigenous people of the Gold Coast including Asante to ensure that persons suffering from tuberculosis of the lungs did a great deal to prevent themselves from becoming a danger to the public. The Senior Medical Officer was of the view that legal measures would not help control the spitting habit of the people of the Gold Coast including Asante. However, he argued that all highly "civilized countries" had stringent regulations against the practice of spitting in public places whether they were suffering from pulmonary tuberculosis or not. Any contravention of these regulations was punished with heavy fines. [484]

In the case of the Gold Coast, the Senior Medical Officer stated that apart from the fact that bad spitting habits spread diseases, spitting is a filthy habit and public opinion in such a country as Great Britain, the colonial masters, did as much to curtail it as had any legal measure. The legal measure could not be fruitful in Ghana including Asante because there was too wide a gap between the lettered and the unlettered in the society. However, it was proposed that some years of education was necessary. It was believed that as education spread, public opinion as in Great

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

Britain would tend to bring the less thoughtful members of the general public into line. Then, legal measures would be required to curb the persistently thoughtless offenders who should and often do know better.[485]

In the 1950s, teachers in the country including Asante were advised to use their influence to educate their pupils to free their minds from the negative spitting habits they had acquired from their parents, clan heads, and uncles, siblings among other members of the nucleus and extended family and the community at large. It was realized that, if the dangers of the bad spitting habit was explained to pupils, they would influence the coming generation to discontinue the ill-spitting habit.[486]

Again, another infectious disease which infected the people of Asante by the first half of the twentieth century was leprosy. In 1927, the Medical Officer of Health stated that leprosy, in his opinion, was largely on the increase in Asante principally due to the influx of people from the northern territories.[487] Several measures were taken by chiefs and the Colonial Administration to contain the situation in Asante. Leprosy was in Asante especially Kumase in the 1930s. The *Asantehene* became very concerned about the rate of infection and how the streets of Kumase were being filled with lepers. [488]

On 27th February, 1936, a letter was sent from the Office of the *Asantehene* to the Acting District Commissioner of Kumase, calling for the removal of lepers off the streets of Kumase. This was

[485] Ibid
[486] Ibid
[487] Manhyia Archives of Ghana, Kumase, MAG 1/17/1A, Report of the Medical Officer of Health, Kumase, 1927
[488] Ibid

necessitated by the fact that a large number of lepers moved about in Kumase. Based on the contagious nature of the disease, it was feared that if the Colonial Administration did not take immediate steps to remove them from the Kumase township and detain them in the Contagious Disease Hospital, in the shortest possible time, the disease would spread through Kumase and the whole township would become a city of lepers.[489]

In contrast, the demand for the removal of lepers by the *Asantehene* did not receive the necessary and urgent response from the Colonial Administration. The Acting District Commissioner denounced the call of the *Asantehene* because the health authorities did not possess powers to segregate lepers. However, the Commissioner suggested that lepers in Kumase should be persuaded to go to the Kumase Leprosarium for treatment. The treatment of lepers was clearly restricted to the Kumase Leprosarium.[490] However, among the indigenous population the disease was considered as a curse which came upon an individual and his household as a result of a misdemeanour on the part of the individual or his family. The notable cause of the disease was not known to the indigenous people of Asante. Treatment was based on recourse to shrines and herbalists whose medicine was rather considered by the indigenous people as more efficacious than the modern medicine introduced by the Colonial Administration.[491]

The disease had dire social consequences. Those infected by the disease in Asante were not only removed from their kin groups.[492] Thus, even when a member of the kin group has been cured

[489] Manhyia Archives of Ghana, Kumase, MAG 1/1/46, Correspondence between the *Asantehene*'s Office and the District Commissioner, February 1936
[490] Manhyia Archives of Ghana, Kumase, MAG 1/1/46,Correspondence between the *Asantehene*'s Office and the District Commissioner, February 1936
[491] Interview with Opanin Kwabena Amoah, Breman, Kumase, 20th January, 2007
[492] Ibid

and reintegrated into the family and the community at large, the stigma of the disease lingered with the family.[493] The more redeeming feature for those who suffered from leprosy from the social and psychological costs was the church which had gained foothold in Asante especially in the 1940s and the Indigenous Healers rather than the medical machinery set up by the Colonial Administration.[494]

Again, another redeeming effort put in place by the Colonial Administration was the establishment of settlements for lepers in Asante. Most importantly, between 7th and 23rd January, 1948, the Medical Officer of Health in Asante, A. M. Kelrie visited various towns and villages in Asante to meet chiefs and the indigenous people to find out their attitude towards leprosy, which the archival records have noted to be chronic during the 1940s in Asante. Some of the people he met included those who were suffering from leprosy, Colonial government officials, missionaries and other non-Africans who could tell their experience with lepers.[495]

Kelrie travelled from Kumase to Lake Bosomtwe near Kumase. He visited seven lakeside villages where he examined lepers who were brought to him. The rate of leprosy in the lakeside area was very high. The reports of Kelrie stressed that except in few places where some of the indigenous people were suspicious of his intentions, the *Odikros* and the people in the villages he visited in Asante were anxious and co-operated with him in an effort to combat leprosy.[496] However, some of the people he met wished for legal powers to compel lepers to be segregated. But within the period segregation or compulsion was noted to have failed in places where they

[493] Ibid
[494] Ibid
[495] Manhyia Archives of Ghana, Kumase, MAG 21/1/6, Correspondence between the Medical Department, Accra and the Ashanti Confederacy Council, 27th January, 1948
[496] Ibid

were instituted. It was noted that if compulsion was used people infected would not report for treatment[497] It was a noticeable fact that segregation of lepers was essentially in the interests of the Asante community and specifically, Kumase as well as the lepers themselves. It was known by the Colonial Medical Authorities in Asante that leprosy could be cured but the cure requires patience on the part of both the patient and the doctor. It was observed by the Colonial Administration in Asante that if lepers were kept together they would be saved from the long marches to treatment centres and their cure would be properly effected by living a life of sufficient supervision under the doctors to ensure that they were fully cured.[498]

As part of social and economic activities of the indigenous people of Asante especially in the first half of the twentieth century, some of them were infected with diseases that infect both man and animals. These infections or diseases have been termed as zoonoses which include rabies, canine rabies, bovine pleuro-pneumonia, taemia solium and trypanosomiasis among others. Significantly, the efficiency of veterinarians during the Colonial period at the Gold Coast and Asante specifically served as a means of prevention of infection in animals and its spread amongst the human population. The first veterinarian at the Gold Coast was appointed in 1921. In 1932, attempts were made to deal with bovine pleuro- pneumonia and rinderpest, the major destroyer of cattle, which in 1896 and 1909 came to Africa and caused great devastation to livestock. Bovine pleuro-pneumonia destroyed many cattle in Asante. A laboratory was opened at Pong in Tamale to help deal with animal diseases including Rinderpest. However, because of shortage of staff nothing was done in north-west Asante until 1941 when anti Rinderpest

[497] Ibid
[498] Ibid

immunization was done.[499]The Pong Laboratory did not have a Pathologist. It was therefore manned by the Director of Veterinary Services and one European Laboratory Technician and later, a Ghanaian who they trained themselves. Since the Director of Veterinary Services worked on part-time basis at the Pong Laboratory, he could not achieve the desired result.[500]

It was advised that all cows, which were reared since 1941 immunization, should be treated and all cattle were to be vaccinated against pleuro-pneumonia annually. Bulls were to be castrated, Native Demonstration Farms were to be set up, and proper shelters were to be built for the livestock. It was also found out that the North-West Asante was under stocked with cattle and breeding cattle were to be sent there. The first in this cattle business were the Wangara, followed by the Banda who bought cattle from the north, reared them and sold them in the Wenchi and Kintampo markets. Sheep and goat rearing also thrived in Asante. Pigs entered and were to be improved by getting good boars from Pong, Tamale.[501]

Pigs at one time were in large numbers in Asante but one sanitarian who has been described by the records as a super-enthusiastic sanitarian, Dr. Selwyn Clarke carried out an extermination crusade against the Asante pig and it was only in the remote areas like Banda that they survived. Pigs used to be in large quantities in and around Kumase but the extermination exercise reduced the number drastically. The idea was that pig was insanitary as a scavenger and became infected with the cystic stage of the human tape worm hence was a danger to health.[502] The Director of Veterinary had this to say concerning pig extermination:

[499] Manhyia Archives of Ghana, Kumase, MAG 1/1/101, Livestock industry, 1942
[500] Ibid
[501] Manhyia Archives of Ghana, Kumase, MAG 1/1/101, Livestock industry, 1942
[502]Ibid

> This may have been quite sound in the old treatment days when Moses was the leading health authority but our hygienic knowledge has progressed since then and we are now aware that adequate latrines and improved animal husbandry will inhibit all together this infection and we can have the dual benefit of pork and freedom from Taemia Solium- a disease which affected pig and human.[503]

Two cases of Canine Rabies were confirmed by the Colonial Administration and a number of suspected but unconfirmed cases occurred in Kumase during the month of May, 1941. It therefore became necessary for the imposition of certain restrictions by the Veterinary Authority in Kumase under the auspices of the Colonial Administration.[504] Five rules were spelt out from the office of V.E. Whitman, the Senior Veterinarian in Kumase in 1941. Firstly, it was enshrined that dogs should be given protective inoculation against Rabies to prevent its transmission to the indigenous people. Also, it was a policy that dogs which had not been inoculated would be destroyed. This was clearly an alternative for recalcitrant pet owners who did not inoculate their dogs. Any animal, which was not inoculated within the past five months of the passage of the Diseases of Animal Ordinance, could not be considered by the Veterinary Authority to be protected against Rabies.[505]

