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UNIVERSITY OF GHANA, LEGON

**A Study of health conditions and disease control in the Northern Territories of the Gold Coast, 1897-1956.**

by

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A Thesis submitted in partial fulfilment of the requirement for the degree of Master of Philosophy in History of the University of Ghana, Legon, Accra.

SEPTEMBER, 1999.

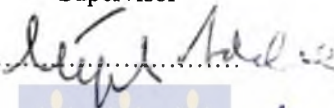
### DECLARATION

I hereby declare that except for references to other works which have been duly acknowledged, this thesis is the result of my own original research, and that this study has not been presented either in whole or in part, for another degree elsewhere.

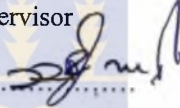
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**ABBREVIATIONS**

ADMS	Assistant Director of Medical Services.
ARNT	Annual Report of the Northern Territories.
CCNT	Chief Commissioner of the Northern Territories.
GCMSDR	Gold Coast Medical and Sanitary Department Report.
GCLCD	Gold Coast Legislative Council Debates.
DMS	Director of Medical Services.
MFU	Medical Field Unit.
MOH	Medical Officer of Health.
OPD	Out-patient Department.
DDMS	Deputy Director of Medical Services.
PRAA	Public Records and Archives Administration.
NTC	Northern Territories Council.
DC	District Commissioner.
PMO	Provincial Medical Officer.
CS	Colonial Secretary.
DDSS	Deputy Director of Sanitary Services.
PC	Provincial Commissioner.
DMSS	Director of Medical and Sanitary Services.
THSG	Transactions of the Historical Society of Ghana.
TRSTMH	Transactions of the Royal Society of Tropical Medicine and Hygiene.
WAMJ	West African Medical Journal.
JAH	Journal of African History.