No dog, whether protected or otherwise, was permitted to leave its owner's house unless muzzled or on a lead and conducted by a responsible person. Any infringement of this section involved seizure of the dog on the first occasion and destruction if repeated. Again, no dog was

[503] Manhyia Archives of Ghana, Kumase, MAG 1/1/101, Livestock industry, 1942. The Director of Veterinary Service, J.L Stewart was unhappy about the ruthless measures employed by the Medical Officer of Health at the time.
[504] Manhyia Archives of Ghana, Kumase, MAG 1/1/134, Disease of Animals Ordinance, May 1941
[505] Manhyia Archives of Ghana, Kumase, MAG 1/1/134, Disease of Animals Ordinance. Five rules were spelt out from the office of V.E. Whitman, the Senior Veterinarian in Kumase, 1941

to be taken to any place where people congregate or to any other person's house. In addition, no dog or cat was to be brought into or taken out of Kumase without the permission of the Medical Officer of Health.[506] Charges were preferred against owners of animals who did not comply with the regulations and in most instances; there was the destruction of the animals concerned by the Veterinary authority.[507]



**5.2 The Genesis of the KPHB**

The Kumase Public Health Board (KPHB) was formed as an outgrowth of the Bubonic plague in 1924 to serve as an agency of the Colonial Administration to forestall the occurrence of epidemics. The Board served as an agency for change as distinct from the activities of the Native Administration presided over by the *Asantehene* and other chiefs and headmen in the Asante Native Confederacy who were also used by the Colonial Administration to prevent the spread of communicable diseases and disease prevention in Asante including Kumase. The system of Native Administration was introduced by the Colonial Administration. It ensured that within a traditional state or a group of smaller states, the paramount chief, their leading sub-chiefs and important counsellors were constituted into a Native Administration later named a Native Authority presided over by a paramount chief.[508] In Asante and elsewhere in the Gold Coast, the Native Authority dealt with matters relating to customary and traditional institutions and practices. They operated under the general direction of the District Commissioner appointed by the Colonial Administration. These functions included the meeting of specific needs including

[506] Ibid
[507] Ibid
[508] PRAAD, Kumase, ADM 22/12/39, Ashanti Native Authority (Amendment) Ordinance, 1939

sanitation needs as would be made necessary by law or as a result of a directive from the Colonial Administration to such Native Authority. [509]

The KPHB comprised eminent people in Kumase and for that matter Asante. At any instance the Board was panelled by a president, Medical Officer of Health, Senior Principal Engineer, Treasurer, Assistant Treasurer, *Asantehene*, *Serkin Zongo*, Officer Commanding Gold Coast Regiment, one chief and two other members.[510] This representation suggests that the board was very extensive in its operations and was both a civil administrative agency and a health providing and promotion machinery.

The KPHB was a precursor to the Kumase Town Council (KTC) which took off in 1943. This section juxtaposes the activities of the KPHB which was the agency of the Colonial Administration with the Native Heads or rulers towards the development of public health or the prevention of diseases in Asante and points out where the Native heads or chiefs and headmen collaborated with the Colonial Administrators especially where ordinances and statutes made it so to forestall the occurrence of epidemics.

**5.3 Efforts of the Colonial Administration and the KPHB**

Ghana passed its first public health law in 1878. This was the Town Police and Public Health Ordinance. Under this law, buildings could only be erected with the permission of the governor, old buildings had to be repaired or demolished. The colonial surveyor was responsible for clearing and draining the streets and the government could impose fines on those committing

[509] Ibid, Buah, *A history of Ghana*,106
[510] Manhyia Archives of Ghana, Kumase, MAG 1/17/1A, Kumase Public Health Board File, 1926-1928

public nuisance. Firstly, the laws were applied to Cape Coast, Elmina, Accra and Lagos and gradually extended to other places including Asante.[511] However, these laws were rarely enforced until the latter part of the nineteenth century and the beginning of the twentieth century when they received much attention.[512]

In Ghana, the outbreak of the plague in 1908 became the fundamental reason for Governor Rodger to establish the basis for a sanitary reform. He placed much emphasis on sanitation including good drinking water. However, the earliest greatest sanitation activity of the colony could be put between 1910 and 1920 during the governorship of Sir Hugh Clifford. Dr. T.E. Rice became the first head of the Sanitary Branch. It was this body, which laid the foundation of sanitation in Ghana.[513]

By the end of 1900, over twenty Asante towns including Kumase were receiving sanitary attention. Sanitation in Kumase included the provision of wells and water tanks, incinerators, public latrines, slaughter houses, improvement of markets and construction of drains and the draining of swamps. Increasing attention was focused on the villages in Asante. By 1920, the wide range and variety of sanitary activities had spread deep into Asante.[514]

Addae argued relying on colonial records that before 1920, countrywide; the issue of filth was far better in Asante than along the coast. He argues:

[511] PRAAD, Accra, ADM 11/10/193, Sanitary Bye-Laws under the Native Jurisdiction Ordinance No.5 of 1883., Addae, S, *History of Western Medicine in Ghana, 1880-1960,* 88
[512] Ibid
[513] Ibid
[514] Addae, *History of Western Medicine in Ghana, 1880-1960,* 91

> Except the Ashantis the Africans in particular the coastal Africans, it would seem to the Europeans, had not the vaguest notion of sanitation, and what was even more extraordinary to Europeans, they were generally most resistant to efforts to change their ingrained insanitary habits. Observations and comments of this nature run through practically the entire medical and sanitary reports between say 1900s and 1920 and it is said seldom if even Africans were able or willing to institute, unassisted, for themselves, even the most elementary sanitary measure.[515]

From the above we understand that in the rural communities progress in sanitation was slow. Even though Asante did not receive colonial sanitation service very early, the response of Asante communities to sanitary reform was far more positive than anywhere else. However, it is true to state that the first half of the twentieth century presented several health challenges to Asante which necessitated the concerns of both the Native Heads and the Colonial Administration. Firstly, the people of Asante and Kumase in particular suffered from several diseases that were more related to their lifestyle mostly as a result of the poor sanitary conditions of their environment. Several of these diseases existed even before the twentieth century. Malaria and fevers, for example, had been with the people of Asante prior to the twentieth century. Lifestyle related diseases like tuberculosis infections, small pox, cholera, amoebic dysentery and typhoid fever were systematically dealt with as a result of the systems that were put in place by the Colonial Administration to promote sanitation and healthy living.

The Colonial Administration created the office of the Town Clerk under the KPHB from where the Medical Officer of Health operated. The Town Clerk was an officer with a municipal experience. At the office of the Town Clerk there were an accountant, two assistant clerks, one junior clerk, an auditor, a legal advisor, a bailiff and a messenger who were responsible for the

[515] Ibid

day to day administration of the office.[516] In addition to the Town Clerk were other officers who saw to the enhancement of the sanitary and health conditions of the people of Kumase. The Colonial Administration created the office of the European Town Inspectors. Their duty was to supervise sanitary inspectors in the various townships.[517] Below the European Town Inspectors were the Second Division Sanitary Overseers who replaced the then Government Sanitary Inspectors. Later, there were the first division sanitary overseers who were responsible for ensuring good sanitary conditions at various municipalities.[518] The first division sanitary overseers also supervised divisional sanitary overseers, who ensured good sanitary conditions in the Kumase Township. At the lower echelon were the latrine gangs who were responsible for the cleaning of latrines.[519] By 1928, in Kumase the labourers were hundred in number. There were also the incinerator and dustbin gangs that were responsible for the maintenance of incinerators and the collection of refuse to ensure good sanitary conditions in the Kumase township. Their work was augmented by the scavengers or street sweepers.[520]

There was also the creation of the Anti-Mosquito Brigade (AMB) whose activities were supported by the Mosquito Ordinance of 1911. Among its provisions, private domestic dwellings in certain designated towns had to submit to authorized entry, Laval and general sanitary inspection by sanitary inspectors between 6am and 6pm any day. Prosecution followed a laval offence with a fine of up to five pounds inflicted.[521] In Asante, they were responsible for the prevention of mosquito that spread malaria. They were tasked by the Colonial Administration to

[516]Manhyia Archives of Ghana, Kumase, MAG 1/17/2, KPHB, Estimates of revenue and expenditure, 1927-1928
[517] Manhyia Archives of Ghana, Kumase, MAG 1/17/2, KPHB, Estimates of revenue and expenditure, 1927-1928
[518] Ibid
[519] Ibid
[520] Manhyia Archives of Ghana, Kumase, MAG 1/17/2, KPHB, Estimates of revenue and expenditure, 1927-1928
[521] Addae, *History of Western Medicine in Ghana, 1880-1960,* 94

fill marshy and lowly areas with indestructible refuse with top dressing of earth, to oil swamps and ponds among other things. Finally, there was the creation of the town works section. They were responsible for the maintenance of town offices, pumps, wells and chlorinization plants. The others included maintenance of plants, tools and tree planting. They were also responsible for the maintenance of sanitary structures, bungalows, and new zongos, market and slaughter houses.[522]