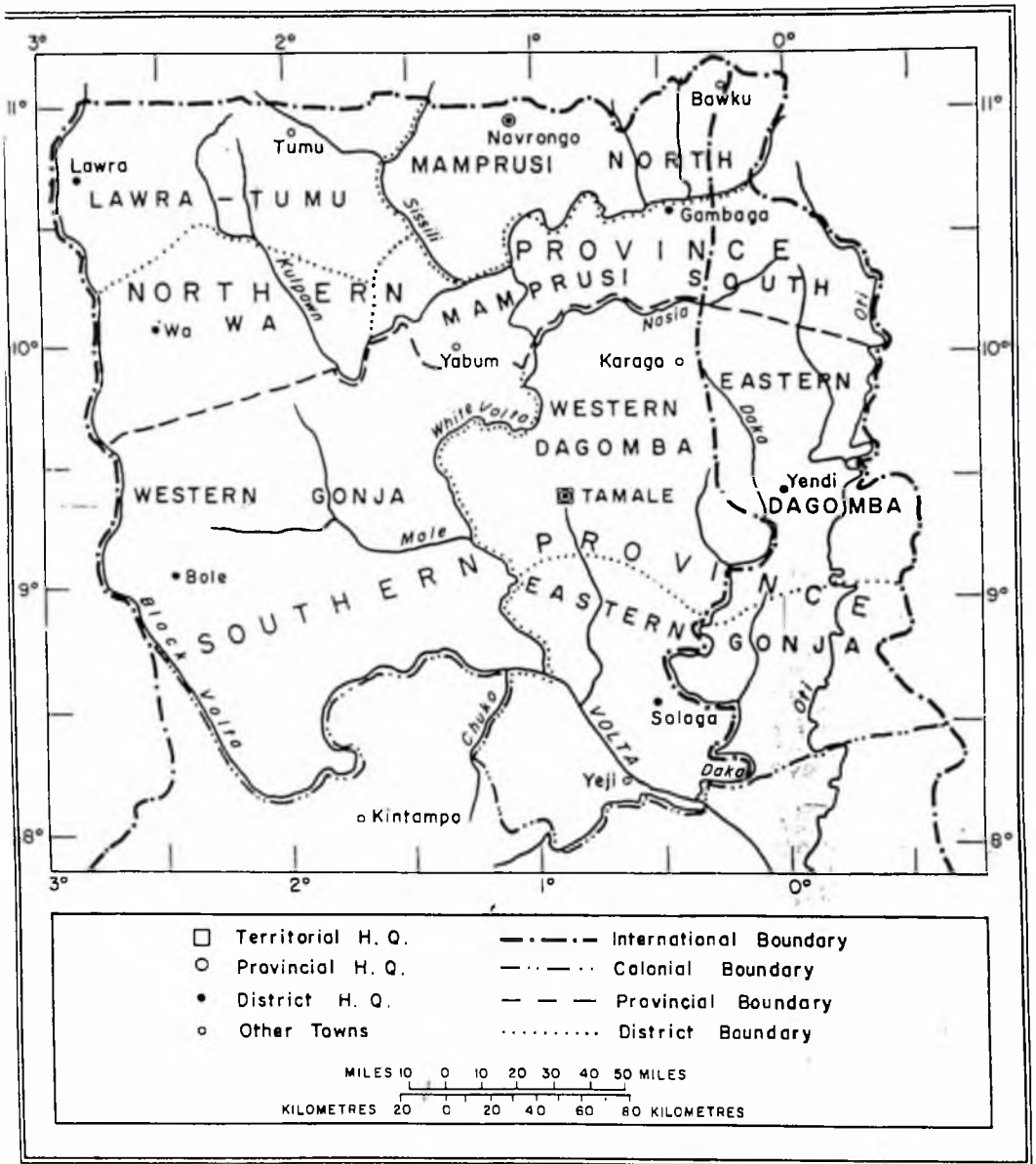
## **ACKNOWLEDGEMENT**

I owe a debt of gratitude to a number of organizations and many people, too numerous to mention here. I must however specifically render special thanks to Professor Stephen Addae my supervisor for his enthusiastic and diligent guidance he gave me. Similar thanks are due to Dr. N. J. K. Brukum, co-supervisor, for his invaluable comments and suggestions.

I also wish to acknowledge with appreciation the assistance I received from the staff of the Public Records and Archives Administration Department, Accra and Tamale as well as the Balme Library, University of Ghana under whose auspices the material for this work was drawn.

Finally, I thank Dr.(Mrs) Akosua Perbi, head of history department for her invaluable assistance and also to Mrs Mary Acquah who typed part of the work.

A MAP OF THE NORTHERN TERRITORIES SHOWING PRINCIPAL TOWNS



Source: Adapted from M. P 65, PRAA-A.

## **ABSTRACT**

This thesis generally is an investigation of the nature of health conditions and disease control in Northern Ghana during the colonial period, 1897-1956. In particular, the study examines the Protectorates disease environment and how the local people and subsequently the colonial authorities handled the disease problems. The study also investigates the extent to which measures designed to combat diseases were efficient.

The conclusions reached in this study are that, the environment of Northern Ghana was fraught with many diseases, both of indigenous and “foreign” origin. The local people had developed their own ways of handling some of the diseases while others like onchocerciasis and leprosy were left to nature. When the colonial government supervised and modern medical systems emerged a multifaceted approach was used. Due to inadequate funds and consequently lack of medical personnel, attention was focused on Europeans. Although it was seen as prudent to cater for the local population from the 1920s onwards the little funds allocated to the Protectorate continued to hold back the local peoples benefit of western medicine. Tremendous development in western medical practice emerged only in the 1930s when the Native Authorities were involved in the health delivery system. Under the aegis of the Native Authorities, planned development of health and medical policies were facilitated, numbers and quality of health facilities improved and hospital attendance became encouraging. Combining strategies of isolation and vaccination, delivered through an efficient organisational network some diseases like smallpox and yaws became extinct by 1956; although others like malaria, trypanosomiasis and cerebro-spinal meningitis prevailed.

## **INTRODUCTION**

Northern Ghana is the portion of Ghana that lies to the North of Brong-Ahafo and Volta Regions. It is bounded on the west by the Black Volta River, on the east by Ghana's international boundary with Togo. On the North, the frontier is formed by latitude 11 degrees north. The area is approximately 37,723 square miles and contains a potpourri of settlements, some non-centralised others centralised in terms of political organisation.<sup>1</sup> The non-centralised groups, largely in the upper regions include; the Kasena, Balsa, Frafra, Tallensi, and Kusasi to the northeast, and Dagarti, Lobi, Sisala to the northwest. The Wala in the northwest, Dagomba, Gonja, and Mamprusi in the southern sections were centralised. Notwithstanding their diverse traditions of origin and political organisation, these groups possessed substantial degrees of cultural affinities. Indeed, though largely based on subsistence agriculture, other economic activities like pottery, leatherwork, spinning of fibre and, above all, local and long distance trade were practised.<sup>2</sup>

Through conclusions of Treaties signed with some chiefs between 1892 and 1897 Northern Ghana came under British influence. In 1901 the area was proclaimed a Protectorate after international settlements with France and Germany were reached.<sup>3</sup> From then on Northern Ghana became known as the Northern Territories<sup>4</sup> and

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<sup>1</sup> E. A., Boateng, A Geography of Ghana (London: 1966) p. 4.

<sup>2</sup> The pre-colonial economy and polity has been extensively dealt with in the following thesis; Benedict Der, *Missionary Enterprise in Northern Ghana 1906-1975: A study in impact*. See Introduction; see also N. J. K. Brukum, *The Northern Territories of the Gold Coast under Colonial Rule, 1897-1956: A study in Political Change*.

<sup>3</sup> This Order came into force on January 1, 1902: these were the Anglo-French and Anglo-German Conventions of 1898 and 1899 respectively.

<sup>4</sup> The phrase Northern Territories, Northern Ghana, Protectorate and dependency are used interchangeably to mean the same geographical location.

remained under British protection and administered by the governor of the Gold Coast through a Chief Commissioner who was assisted by District Commissioners. For administrative convenience in 1907 the area was divided into three main enclaves; the North-Western, North-Eastern and Southern Provinces under the supervision of Provincial Commissioners.<sup>5</sup> Each of these Provinces was further split into districts and sub-districts under the control of District Commissioners. Whilst the governors were saddled with questions of political restructuring of the Protectorate, the health conditions of the area hardly eluded them. Prevalent in the North were varied diseases such as: malaria, yellow fever, trypanosomiasis (Sleeping Sickness), filariasis, measles and tropical ulcer. Besides, Northern Ghana was an area prone to frequent outbreaks of cerebro-spinal meningitis and smallpox among others. Determined to avoid being encircled by the French and perhaps more importantly to turn the territory into a labour reserve for the mineral and cocoa industries and the construction of roads and railways in the southern Gold Coast, the colonial government was bound to devise measures that aided in battling the diseases prevalent in the dependency.

## LITERATURE REVIEW

Studies in the history of medicine and medical health services in Ghana has attracted few researchers. Pioneering works in this area have been done by Scott, D., Epidemic Diseases in Ghana (London: 1965) and Patterson, D., Health in Colonial Ghana: Disease, Medicine and Socio-economic Change 1900-1955 (Massachusetts:

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<sup>5</sup> See R. B., Bening The Evolution of the Administrative Boundaries of Northern Ghana, 1898-1965 (PhD Thesis, University of London 1971) p. 121. Previous to 1907 the Protectorate was divided into the Black Volta, White Volta and Kintampo districts. On 1<sup>st</sup> January 1921, the Northwestern, Northeastern and Southern Provinces were replaced by the Western and Eastern Provinces. Then on 1<sup>st</sup> June 1921, the former North eastern and North-

1981). As the title of his publication depicts, Scott discusses essentially, the development of epidemic diseases. Patterson similarly adopts an epidemiological perspective. However his work focuses on the impact of socio-economic transformations on the disease environment that confronted colonial Ghana. A more recent work by Addae, S., Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960 (Durham: 1997) constitutes the single principal study that presents a systematic history of western medicine and medical health services in Ghana. Focusing on public health services, Addae's work brings out clearly the changes which have occurred in medicine and health services from 1880-1960. Much as these works cover colonial Ghana, little attention has been drawn to the Northern Territories.