To ensure effective health administration, the Colonial Administration under the auspices of the KPHB was able to generate funds from the various services it rendered to the people of Kumase and also from taxes. The Colonial Administration generated revenue from licenses on alcohol, hotels and restaurants. Some of the revenue also came from wheel rates, bicycles, and motor licenses. Another source of revenue came from fees or dues from the slaughter houses, market table dues, and payments for the clearing of private latrines. The other sources included revenue generated from dustbin clearance, building plans and permit fees, quarrying fees, receipts for vehicle badges, property transfer duty, sanitary utensils and latrine pans.[523] From the period 1927 to 1928 the estimated revenue for the KPHB of the Gold Coast Colony was thirty-six thousand seven hundred and thirty pounds.[524]

All the workers in the Town Clerk's office including the sanitarians were remunerated through the revenue generated by the KPHB. The allowance for the European Town Inspectors as at 1st April to 31st October 1926 was fifty pounds. However, to improve the service and to boost the working moral of the public health workers, the KPHB by an estimated budget of the period

[522] Manhyia Archives of Ghana, Kumase, MAG 1/1/4, KPHB Estimates of revenue and expenditure,1927-1928
[523] Ibid
[524] Ibid

1927 to 1928 increased the allowance to hundred pounds.[525] As at 1926, there were one hundred labourers in the sanitary division. Twenty people were added by 1927, this became necessary as a result of the additional latrines to be cleared and cleansed. Significantly, during this period there were construction and development of new schools, new railway quarters and new bungalows.[526]



Beyond meeting the needs of the officers of the Town Clerk's office and other sanitary workers, the KPHB was also responsible for proper infrastructural development as exemplified by the revenue it generated from building plans and permits. It was responsible for the maintenance and repairs of the available infrastructure and facilities in the departments of the Colonial Administration whose rippling effect was a viable and a progressive sustenance and promotion of public health. The KPHB provided funds for the maintenance of slaughter houses, ponds, sanitary structures, improvement of water supply, maintenance of pumps, wells and chlorinization plants, purchasing and maintenance of plants and tools, motor conservancy and meeting specific and entire needs of various departments like the Town Engineer's Department. The KPHB also financed tree planting, maintenance of bungalows, markets, provision of railway freight on materials, office furniture, petrol and oil for lorries.[527] As already emphasized the KPHB financed the Anti-Mosquito Brigade. By the 1930s the KPHB, presided over by John Maxwell, provided for the Anti-Mosquito Brigade new items required to fill marshy and low lying areas to prevent the breeding of mosquitoes.[528]

[525]Manhyia Archives of Ghana, Kumase, MAG 1/17/1A, KPHB File, 1926-1928
[526] Manhyia Archives of Ghana, Kumase, MAG 1/1/4A, KPHB, Estimates of revenue and expenditure, 1927-1928
[527] Manhyia Archives of Ghana, Kumase, MAG 1/17/1A:,KPHB File, 1926-1928
[528]Manhyia Archives of Ghana, Kumase, MAG 1/1/4A, KPHB, Estimates of revenue and expenditure, 1927-1928

By the 1930s, it had become relevant to deal with the health and sanitary conditions of the physical environment of Asante. The health and sanitary conditions of some of the villages were described by the Colonial Administration as appalling. The Colonial Administration as a result of its findings in Asante and elsewhere developed a pamphlet on village health issued by the Director of Education. The major issues for discussion during this period were based on the theme that "health is a life to be lived and not a subject to be taught."[529] In the 1930s there was a steady growth for the value of a clean sanitary layout for villages. Although the picture seemed to be bright there lurked a shadow of regret. There were several villages and dwellings in Kumase and surrounding villages that had poor sanitary conditions.[530]

According to the Colonial Administration, the hindrance to good dwellings and proper sanitation was based on local custom, apathy and prejudice. An active opposition to the efforts of the Colonial Administration to change the health and sanitary conditions in Asante came from those Indigenous Healers who perceived a diminution of their influence as a result of the presence of Europeans.[531] Above all, the fear of incurring expenses on the part of the local people also served as a hindrance to the introduction of modern ideas of sanitation and healthy living. The Colonial Administration suggested that the villages, small towns and communities in Asante could improve the health of their inhabitants by a small expenditure, labour and organization or planning.[532]

[529] Manhyia Archives of Ghana, Kumase, MAG 1/1/12, *Asantehene's* secretary's office, Eastern Province, Asante, 1930-1940
[530] Ibid
[531] Ibid
[532] Ibid

Also of major concern to the Colonial Administration was the disposal of refuse. It was suggested that care should be taken in the disposal of refuse. The Colonial Administration noted that refuse dumps should be marked out at least one hundred yards from the nearest house and all people were directed to dump their household refuse there. Closely linked to this, the Colonial Administration advised that as often as necessary, refuse had to be burnt and combustible refuse were to be raked when dried. All tins and bottles were also to be buried.[533] Urban dwellers like those in Kumase were also encouraged by the Colonial Administration to construct pit latrines whose duration was specifically stated. For instance, it was noted that if a pit was thirty feet deep it was to last for three years.[534] Such latrines were not to be close to main roads and were to be hundred yards from any house.[535] The reason was to prevent people from contracting diseases as a result of their nearness to the latrine. By 1930, under the auspices of the KPHB there was the construction of eight latrines at some of the suburbs in Kumase at the cost of two hundred pounds each with the total cost being one thousand six hundred pounds. There was also the construction of two washing sheds at the cost of fifty pounds each.[536]

To prevent nuisance and zoonotic diseases, it became paramount for the Colonial Administration to ensure that animals were kept away from villages and rather kept in enclosures on farms. The records note that pigs were a great nuisance and were capable of transmitting diseases to man. The Colonial Administration ensured that disease and mangy dogs were not allowed to roam but rather destroyed.[537]

[533] Manhyia Archives of Ghana, Kumase, MAG 1/1/12, *Asantehene's* secretary's office, Eastern Province, Asante, 1930-1940
[533] Ibid
[534] Ibid
[535] Ibid
[536] Manhyia Archives of Ghana, Kumase, MAG 1/17/1A, KPHB File, 1926-1928
[537] Manhyia Archives of Ghana, Kumase, MAG 1/1/4A, KPHB, Estimates of revenue and expenditure, 1927-1928

As part of keeping Kumase clean, the Colonial Administration used incinerators to burn refuse. It required that additional labourers be added to the existing ones to work on the existing incinerators in the various vicinities in Kumase. By the turn of 1930, it had caused the KPHB more than thousand four hundred and sixty-five pounds in paying the allowances of health workers.[538]Another section of the sanitary division of the KPHB, the Water Guards were required to help prevent tampering with water chlorinization plant in Kumase. The Colonial Administration saw the need to provide good water for the people to ensure that they were free from waterborne diseases. Polluted drinking water had the propensity of increasing infestation. Some of the waterborne diseases which affected the people included dysentery, enteric fever or typhoid, cholera, swollen neck or endemic goitre, guinea worm and epidemic diarrhoea. It was observed that water containing gritty earth in suspension could cause the most painful virulent diarrhoea even if no harmful organism was present. This disease often produces an attack of jaundice of an obstructive nature. In line with this, it was suggested that deep-water wells and springs were to be constructed to prevent the occurrence of such health hazards.[539]

To prevent congestion, stuffiness and also to improve ventilation, the Colonial Administration advised that buildings should be spaced. The administration further stated that the overhanging roofs encouraged in African dwellings instead of verandas were good but where it was enclosed and sub-divided it rendered a house unclean. In 1930, Mamponten, a village near Kumase became a model town with its beautiful layout. It had straight street lines and spacing of homes

[538] Ibid

[539]Manhyia Archives of Ghana, Kumase, MAG 1/1/12, *Asantehene's* secretary's office, Eastern Province, Asante, 1930-1940

with good solid swish. It was certainly a model for a good sanitary condition in housing.[540] This was in affirmation of what Guggisberg called for in the 1920s. In his address to the Legislative Council he expressed that:

> A clean, well drained town, with broad streets, numerous open spaces and intervals between the houses is not only essential to the health of its inhabitants but is the finest measure that can be adopted to prevent the rapid spread of an epidemic.[541]



The nature of homes and village settings in Kumase and some villages in Asante were still generally not impressive. The indigenous people failed to realize the value of healthy homes. For example, in February 1935, it was noted that Besiase, a village near Kumase was filthy. Rubbish, human excretor, tins and bottles were disposed on every corner of the village and around the outskirts. Also, there were no sanitary pit latrines. The place was bushy with inadequate refuse dump, dirty water supply and no proper public cemetery; the children also defecated behind houses.[542]

The Colonial Administration was also concerned with the kind of food the people of Kumase and Asante in general ate since there were dietary related diseases. The administration suggested that fresh meat, goat, mutton or beef should always be used in preference to tin meat of any kind. This was so because they argued that the latter lacked nutrients or properties that are essential for the healthy growth of the body. Also, starchy foods such as cassava, cocoyam, yam and rice were to be taken in small quantities with much soup. It was argued that the stomach can only digest a

[540] Manhyia archives of Ghana, Kumase, MAG 1/1/12, *Asantehene's* secretary's office Eastern province, Asante, 1930-1940
[541] Addae, *History of Western Medicine in Ghana, 1880-1960* , 22
[542] Manhyia Archives of Ghana, Kumase, MAG 1/1/34A, *Asantehene's* secretary's office, Eastern Province, Asante, 1930-1940

certain amount of starch and when much soup was not taken and carbohydrates were not taken in moderation one could suffer from indigestion and constipation. The people of Asante were also encouraged to eat green vegetables daily as part of their regular meals.[543] The Colonial Administration further suggested that people should opt for goat milk because it was cheap and wholesome. Another major concern of the Colonial Administration was the taking in of drinks by the indigenous people. Drinks apart from water were categorized into alcoholic, non-alcoholic and stimulants. Some of the stimulated drinks were noted to be coffee, tea and kola extracts.[544] When these are taken in excess they cause a disordered heart action. With alcoholic drinks, it was advised by the Colonial Administration that if they were not taken in moderation then they were better left alone.[545]