However, researches on the Northern Territories in general have been impressive. Notable among these include the following thesis: Saaka Yakubu, Evolution of political consciousness in the North; Marville, R.O.G., The formation of Northern Ghana; Bening, R.B., The Evolution of the Administrative Boundaries of Northern Ghana 1898-1965 and A History of Education in Northern Ghana 1907-1976; Der, B., Missionary Enterprise in Northern Ghana 1906-1975: a study in impact; Brukum, N.J.K., The Northern Territories of the Gold Coast under Colonial rule 1897-1956: A study in Political Change. However, apart from Der none has talked about the health of the people and the area. Against this background this study investigates the development of health and health service system to determine what major changes have occurred and how the local population reacted to these transformations in the Protectorate of Northern Ghana as a whole during the colonial period.

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western Provinces were amalgamated to form the Northern Province while the former Southern Province was revived. In 1932, the Provincial boundary system was abolished.

## METHODOLOGY

The main sources consulted in this study include archival material, oral interviews and other published documents and medical literature. For the pre-colonial periods information was largely obtained from interviews, the Salaga Papers and The papers of George Ekem Ferguson. A wealth of information on the incidence of diseases and sanitary conditions has been obtained from the Salaga Papers. For the colonial period use was made of the dispatches and reports of District, Provincial, and Chief Commissioners; Medical and Sanitary Department Reports; Annual Reports of the Northern Territories; Legislative Council Debates and Sessional Papers, and personal files of medical officers. The Medical and Sanitary Department Reports and the Annual Reports of the Northern Territories in particular provided invaluable data on hospitals, clinics, dispensaries curative and preventive health measures. The Gold Coast Blue Book provided data on budgets, health and medical staff numbers as well as population figures. All these material, (it is important to state) were obtained in Ghana from, the Public Records and Archives Administration Department, Accra and Tamale and Balme Library, University of Ghana.

## STRUCTURE

A topical and chronological approach has been used in this study. In a broader context each of the chapters is based on a topic. The first chapter discusses the disease environment and some traditional health practices of the local inhabitants prior to the inception of official British occupation. Chapters two and three focus on developments in curative health and the handling of epidemic and endemic diseases respectively.

The fourth chapter is devoted to preventive health services and chapter five which completes the study discusses training of medical and health staff.

## CHAPTER ONE

### THE DISEASE ENVIRONMENT

Disease is as old as civilisation and Northern Ghana was not without it prior to British occupation and administration. The import of this chapter is to give an insight into the disease environment of the dependency at least up to 1950 when an African government assumed control over the Gold Coast. In this survey it will be shown that, most of the diseases experienced pre-date British occupation; it will also be revealed that other categories of diseases for example tuberculosis, syphilis and gonorrhoea emerged in the Protectorate as by-products of British economic policy. How the Africans and subsequently the early Europeans handled these diseases in the absence of modern medical systems is also explored.

#### 1.1 PRE-COLONIAL DISEASE SITUATION

The environment of the North like that of the south was replete with numerous diseases. Prominent and most common among these were malaria, smallpox, guinea worm, bacillary and amoebic dysentery, sleeping sickness, yaws and tropical ulcers. Early travellers who visited the area to trade and do missionary work reveal evidence of the prevalence of some of these. In 1888 when Von Françoise visited Salaga he observed that smallpox was one of the commonest diseases. He also noted that among the most prevalent diseases were skin diseases and worms, and he believed that a “man without worms would be considered sick.”<sup>1</sup> Two years later Kling another visitor,

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<sup>1</sup> Johnson, M., Salaga papers vol. 1. Institute of African Studies, University of Ghana Legon. Acc. no. SAL/18/3.

noticed that Abu Karimo who accompanied him, had no fewer than thirty-one guinea worms.<sup>2</sup> These diseases indeed were not limited to the southern portions of Northern Ghana. In 1899 Northcott, the Chief Commissioner of the Northern Territories (CCNT) in his maiden report from Gambaga admitted that among the prominent diseases which afflicted the local inhabitants were: guinea worm, fever, and dysentery.<sup>3</sup> Similarly, when George Ekem Ferguson visited Northern Ghana in the 1890s to sign treaties with some local rulers he reported the existence of dysentery, diarrhoea, colic, rheumatism, and guinea worm.<sup>4</sup> Besides the above reports of the local diseases of some parts of Northern Ghana, other early visitors suffered from some of the diseases of the area. Buss, a German visitor to Salaga in 1878 suffered fever for a very long period and was cared for by his landlord and other Mohammedans.<sup>5</sup> Theophil Opoku, a Basel Missionary contracted severe bouts of fever, during his three weeks stay in Salaga. To add to his plight he is reported to have developed smallpox on his journey to Krepi.<sup>6</sup>

Although common diseases afflicted Northern Ghana and the rest of the country, it appears some of the diseases prevalent in the North were milder than what pertained in the coastal areas. This was particularly true of the Northern fevers. The climate of the North was appreciably more merciful. In the months of March, April, and May severe heat is experienced but the air free from the load of moisture, a phenomenon common in the coastal regions. Though rains were heavy, it was not continual as in the coast to cause collection of pockets of stagnant water. Furthermore the fevers in the North were not only comparatively mild, but also convalescence from them was speedy. Although the climatic conditions described applied to the North in general, differences occurred,

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<sup>2</sup> Johnson, *op. cit.* acc. no. SAL/67/1.

<sup>3</sup> ARNT 1899.

<sup>4</sup> K., Arhin, *The papers of George Ekem Ferguson, a Fanti official of the Government of the Gold Coast 1890-1892* Leiden: Africa studiecentrum, 1974 vol. 7 p. 80.

<sup>5</sup> Johnson, *op. cit.* acc. no. SAL 9/2.

in health pattern in different parts. The upper parts of the Protectorate appear to have been healthier than the southern parts, like Kintampo and Yeji. It was observed in the 1890s that European officers who were temporarily stationed at Yeji and its neighbourhood suffered more from attacks of malaria than their counterparts North of latitude 10.<sup>7</sup> Mild as some of the diseases of Northern Ghana may have been, evidence suggests that others were very severe and widespread. This was the case with guinea worm and tropical ulcers. In Salaga for instance, one rarely met an African who did not have guinea worm or tropical ulcers. Abu Karimo as stated elsewhere harboured about thirty-one or so worms in various parts of his body.<sup>8</sup> It appears some of the diseases, particularly smallpox, existed in epidemic form. Theophil Opoku observed that there were outbreaks of smallpox especially at the beginning of the rains.<sup>9</sup> The practice whereby attempts were made to cure smallpox by the local inhabitants is an indication that the disease could assume epidemic form. It was common among locals to get inoculated with pus from a smallpox victim with the aim of conferring immunity.<sup>10</sup> This practice aided the wide dissemination of the virus.

## 1.2 COLONIAL RULE AND EMERGENCE OF 'NEW' DISEASES

Until the early 1920s certain diseases particularly tuberculosis, gonorrhoea and syphilis appeared to have been unknown in Northern Ghana. Prior to this period however, the incidence of these diseases were reported high, by the medical department in the mining and urban centres of the south. Keta was reported to have been “saturated

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<sup>6</sup> Johnson, op cit acc. no. SAL8/7.

<sup>7</sup> ARNT 1899 p. 52.

<sup>8</sup> Johnson, op. cit.

<sup>9</sup> Johnson, op. cit. acc. no. SAL8/4.