### 5.4 Sanitary Conditions at Suame and Aboabo, a challenge to the Sanitary Division

By the first half of the twentieth century, the Sanitary Division made efforts to improve sanitation in Kumase. At a meeting held on 6th January, 1927, the KPHB approved a budget of two thousand and seventy pounds for the construction of sanitary facilities. Monthly reports were presented by the Medical Officer of Health concerning sanitation in some of the suburbs of Kumase. Some of the reports that came out especially in the 1940s when the work of the KPHB had folded up were not encouraging. In 1947, the reports on Suame and Aboabo were appalling. Suame had only one septic tank and four pit latrines, which were maintained by the Kumase

[543]Manhyia Archives of Ghana, Kumase, MAG 1/1/12, *Asantehene's* Secretary's Office, Eastern Province, Asante, 1930-1940
[544] Ibid
[545] Ibid

Town Council. The other existing three latrines were filled to overflow, strewn with faeces over the floor infested with maggots and flies and close to the public.[546]

Where incinerators were provided for the burning of refuse, the people did not maintain them. In Suame, the Kumase Divisional Council provided five incinerators. Each was situated by a latrine. By 1950, all the incinerators had broken down and were out of use. Refuse was dumped near the incinerators unburnt and there was no means of transport to dispose the waste.[547] Since the incinerators were out of use there was an indiscriminate disposal of refuse which resulted in poor sanitary conditions. At Aboabo, the sanitary condition was very appalling. The inhabitants had six pit latrines; however, they eased themselves anywhere at the outskirt of the township. Lack of incinerators precipitated an indiscriminate dumping of refuse by the inhabitants.[548]

Most of the suburbs in Kumase including Aboabo, which formed part of the growth of Zongos (places habited by migrants or strangers) and its consequent challenges, served as one of the congested and insanitary precincts favoured by people from the northern part of the country.[549] It had few or no slaughter houses. Where they had slaughter houses they had no proper slaughtering tools and in most instances cattle were slaughtered on bare ground which was highly unsanitary.[550] Mostly, slaughtering areas were filled with the stench of decayed blood. It was also a shelter for vultures and habitation for vermin and flies. There was also inadequate water supply. In the Suame area, available wells were dangerous to drink since all the filth in the area was washed by rainfall into the valley where the wells were dug. In an attempt to salvage

[546] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Sanitation and Roads, 1935
[547] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Sanitation and Roads, 1935
[548] Ibid
[549] Addae, Stephen, *History of Western Medicine in Ghana, 1880-1960*, 93
[550] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Sanitation and Roads, 1935

the situation, the Divisional Council made some recommendations.[551]It was recommended that new latrines should be provided for the people to avert the future threat of diseases. These latrines were also to be provided with incinerators.[552] Again, it was recommended that work should be done to improve existing temporary market sheds to render them rain and sun proof and the sheds should be rented to marketers. With regard to the slaughtering of animals, a slaughtering area was to be provided with a concrete slab for slaughtering animals and a sump provided to drain blood. Also, those who patronized the slaughtering houses were required to pay some fees to enable the authorities to equip them with slaughtering appliances and other tools to enable them to function efficiently and to provide the indigenes with sickness free meat.[553]

The Kumase Water Supply Department was approached to provide three standing pipes for the people of Suame. The water supply in Accra was far advanced than that of Kumase, therefore the Accra model was to be adopted to provide good drinking water for the people.[554] Another strategy that was employed by the Colonial Administration was the formation of health boards especially with the case of Suame (Suame Health Board, SHB) and Aboabo (Aboabo Health Board, AHB) to advice the Colonial Administration on matters pertaining to sanitation. Again, additional twenty sanitary workers were employed to clean the community and the outskirts of rubbish and dung.[555]

[551] Ibid
[552] Ibid
[553] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Sanitation and Roads, 1935
[554] K. David Patterson, *Health in Colonial Ghana: Disease, Medicine and socio-economic change,1900-1955*, 1981, 47
[555] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Sanitation and Roads, 1935

The sanitary condition of Asante especially Kumase was very paramount such that the Secretary of the Kumase Divisional Council was not hesitant to call on the Colonial Administration to hurriedly meet the needs of the people. In his remarks the secretary of the Kumase Divisional Council stated,

> The indifference of the administration towards the provision of sanitary amenities to the township has seriously affected the morale of the inhabitants and the Native Administration Sanitary Overseer now finds it difficult to collect the monthly rent of five pounds from house owners who for the reason of the neglect of sanitation, consider it unjustifiable to continue to pay rents.[556]

By 1946, sanitation issues in some of the villages in Asante were of concern to the Kumase Town Council. The council identified the needs of villages like Old Amakom, Asokwa and Patase. Five pit latrines and incinerators were provided for each of these villages. Sanitary labour gangs were posted to attend to sanitary duties in these areas. There was also the collection of a flat sanitation rate of one pound per month per household at the villages that were offered sanitary services.[557]

## 5.5 Attempts of Chiefs or Headmen at Providing Clean Environment for the People of Kumase

By the late 1920s progress had been made in urban and village sanitation especially in Asante.[558] The Native Heads generally showed keen interest in ensuring sanitation. To assist the Native Heads in enforcing sanitary principles, bye-laws were passed under the Native Jurisdiction

[556] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Sanitation and Roads, 1935
[557] Ibid
[558] Addae, S, *History of Western Medicine in Ghana, 1880-1960,* 93

Ordinance laying down penalties for breaches. These bye-laws were adopted by many of the paramount chiefs especially the "enlightened" ones like the *Asantehene.*[559]

In the first half of the twentieth century, Asante experienced sanitary campaigns from both the Native Heads and Colonial Administration. The sanitary collaboration between the Colonial Administration and the Native Heads resulted in the arrest of people especially hawkers who were considered as nuisance to the public health of the people. In December, 1928, some hawkers were arrested by a sanitary inspector at Manhyia for plying their trade at the premises. The Native Heads also received fines from offenders who flouted the sanitary rules in Kumase. Fines for sanitary cases from the *Asantehene*'s court B2 from January to June 1945 amounted to 12,726 pounds. In 1944 the people of Asante were continuously entreated by both the Colonial Administration and the Native Heads to undertake communal labour and people who refused were summonsed to appear before the *Asantehene's* court B.[560]

Cooperation between the Native Authorities and the Colonial Administration took a gradual turn. For instance, in 1928, the *Asantehene* wrote a letter to the District Commissioner requesting the release of hawkers who had been arrested and also permitting them to hawk at Manhyia. The *Asantehene* argued that there were old people and children at Manhyia some of whom could not go to the market to buy hence, the need to buy bread and other food items from the hawkers who had been arrested.[561] It is important to note that such a request was made by the *Asantehene* in an

[559] Ibid
[560] Manhyia Archives of Ghana, Kumase, MAG 1/1/12, *Asantehene's* secretary's office, Eastern Province, Asante, 1928-1930
[561] Manhyia Archives of Ghana, MAG 1/1/4B, Correspondence between the *Asantehene* and the District Commissioner,1928

attempt to persuade the Colonial Administration to reduce the strictness of some of the laws on sanitation that were seen to be harsh.

The Native Authorities also passed certain ordinances that ensured that chiefs were responsible for proper sanitary and healthy conditions in their villages. In 1935, there were orders from the Asante Confederacy Native Authority under Section 9 of the Native Authority Ordinance. These orders were cited as the Asante Confederacy Native Authority Sanitation Orders and applied to all villages within the area of the Asante Native Authority. The ordinance gave specific instructions to chiefs in Asante. The chief of every village, where necessary, was to select sites in the vicinity of his village for latrines and rubbish dumps, these sites were not to be less than fifty yards from any house or hundred yards from any water supply.[562] Significantly, the distance was to ensure that the stench from the solid and liquid waste did not contaminate the existing water bodies that would render them unsafe for human consumption. The closeness of refuse dumps and latrines to human settlement has the propensity to spark off epidemics.