<sup>10</sup> Ibid.

with syphilis”(1900).<sup>11</sup> Similarly, cases of tuberculosis were reported in the coastal regions.<sup>12</sup> It was from these foci that tuberculosis, gonorrhoea and syphilis spread to Northern Ghana. How did this happen? Throughout the early decades of the twentieth century there was severe, alarming, shortage of labour in the mining centres. The underground work was hazardous, unattractive and under-paid; hence people from the Colony and Ashanti avoided it. This labour requirement was met with recruitment of labour from Northern Ghana. In 1905 the maiden demand for labour from Northern Ghana was made.<sup>13</sup> This labour, as is obvious, was associated with the fine dust in the mine shafts. This damaged their lungs, culminating in silicosis and tuberculosis. For several years, Tarkwa, the nucleus of the mining industry returned by far the highest percentages of cases of pulmonary tuberculosis. Indeed 24% of all registered deaths in Tarkwa in males were due to pulmonary tuberculosis.<sup>14</sup> Though miners who contracted tuberculosis had the option of being treated in mine hospitals, they most seldom, if at all, presented themselves for treatment. Many made attempts to return to their homes possibly to seek traditional treatment or perhaps die. Some made the journey back home but others died en route.<sup>15</sup> The few who succeeded in reaching home set in motion the propagation of the infection. Beginning from the 1920s, there were yearly reports about the prevalence of tuberculosis in Northern Ghana. In 1926 for instance, 8 cases of pulmonary tuberculosis were reported to have been treated in Krachi District.<sup>16</sup>

Gonorrhoea and syphilis were other diseases whose spread to Northern Ghana was

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<sup>11</sup> Gold Coast Medical and Sanitary Department Report (Hereafter, GCMSDR), 1900 p. 14.

<sup>12</sup> See S. Addae, *Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960* (Durham: 1997) p. 387-93.

<sup>13</sup> PRAA-A ADM 56/1/3; Secretary of Mines to Chief Commissioner of the Northern Territories 15.8.1905.

<sup>14</sup> GCMSDR 1929-30 pp. 30-31; 1931-32 p. 22.

<sup>15</sup> In 1910 for instance, over 543 and 73 northern mine workers returned to Wa and Dagomba districts respectively. Illiasu Papers:-a collection of archival material by Dr. Illiasu of the History Department, University of Ghana, Legon.

<sup>16</sup> Togoland Report 1926 p. 48.

largely influenced by mine labour returnees. Hundreds of these young men, usually away for several months without their wives, had no option but to turn to prostitutes for the satisfaction of their sexual desires. Tarkwa mines for instance had the services of prostitutes from Calabar.<sup>17</sup> The mine labour returnees were not alone in the guilt of spreading venereal diseases into Northern Ghana. Indeed some of the prostitutes in the urban centres were natives of Northern Ghana.<sup>18</sup> In 1926 48 cases of gonorrhoea were treated at Kete Krachi and 12 at the Eastern Dagomba district.<sup>19</sup> In the latter parts of the 1920s cases of gonorrhoea were on the increase in the upper parts of the North. This increase was apparent in areas like Navrongo and Zuarungu where it was commonly known as the “Kumasi disease”, suggesting its alien origin.<sup>20</sup> The increase in cases of venereal disease and indeed tuberculosis was mainly due to the opening up of the North by a network of roads and improved transport.

### 1.3 EPIDEMIC OUTBREAKS

Besides the diseases described above, which were clearly endemic, the North was also prone to severe outbreaks of epidemics. Prominent among these were: influenza, smallpox and cerebro-spinal meningitis. Two influenza pandemics have wreaked havoc in Northern Ghana between 1900 and 1950. The first one was in 1918-19, and the second in 1929. Besides these instances there have been no reports of influenza outbreak in the North. The first recorded influenza epidemic appears to have originated from two distinct directions, the coast and the French territory of Wagadugu

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<sup>17</sup>. PRAA-A ADM 27/5/3 Tarkwa District Record Book, 1939 p.124.

<sup>18</sup> Togoland Report 1923 pp. 33-34.