Again, a chief of every village in Asante constructed and maintained sufficient latrines in accordance with specifications approved by the Health Officers. Chiefs saw to the closure and filling with earth any existing pit latrine and were to construct new ones when instructed in writing by the Native Authority.[563] Also, chiefs ensured that the vicinity of the latrines was kept clean and in good order. In addition, the chief ensured that the clearing of bushes was at least fifty yards to the outskirts of the village and he also saw to it that the clearance was

[562] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Asante Confederacy Native Authority Sanitation Orders, 1935. Sanitary Bye-Laws under Native Jurisdiction Ordinance No.5 of 1883
[563] Ibid

maintained.[564] This condition prevented snake bite, harmful flies and insects. It also secured the indigenous people from coming into contact with poisonous plants and wild animals that could be injurious to their health and well-being.[565]

Furthermore, when a chief is called upon by the Native Authority or given instruction by such authority to demolish any ruined house standing in his village, he should have it levelled and the site cleared of rubbish. These directives were to be carried out with the hope of saving his community from any danger or physical injury such a structure could bring to his people.[566] Chiefs in Asante wielded lots of power and most importantly regarding sanitation; the order of a chief was to be duly complied with as required by statute. Any inhabitant of a village who wilfully disobeyed the orders of a chief concerning the clearing of the vicinity of bushes and weeds, market sites, the demolition of ruined houses within a stated period of which a demolition order approved by the District Commissioner had been received by the chief, was liable to some penalties.[567]

In addition, no person was able to erect any building or made an extension to any existing building in any village without the permission of the chief of the particular village. It was the responsibility of the chief to ensure that a space not less than twenty clear feet was the distance between the building or buildings on one plot and the nearest building or buildings of the adjacent plot.[568] Significantly, this was done to ensure proper ventilation and space to allow free movement of settlers that was relevant so far as the health needs of the people of Asante was

[564] Ibid
[565] Ibid
[566] Ibid
[567] Manhyia Archives of Ghana, MAG 1/1/35, Asante Confederacy Native Authority Sanitation Orders, 1935
[568] Ibid

concerned. Closely linked to this was the demand that each building plot was not to be less than 60 x 80 feet in size. Also, the building was not to block or be an obstruction to any road or path and such a building was supposed to be in line with other buildings. A chief ensured that all buildings conformed to the layout of the village as approved by the Native Authority.[569]

To ensure public safety, it was required that no building or additional street was constructed without a permit from the Native Authority. Also, if such building was not of an approved type design and with a small-scale block plan and a short specification of materials with which the structure is proposed to be built, which their dimensions have been provided for and approved by the Health Officer, the Native Authority ensured the demolition of such building. Again, no room was constructed of a less horizontal dimension of 120 square feet or an average height of 10 feet. Windows and louvers in every room by statute were to provide a total ventilation area of not less than one length of the floor space.[570] All floors were to be six metres thick above ground level and also due provision was to be made for the drainage of the yard. To ensure that these provisions were complied with and for buildings to be properly maintained, owners of buildings in the Asante Confederacy were charged by the Native Authorities to keep their buildings in a proper state of repair. It was unlawful for a landlord to remove any building material from any building without the consent of the chief of the village or town in which the building was situated.[571]

Chiefs in Asante were empowered to prevent people to trade in anything that were detrimental to the health of the people. No person was allowed to conduct any work, manufacturing, trade or

[569] Ibid
[570] Ibid
[571] Manhyia Archives of Ghana, MAG 1/1/35, Asante Confederacy Native Authority Sanitation Orders, 1935

business in such a manner as to be or likely to be a nuisance or injurious to health. Again, no person was allowed to keep any animal in a way that was a nuisance or injurious to health in any public place.[572] The keeper of an animal was not allowed to use any site for the purpose of avoiding excrement or depositing rubbish other than that appointed by the chief. Also the people of Asante were not permitted to grow crops within hundred feet of any building unless the crops were low growing crops that were allowed to grow within 20 feet of a building. Rats were also identified as major carriers of bubonic plague. Occupants of various households were therefore tasked by the Native Authority to rid their premises of rats. Landlords and tenants of various premises were charged by the Native Authority to prevent the carrion of filth, rags, broken bottles, empty tins including refuse and other things which are detrimental to the health of the indigenous people of Asante. Again, an occupant of a plot was responsible for keeping clean only one half of a street and a drain, gutter or channel on the side of the street near his lot.[573]

Chiefs in Asante also ensured that the occupants of a land or a building in a village prevented the growth of weeds, long grass, or wild bush of any sort or any standing water or any other reasonably preventable condition, which in any way was favourable for the breeding of the mosquito which causes malaria to remain on such land or within such building or an unoccupied land adjoining and within twenty yards of it. Individuals were tasked not to permit at any time on their premises the presence of any receptacle for water containing mosquito larvae or allow any water to be kept on their premises in any container unless such container was properly protected to the satisfaction of the Health Officer. It was also a serious offence for one not to inform the

[572] Ibid
[573] Ibid

chief of his village of the presence of any sick person who in his opinion was suffering from any infectious disease.[574]

One of the major concerns of Asante chiefs bordered on water supply. Chiefs in Asante according to the orders of the Native Authority constructed water supply of a particular type on a site approved by the Health Officer. Asante chiefs ensured that the surroundings of their sources of water were kept clean and their wells were protected from surface water. It was unlawful for any person to contaminate any source of water used for drinking purposes. Persons who flouted this were liable to the penalties provided by section 11 of cap 79. Penalties were slammed on those who failed to comply with the order of a chief to clean, drain or build in the way of water supply. Pertaining to the burial of the dead, the chief of a village notified the Native Authority of the occurrence of all death and the place of burial. Except with the approval of the Native Authority, dead bodies were to be interred only in the village cemetery or the ethnic cemetery of the deceased.[575]

To recapitulate, chiefs or native heads under the office of the Inspector of Nuisance wielded some powers under Section 20 (1) of the Town Ordinance to call on people to abate or reduce nuisance that were in the form of bushes, unkempt latrines, and rubbish dumps. Again, the existing Native Courts also had the power to summon people who committed the offence of nuisance. These offenders were made to fill sanitary forms from which various fines were received by the Native Authority. Fines for sanitary cases in the Native Administrative courts by

[574] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Asante Confederacy Native Authority Sanitation Orders, 1935
[575] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Section 7 of cap 79 of the Colonial Administration Ordinance

1945 amounted to 12, 726 pounds. Significantly, by 1945, the people of Kumase were continually inspired to undertake communal labour. People who refused to attend were mostly brought before the *Asantehene.* [576] The efforts of the Colonial Administration as well as the Native Authorities or chiefs in Asante improved the health of the indigenous people and ensured that there was the prevention of another epidemic especially after 1924 and the indigenous people were able to engage in their economic activities especially in Kumase without fear.



[576]Manhyia Archives of Ghana, Kumase, MAG 1/1//35, Section 20(1) of the Town Ordinance

# CHAPTER SIX

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

This chapter makes a summary of the findings of the study and shows the way forward. It analyses the findings on medicine in Asante and the training of indigenous healers from 1902 to 1957. The findings also include Colonial influence and changes in indigenous medical practices in Asante, and prevalent health challenges in Asante as well as responses from both the indigenous medical practitioners and the Colonial Administration. The others include findings on roles of the Colonial Administration, the KPHB and the cooperation of the indigenous people through the Native Heads in an attempt to forestall the occurrence of epidemics in Asante and Kumase specifically.

### 6.1 Summary of Findings and Recommendations

The study found out that in Asante the earliest indigenous medical practitioners included IPHs. From the period under review and beyond, the study, based on primary and secondary data, found out that the practice persisted. However, it was identified that the IPHs in Asante and Kumase also used herbs but the efficacy of their medicament was noted to be resident in the powers they invoked from deities. The study has postulated that in Asante the supernatural was the motive of the IPHs but medicine became the end result. Archival records have added to the fact that the efficacy of medicaments of IPHs in Asante and particularly Kumase from 1902 to 1957 is well attested to by adherents or those who patronized their activities.[577] According to one respondent, Kwabena Amoah, diseases sent to IPHs were those considered by the indigenous

[577] Manhyia Archives of Ghana, Kumase, MAG 1/1/10 2A, Correspondence between Ghana Psychic and Traditional Healing Association and the Asantehene 1963., Early Medication by Deities, A presentation from Dr. J.E Kofie, 3rd August 1963

people or the sick to require some form of supernatural intervention.[578] Several others also argued that the roles of IPHs were very persistent in rural Asante although by the turn of the 1930s and 1940s, due to urbanization, medical choices in Kumase were gradually tilting in favour of modern medicine. This notwithstanding, others have argued that the use of herbs widely formed part of the treatment people used both in Kumase and the entire Asante.[579]



The study has pointed out that the use of charms and amulets formed part of indigenous medicine in Kumase mostly administered by priest healers in spite of European presence. Charms and amulets were figures nicely shaped by indigenous craftsmen in Asante and Kumase who made a living out of them. Hanging of charms or amulets about the neck on a cord, or on the wrist or waist to ward off evil spirits that could cause physical injury, disease or psychological harm to the body of a person became a popular phenomenon even in the 1940s and 1950s in Asante.[580] Oral evidence has pointed out that those who made these charms and amulets fattened their purses.[581] The study found out that as a result of the increasing Christian influence on Kumase some bearers of these charms described them as crucifix. What accounted for this is due to Catholicism. This notwithstanding, it was either termed a crucifix or an amulet based on the social or religious orientation of the bearer at the time. The indigenous people could easily identify with statues and statuettes that were made by Catholics as part of their worship. Such physical forms of worship are known in traditional worship of the Supreme Being through deities. Talismans, as found out by the study within the period, were considered to be an advanced form of amulets. It also attests to Islamic influence in indigenous medicaments. It

[578] Interview with Opayin Kwabena Amoah, At his residence, Breman, Kumase, 20th February, 2009
[579] Ibid
[580] Interview with Papa Agyebi Nti, At his residence, Petrensa, 10th May, 2009
[581] Ibid

suffices to mention that the indigenous people who had been influenced by Christianity also alluded to the fact that talismans were hanged in temples to make votive offerings even from the 1940s onwards in Kumase.[582] Again, such beliefs as they existed in Asante and Kumase assuaged the perception that the presence of Europeans in Asante stifled the use and practice of indigenous medicaments.



The study also revealed that IPHs in Kumase and villages outside the township made financial gains within the period under study. Co-worshippers (The term refers to adherents who are not *akomfo* or *abosomfoo*- subjects to *akomfo*) paid to IPHs a sum of one pound six shillings and as a result of increasing adherents or co-worshippers in the 1930s the IPHs fattened their purses. Offenders who as a result of their misdeeds suffered from diseases and other misfortunes turned to IPHs to propitiate the particular deities concerned. IPHs received three pounds, six shillings from each individual who came to propitiate the deities. In the case of witchcraft the offender paid three pounds or the cost of cow in the north. Witch finding became a persistent feature in the medical practice of IPHs in Asante and Kumase specifically from 1907 through to the 1940s as pointed out by the study.[583] Witch finding took the form where the IPH ascertained whether the accused is innocent or guilty of such accusations levelled against him or her by the community, family or individual whom he/she is supposed to have bewitched. Such bewitchment took the form of visitation of a disaster or misfortune, physical injury or disease, among other things, on the bewitched. The increasing nature of witch finding in Asante from 1907 onwards in Asante and Kumase caught the attention of the Colonial Administration who started to close

[582] Ibid
[583] Manhyia Archives of Ghana, Kumase, MAG 1/1/22, Application for Physician license 1934-1940

down witch-finding shrines in Asante and elsewhere in the Gold Coast.[584] In spite of this, the office of the Secretary for Native affairs continued to enhance the relationship between the Colonial Administration and the indigenous people especially in their practice of certain customs or beliefs that was considered not to be inimical to public well being. However, witch-finding medicine continued to be a regular practice of some of the IPHs mostly in the villages at the outskirt of Kumase. The practice continued especially in the 1930s when it was not publicly assailed. Yet, it was within the same period the Asante Native Authority through Colonial Administrative legislation barred it as an unacceptable practice in Kumase.[585]

Yet, it has been buttressed by the study that the services of indigenous medical practitioners became a reliable option for a majority of the indigenous population in Asante within the period under study because the indigenous medical practitioners were people who had cordial relationship with the indigenous people and were well respected in the communities in which they served. It is therefore pertinent to encourage and include in the syllabus for the training of doctors, nurses, pharmacists and other modern health and Para health professionals, the history of medicine in Ghana, Medical Sociology, and Anthropology to ensure that modern health care practitioners understand the way of life of the respective communities they are posted to serve. This would improve efficiency. Closely linked to this is the fact that traditional Asante had deep-seated regard for IPHs. Generally, within the period under study, several indigenous Asantes were Christianized and their faith in the Christian Priests ran concurrently with that of the IPHs. It is therefore essential that the education of the indigenous population on matters relating to the prevention and treatment of diseases should include both the Christian Priests and IPHs.

[584] PRAAD, Accra, ADM 11/1/86, witchcraft-Persecution of persons accused, 1932
[585] Ibid

The general notion of indigenous people of Asante and Kumase about the infection of diseases and misfortunes in the first half of the twentieth century still persists. However, it further deepens the reliance of the indigenous people on the roles of IPHs in effecting treatment amongst the population. It should be noted that one of the influences of colonization is Christianization of the indigenous people. It is therefore understood that those who took to Christianity especially with the upsurge of Pentecostal and Apostolic churches in the 1940s and 1950s did so to allay their fears of being bewitched whose resultant effect could include physical harm or injury, diseases that are mostly incurable so far as modern medical therapies are concerned.[586]

There is an attestation of the fact that due to European influence the early twentieth century Asante saw a gradual shift from the supernatural or sacred beliefs to secularism. It was a kind of society that was gradually accepting European ideals especially in scientific and technological reasoning. This further influenced the indigenous people's choice of treatment for diseases in urban Asante especially Kumase. It was further advanced through increasing formal education in the 1940s and 50s. Again, increasing income of the elitists group in Asante placed emphasis on modern health care treatment whereas those on the outskirts focused much on indigenous medicament.[587] Two things accounted for this, the indigenous population had not seen much of modern medicine and secondly, their social orientation or worldview made them believe in the medicament of the IPHs, Herbalists or Bone-Setters among others. Yet, their educated chiefs who were exposed to modern health care and its benefits yearned, lobbied, appealed generally for such health systems and personnel to be sent to their inaccessible villages. Specifically, from

[586] Ibid
[587] Interview with Kwaku Nyanor, At his residence, Dichemso, 10th June 2009

1902, European dominance in the field of modern medical care in Kumase dictated the health discussions that emerged during the period. Thus, at the meetings of the Asante Confederacy Council from 1946 onwards, Asante chiefs raised issues pertaining to the dangers of the little or no modern health care facilities for some of the territories in Asante.[588] In 1946 Asante including Brong Ahafo had only two hospitals, one in Kumase and the other in Sunyani with a handful of dispensaries.[589] It is distressing to think of the number of persons in Asante who suffered and unduly died as a result of the absence of modern medical attendance. The request made by chiefs of Asante who met in Kumase in 1946 would not be totally different in the twenty-first century Asante, especially the pressing health challenges of the indigenous people clearly suggested that they could not wholly rely on indigenous medicaments. The request by Asante chiefs for the Colonial Administration to assist their communities towards the building of up-to-date hospitals, the need for villages to be provided with sufficient numbers of fully equipped dispensaries and qualified health personnel cannot be overlooked in the twenty-first century.[590] Also, the request made by Asante chiefs asking for one or two mobile dispensaries to be set up by the Colonial Administration in distant areas where patients would find it difficult to travel to the nearest dispensary or hospital is also relevant in the twenty-first century. These requests were made because if the sick received first aid treatment at the various mobile dispensaries or major dispensaries they could be transferred to major hospitals without life threatening complications. For example, in 1946 the *Mamponhene* argued that Asante was thinly populated and was afraid that if modern medical facilities were not made available the population might continue to be thinner.[591]

[588] Minutes of the Eight Session of the Ashanti Confederacy Council, 11th March, 1946
[589] Ibid
[590] Ibid
[591] Minutes of the Eight Session of the Ashanti Confederacy Council, 11th March,1946

Significantly, strong European presence in the 1940s and 1950s in Asante did not change indigenous patronage and regard for IPHs in both Kumase and rural Asante. Patronage mostly came from those who aspired to be rich and were afraid to suffer ailment or attack from negative forces in the venture they hoped to undertake. Mostly, it was also based on the belief that their association with them would attract good fortune.[592] In essence it is understood that the complex world view including those that played a greater role in defining existence, well-being and hereafter could not be easily erased by over fifty three years of strong European presence in Asante. It is therefore pertinent if indigenous medical practitioners were given the necessary training and support to enable them augment the services of modern medical practitioners especially in places where modern health facilities are limited or inaccessible. The persistent fears of some of the indigenous people in Asante of being surgically operated upon by modern medical practitioners as noted by the study formed part of the reasons they patronized the services of indigenous medical practitioners. It is important to find out whether there is evidence to show that these indigenous medical practitioners were and are still able to cure certain diseases which in modern medical sense were and are still considered incurable or could only be cured through modern surgery.

Similarly, the 1940s and 1950s saw a new affluence of a cocoa economy and opportunity for a distributive trade which made some indigenous people rich. During that time those who considered themselves to be economically rich in Asante entertained morbid fears about possible machinations of evil hated persons and therefore some of them relied on the services of IPHs of

[592] interview with Opayin Kwabena Amoah, At his residence, Breman, 20th February, 2009, Conversation with Papa Agyebi Nti, Petrensa, 10th May, 2009

what would be termed in modern terms as psychological relief but rather what they sought for was spiritual protection.[593] Although most of these people who reported to these shrines or healing centres were not severely ill, they sought to allay their anxieties attributed to witchcraft.[594]

Again, European presence and influence in Asante created the need for indigenous healers in Asante to advertise and, better still, start branding their medicaments especially in Kumase. The indigenous medical practitioners especially in the priest and herbalist class vehemently brought to the knowledge of the Asante Confederacy and the Colonial Administration the efficacy of the potions they administered. Especially from the 1920s to 1950s, several diseases they believed their medicines could cure included convulsion, leprosy, madness and blindness among others. What underscores their persistence in claiming to have the cure to these diseases was that amongst the indigenous population, there were diseases that were connected to the acts of deities against offenders or the misdemeanour on the part of an individual, the family or community which the patient is part of.[595]

The study found that during the first half of the twentieth century Asante the indigenous medical practitioners were traditionally organized under the *Nsumankwaafieso*. The study found out through archival information and oral data that the *Nsumankwaahene* is the chief physician of the *Asantehene* and was recognized as the head of all indigenous healers resident in Asante and Kumase specifically. Such an organization ensured that any practitioner under the jurisdiction of the *Asantehene* adhered to the demands of the indigenous healing milieu in Asante as supervised

[593] Interview with Opanin Seth Addae, at his residence, Ash-Town, 11th June, 2009
[594] Ibid
[595] Manhyia Archives of Ghana, MAG 1/1/22, Application for Physician license 1934-1940

by the *Nsumankwaahene*.[596] In the 1930s the Association of African Herbalists was formed to organize practitioners countrywide and to shape their practices to suit the standards of the Colonial Administration. Some of the standards included the use of herbs and potions which were considered not harmful to the health of the indigenous people as well as scientific reasoning and the dissociation of their practice from religious observances. Again as a result of Colonial influence and presidential directives in the 1950s there was the formation of the Ghana Psychic and Herbal Healers Association which further helped in organizing indigenous healers in Ghana and Asante in particular.



The study found out that the first half of the twentieth century Asante witnessed the influx of migrant physicians from outside the region of the Gold Coast into Asante. They came from countries like Togo, Nigeria and Burkina Faso. They claimed that their medicines could cure diseases like epilepsy, blindness, stomach ache, cough, piles and rheumatism. The medical environment as proposed by the study attests to the presence of different indigenous therapies as well as the presence of modern medical therapeutics. The different medical forms in Asante during the first half of the twentieth century made it a medically pluralistic society.

Again, the medically pluralistic society of Asante is emphasized in the persistence of Islamic medicine and culture in Asante which predates the first half of the twentieth century. The study has laid emphasis on the fact that it was non Asantes who introduced circumcision surgery into Asante. The study has also found out that significant indigenous Asante patronage of circumcision took effect from the 1920s onwards. The study has further deduced that the choice

[596] Manhyia Archives of Ghana, MAG 1/1/22, Correspondence between Agyeman Prempeh I and the District Commissioner, 14th April 1928

of circumcision was based on the demands made by female suitors who by the turn of the 1920s in Asante deemed an uncircumcised penis to be detestable rather than purely on medical grounds. Persistent Islamic influence especially in the 1940s and 1950s increased the patronage of circumcision. Colonial change further shifted focus from the stigmatization of scarification, mutilation and male circumcision.[597]

The study has also found that circumcision was not void of "superstition" (spiritual or religious inclinations). As an Islamic practice, practitioners mostly made Arabic recitation to prevent haemorrhaging during circumcision, which could have been instigated by the opposing spirit forces from the baby's family or the adult being circumcised or it could be as a result of the evil spirits invoked by a competitor.[598] It was believed by some practitioners that the recitation did not only stem the flow of blood but it hastened the healing process. The earlier part of the twentieth century Asante witnessed the use of herbal concoctions and decoctions to dress and heal the wound of the circumcised. However, the study has spelt out that by the 1950s, there was an admixture of modern drugs and palm kernel oil to form a decoction to dress the wound of a circumcised penis.

Again, another Colonial influence as pointed out by the study is that *Wanzams* shifted attention from the use of knives to blade. This, in essence, prevented the spread of communicable diseases. The study has found out that circumcision was not a direct medical interest of Britain hence, the British trained doctors in Asante and the Gold Coast in general did not provide circumcision service. This, as it were gave room for the activities of *Wanzams* to thrive in Asante

[597] Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, 19th February 2008. , Appiah J., *The Autobiography of an African Patriot* , 22

[598] Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, 19th February 2008.

and Kumase in particular from the 1920s to 1957. The study has also found out that effort by practitioners to come together in Asante to form an association proved futile. Nepotism on the part of practitioners on one hand and apathy on the part of the Colonial Administration has been found to be the cause. Generally, from the 1920s to the 1950s practitioners did not employ the Anti-Septic technique hence, transfer of infection from one person to the other was possible and the unreported cases in Asante could have been alarming.[599]



The study has pointed out bone-setting as one of the indigenous medical practices during the first half of the twentieth century Asante. The study has found two reasons in the first half of the twentieth century which made bone-setting thrive. It was believed by some bone-setters in Asante that modern health care practitioners did not set bones. The second view is based on testimonies of those who patronized the activities of bone-setters in Asante. Respondents generally claimed that they returned from hospitals to seek the services of bone-setters to enable them to heal faster. They vehemently considered the treatment of bone-setters in Kumase to be efficacious.[600]

The study found out that Colonial Influence shifted attention of practitioners in Asante and specifically Kumase from the use of rattan canes and bamboos to the use of gauze bandages and cotton bandages. Practitioners in Asante were seen to be using both sticks and herbal potions in addition to cotton and gauze bandages. Sometimes too TBS in Asante, especially in the 1950s, encouraged patients to use modern medicine (antibiotics) to ease off pain when they applied manipulative techniques at various Bone-Setting centres in Asante. Again, in the 1950s, TBS

[599] Ibid
[600] Interview with Adamu Allah Bar, At his residence, Allah Bar, Kumase, 9th February, 2008

permitted their patients to receive x-ray reports which further informed the TBS on the path with which the bone is to be set. Most importantly, the study has found that fracture treatment in Asante and Kumase specifically could serve as a model for a respectful co-existence of indigenous and bio-medical medicine in Ghana.[601]

The study has noted that Traditional Birth Attendants also formed part of the indigenous medical practitioners in Asante. Practitioners were mostly elderly women who were mostly non-literate and formed part of the kin group. The study has found out that complete disregard for surgery for several pregnant women in Asante and the apparent fear of death through surgery on the part of the indigenous population especially during the first half of the twentieth century in Asante enhanced the position of TBAs.[602]

By the 1950s practitioners still believed in the persistence of witchcraft in causing harm to pregnant women and their foetuses. TBAs forbade pregnant women from eating certain foods and drinks such as alcohol. Amulets were hanged about the neck of an expectant mother and some were hanged by the door to ward off spiritual attacks and the activities of witchcraft. The study has also found out that TBAs in Asante also worked as paediatricians. They met the health needs of both infants and their mothers. In Kumase TBAs treated babies with such conditions as convulsion, bloated stomach, abnormal head, boils, feverishness and malaria.[603]

Interviews conducted during the study buttressed the fact that TBAs did insertion of the cervix to

[601] Ibid
[602] Interview with Kwaku Gyewahom, at his residence, Krofrom Abodwese, Kumase, 10th December,2007
[603] Interview with Kwaku Gyewahom, at his residence, Krofrom Abodwese, Kumase, 10th December 2007. , Sarpong., *Ghana in Retrospect; Some aspects of Ghanaian culture* , 85

aid delivery. This was apparently done without the use of gloves to prevent transfer of bacteria or germs to the cervix area from the hand of the practitioner. Mostly, during complication in child birth, insertions were done by the use of certain slippery herbal concoctions or decoctions. Since these decoctions were mostly not properly measured in terms of dosage they triggered further complications and the unreported cases could have been alarming. Lack of in-depth knowledge in anatomy and surgery worsened the plight of mothers who had complications at the outskirts of Kumase.[604]



Similarly, the study reveals the upsurge of Colonial influence on midwifery care in Asante and specifically, Kumase. From the 1920s, there was still lack of patronage of modern midwifery care especially on the part of pregnant women who were outside Kumase. Efforts by an European medical officer referred to in the records as "Lady Medical Officer Chapell" to get pregnant women who had visited hospitals in Kumase to return for further treatment proved futile even in the 1930s and 1940s as a result of distance. This notwithstanding, the Midwives Ordinance introduced by the Colonial Administration in 1931 had the potential to reduce complications in childbirth especially for those who accessed modern health posts in Asante. The Colonial Administration emphasized the patronage and registration of modern health care providers. However, the study has shown that a window of opportunity was given by the Colonial Administration to also register TBAs who were noted to have a refined practice. Those TBAs who had not registered and still indulged in their illegal practice were arrested by the Colonial Administration, charged with quackery and were fined ten pounds.[605]

[604] Ibid
[605] Manhyia Archives of Ghana, Kumase, MAG 21/1/72, The Midwives Ordinance, 1931, ratified in Asante in Gazette number 85 of 1931

Yet, the study has found out that the powers of such regulations could not stretch further than the villages in and around Kumase. This raises the issue of apparent lack of logistics or infrastructure and human resource on the part the Colonial Administration to meet the entire medical needs of the people of Asante most especially in maternal health care. This, as it were, pushed forward the fact that by 1940s and 1950s, TBAs played a dominant role in Asante especially in maternal healthcare delivery.[606]



This notwithstanding, the study has found out that on 30th November, 1949, the Medical Department in Kumase made efforts to recruit indigenous people from the age of seventeen to twenty years to train to become Pupil Nurses at the General Hospital. The response of the indigenous people was very low. However, in Asante, the indigenous people were given scholarship to study Nursing and were bonded to serve in the Medical Department for five years. The study has also found out that in the 1940s while modern midwifery care was advancing in Kumase places like Offinso and Bekwai sometimes had little or no modern midwifery care.[607]

Similarly, it has been noted that the acquisition of indigenous herbal knowledge and specialized skills in bone-setting or circumcision surgery and traditional midwifery care was based on transfer of knowledge from one person to another in the kin group. General knowledge about indigenous treatment was known by several indigenous members of the community. However, to be counted amongst the professionals in the indigenous medical milieu one should have served as an apprentice for a period of three or four years. Acquisition of knowledge was quite rudimentary. It was based on observation and experimentation of the knowledge the trainee

[606] Ibid
[607] Manhyia Archives of Ghana, Kumase, MAG 21/1/72, Correspondence between the Medical Department Ashanti and the Ashanti Confederacy Council, 30th November, 1949

acquired daily as for example, when he/she helped in the preparation of potions, witnessed the TBA aiding a pregnant woman during childbirth or observed the setting of a bone by his mentor. The training was in the form of mentoring, yet, the belief that unless one was supernaturally called into a particular healing vocation he would not be able to heal the sick was persistent in Asante during the period under study.[608]



The study found out that in Asante, there was no direct Colonial measure to retrain or train indigenous healers in modern scientific therapeutics except for rules set to prevent quackery in the indigenous healing environment. This notwithstanding, the rules set by the Colonial Administration lessened the complications the sick in Asante especially Kumase suffered from the hands of some quack indigenous medical practitioners. Colonial reform policies instigated the formation of indigenous herbal associations in Asante and elsewhere in the Gold Coast that sought free and unhindered practice by its members especially from the Colonial Administration.[609] Future indigenous medical associations in Asante were faced with the issues pertaining to nepotism on the part of literate members who were not practitioners themselves and did not have appreciation of the nuances of the indigenous medical field. Again, there were several internal unrests among association members in Kumase as a result of disrespect and disregard shown to chiefs or District Commissioners by association members. There was also the so-called interference of modern medical authorities, which further disrupted the indigenous medical drive during the first half of the twentieth century Asante.[610]

[608] Interview with Kwaku Gyewahom, at residence, Krofrom Abodwese, Kumase, 10th December 2007. , Interview with Adamu Allah bar, at his residence, Allah Bar, Kumase, 9th February, 2008. , Interview with Mohammed Fuseini and Mustapha Fuseini, at their residence, Aboabo, Kumase, 19th February, 2008

[609] Constitution of the Ghana Psychic and Traditional Healing Association, 1963, Correspondence between the Ghana Psychic and Healing Association and the Asantehene, 3rd August, 1963.

[610] Ibid

From the 1950s onwards some of the emerging indigenous medical fraternities in Asante aimed at fostering cooperation with modern medical bodies like the Ghana Medical Association and the Ghana Academy of Sciences in the promotion of the science of herbalism as well as psychiatric and psychosomatic treatment. Significantly, what underscores the formation of such indigenous medical fraternities in the Gold Coast and Asante specifically was that during the 1950s in Kumase the indigenous medical profession was well organized with its members bonded with a code of conduct primarily to engage in practices which would put the names of the associations in disrepute and further to practise in any medicine that endanger human life.[611]

From the 1930s, as part of the efforts by the Colonial Administration to streamline the activities of indigenous medical practitioners in Asante and Kumase specifically, registration licences were issued to practitioners who were found to be genuine by references the *Nsumankwaahene* received from chiefs in Asante whose jurisdictions the said practitioners wanted to practice their medicine.[612] Indigenous practitioners were barred by regulation to charge beyond thirteen shillings and this provision was to check profiteering. Licensees were charged by the Native Authority not to defraud, extort or charge unreasonable fee. Those who were found charging unreasonable fee or defrauding people were summarily convicted with a fine not exceeding twenty-five pounds or with an imprisonment with or without hard labour not exceeding three months or both. By the 1940s, the Colonial Administration got the Colonial Police involved to ascertain through police investigations whether indigenous healers who applied for licenses to commence operation had no dangerous practices in their medicines. Such police investigation

[611] Ibid
[612] Manhyia Archives of Ghana, Kumase, MAG 1/1/ 22, Application for Physician licenses, 1934-1947

reports produced a class of indigenous practitioners who became vigilant and made efforts to live up to the expectations of the Colonial Administration.[613]

One of the noticeable influences of the Colonial Administration on indigenous medical practices especially with maternal and infant health care was the setting up of midwifery schools and scholarships for pupils as well as the building of the Child Welfare Clinic in Kumase that met the needs of pregnant women and children. The establishment of such training schools produced modern health care professionals who lessened the burden on the TBAs who were not endowed with modern techniques of child delivery and health care.[614] Efforts by the Colonial Administration also had the propensity to lessen the number of deaths of mothers during delivery. Yet, the study has found that apart from Kumase there were several unreached territories so far as modern maternal health care delivery was concerned. Hence, one of the innovative ideas was when the Colonial Administration legislated that unqualified midwives, here referring to TBAs in Kumase, be registered by Dr. Chappelle, the Director of Medical Service. Firstly, the intent was to prevent quackery but secondly, it was to find out the number of efficient TBAs and also modern health professionals who were meeting the dire health needs of pregnant women and their children.[615] The legislation was ideal but it did not pass beyond Kumase, suggesting that the rest of the Asante population were still left in the hands of TBAs whose genuineness or quackery could not be easily ascertained.

Concerning response to diseases by the Colonial Administration in Asante and Kumase

[613] Ibid
[614] Manhyia Archives of Ghana, Kumase, MAG 1/17/6 , Medical Hospital file, 1928-1947
[615] Ibid

specifically, there was the use of both preventive and curative approaches. The Colonial Administration in Asante proposed the use of mosquito nets to prevent mosquito bites, the promulgation of anti laval laws, and the introduction of quinine to combat malaria in Asante. It also used defense clearing, and vaccination to prevent trypanosomiasis. However, the indigenous people who were infected by the disease and started treatment were quarantined by the Colonial Administration under the supervision of chiefs. Surveys and screening were done in villages near Kumase to prevent the spread of the disease. Indigenous knowledge about the disease and its transmission were shrouded with superstition. Vaccination served a primary purpose in the prevention of transmission and curing of diseases like small pox, bubonic plaque, and non-tuberculous infection of the respiratory system as well as CSM. Quarantine rules were instilled without delay. The rule was sometimes applicable to both man and his pets. The passage of Disease of Animal Ordinance and the Infectious Disease Ordinance in Asante mandated the extermination of animals especially the Asante pig to prevent the spread of diseases that affected both man and animals.[616] Leprosy was a curse so far as indigenous mindset was concerned but Christianity reduced the social stigmatization as shown in the records. The Colonial Administration treated patients at leprosarium and embarked on educational campaigns and also treated the infected. Segregation was not an enforceable rule in Asante. Even the demands of the *Asantehene* in the 1930s and 1940s could not compel the Chief Commissioner to forcefully segregate the Kumase leper.[617] The use of educational campaigns especially with the introduction of new drugs like quinine by the Colonial Administration to combat malaria was dispassionately done to meet the medical needs of the indigenous people in Asante. The archival

[616] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Report of the Medical officer of Health Kumase, September 1947

[617] Manhyia Archives of Ghana, Kumase, MAG 21/1/6, Correspondence between the Medical Officer of Health and the Ashanti Confederacy Council, 27th January, 1948

records have shown that the inscriptions on the quinine drug pertaining to its dosage and side effects among other things were translated into local dialects including Twi by the Colonial Administration.[618] The use of local dialects to explain the use and proper dosage of newly introduced drug(s) should be emulated. Such interventions made by the Colonial Administration in the provision of strategic and required drugs to meet the medical needs of the indigenous population should be emulated by governments of the twenty-first century.



Meanwhile, to prevent the spread of another bubonic plague in Kumase and the outbreak of other communicable diseases, sanitation laws were enforced in Kumase and surrounding villages. The Kumase Public Health Board (KPHB) was formed by the Colonial Administration to serve as health promotion machinery and a Civil Administrative agency in Kumase. Their roles from 1924 to the 1940s included the provision of sanitary infrastructure, personnel and cleaning tools to keep Kumase clean. Chiefs enforced the Colonial rules through the powers such rules vested in them to supervise clearing of bushes in the vicinities of their respective villages or towns, the putting up of proper habitats or buildings, digging of new latrines and the closure of old ones as well as the proper burial of the dead. These rules prevented another epidemic in Kumase and increased the socio-economic life of the people of Asante and Kumase for that matter from 1924 to 1957.[619] Essentially, the formation of such health boards like the KPHB and the Suame Health Board (SHB) that emerged in the 1920s and 1940s respectively should not be a thing of the past.[620] It is also important that the findings and reports of similar health boards and committees

[618] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, A short talk to African Mothers Broadcast, Accra, , By Dr Duff, Director of Medical Service in the Gold Coast, 1st Jjuly, 1936,
[619] Manhyia Archives of Ghana, Kumase, MAG 1/1/35, Ashanti Native Amendment Ordinance, 1939, Sanitary Bye-laws under the Native Jurisdiction Ordinance N0. 5 of 1883., Manhyia Archives of Ghana, Kumase, MAG 1/17/ 1A, KPHB File, 1926-1928
[620] Manhyia Archives of Ghana, Kumase, MAG /1/1/35, Sanitation and Roads, 1935

in the 21st century like that of Suame-Kumase in the 1940s should be duly studied by the appropriate authorities and their findings duly implemented. Significantly, the success attained by such health boards was the prevention of communicable diseases or the outbreak of another plague in Kumase and Asante as a whole from 1925 onwards. This promoted effective economic and social integration amongst the members of the Kumase community and Asante as a whole. This in essence meant economic growth and good public health amongst the indigenous population in Asante within the period 1925 to 1957.



Colonial Administration's expert knowledge on diet and disease prevention that were communicated to the indigenous population in Asante within the period under study could achieve the desired objectives only through the cooperation and consent of community leaders, namely, local chiefs, traditional elders, school teachers among others. The use of community mobilization and organization by the Colonial Administration through legislation to help professionally trained health workers to use chiefs and other opinion leaders in the Asante community as mouth-piece made the dissemination of information on health enhancing and promotion to the indigenous population quite easier. Thus, it is essential to see the need to involve these traditional actors in matters pertaining to health education in Asante and Kumase. This could be emulated in the twenty-first century. Chiefs, for instance, should be encouraged to serve on health development committees with well-defined terms or reference. Each of these committees could have guidelines with simple clear language on what community leaders and the population can do to promote health, prevent disease and contribute to their own physical, mental and social well being.

In spite of the areas this research has covered, it has opened up the need for further research in the field of history of social medicine. Some of the areas that could be further looked at include Witchcraft perceptions in determining the choice of treatment for diseases by the indigenous population in Asante. We could also take a critical look at the various indigenous medical practices and the contributions they have made towards our national development. We could also study some of the excesses or dangers some of these indigenous practitioners have brought on particular communities in Ghana and look at the possible means of averting them. In addition, it is essential to encourage the dialogue between indigenous and modern medical practices with the hope that best practices would be adopted for the good of society and the nation at large. Finally, the perceptions of various communities in Ghana about some customary practices such as female circumcision, facial scarification and widowhood rites that have psychological and health implications should be duly studied. Government and health facilitators should encourage a continuous dialogue between chiefs and their subjects on one hand and modern medical educators and experts in indigenous pharmacopoeia on the other hand to encourage the indigenous population to do away with certain customary practices and medicines that are injurious to the health and well being of the population.

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