<sup>19</sup> Togoland Report 1926 p. 48. These figures do not present a true reflection of the magnitude of venereal diseases for the simple reason that most victims felt reluctant to report for treatment.

<sup>20</sup> GCMSDR 1928-29 p.13. Kumasi was a garrison town where troops were stationed and it was here that venereal diseases commenced. And because it was a transit point of Northern mine labour, the disease was acquired and spread in the North.

(Ouagadougou) and neighbouring towns. The epidemic first appeared in the Gold Coast, specifically at Cape Coast via a SS Shonga (An American vessel) outbound from Freetown, Sierra Leone. It is tempting to argue that the spread of the epidemic to the Gold Coast was due to the negligence of governor Clifford. Regardless of a letter from the governor to him with a warning of the outbreak of influenza in Sierra Leone, the SS Shonga was allowed to enter Cape Coast on 31st August 1918 with people who perhaps had contracted the disease. This would however be an unfair accusation as it was a world wide pandemic and no quarantine measure could contain it. Approximately two weeks after the call of the SS Shonga at Accra from Cape Coast, several cases of influenza were reported among dock workers.<sup>21</sup> Perhaps it was from the coast that the influenza found its way into the interior mainly through trade routes. The first reported cases in the North of this Coast-interior movement of the epidemic was at Yeji in the first week of October 1918.<sup>22</sup> Two or so weeks later the epidemic reached Salaga, a key commercial centre, approximately twenty miles north of Yeji.<sup>23</sup> From the Yeji and Salaga areas it appears the epidemic assumed a westward movement, reaching Bole by October 26th, 1918. It also appears this wave of influenza movement advanced in the direction of Wa and Lawra. The first case in Wa was reported on November 7th. Lawra felt the presence of the scourge by the middle of the same month.<sup>24</sup>

The northeastern and the northwestern parts of Northern Ghana experienced a surge of influenza spreading from Wagadugu (French territory). In a letter to the district commissioner of Lawra, the Resident of Leo reported the outbreak of influenza in his town. To prevent a possible spread to the Gold Coast, the Resident closed all possible

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<sup>21</sup> GCMSDR 1918 p. 11.

<sup>22</sup> Ibid.

<sup>23</sup> CCNT to Col. Sec. 23.10.1918 PRAA-A Acc No. 2753/58.

<sup>24</sup> GCMSDR 1918 p. 11; PRAA-A ADM 56/1/209 Lorha District Informal Diary 15.11.1918.

outlets. Reacting to this warning, the medical officer proposed to close all roads leading to Tamboko, Nasia, Tanga, and Kubari because signs of the disease were absent from these areas.<sup>25</sup> This measure was rejected by the Provincial Medical Officer. Giving the reasons for the objection (on behalf of the Provincial Medical Officer), S.D. Nash the acting Provincial Commissioner of the North Eastern Province wrote:

. . .the medical officer here sees no object in closing the trade routes as such action has not been taken in the Colony, Ashanti or any part of the Northern Territories; and he is of opinion that the disease will run its course and isolation of the inhabitants is not feasible . . .<sup>26</sup>

Two other factors influenced this objection. Trade was one of the main sources through which the colonial authorities obtained revenue in Northern Ghana. Closure of trade routes would severely reduce revenue from this source at a time funds were most required for the prosecution of the First World War. It is possible also that the low mortality rate at the beginning of the outbreak, made the authorities to believe that the disease would be less severe. At Wa, while many of the locals suffered from this disease, the total number of deaths was only four. In Tumu and Golu, out of 43 cases only three ended fatally.<sup>27</sup> By the end of December 1918 all towns had tasted a fair dose of the raging epidemic. Indeed the district of Navrongo for instance was widely affected by the influenza with “. . .large numbers of deaths taking place daily”. Funeral lamentation, a cherished custom of the North, was suspended and no crying allowed.<sup>28</sup> One effect of this scourge was that it temporarily disrupted daily work. A permanent effect however was the serious depopulation caused by the huge number of deaths throughout Northern Ghana. By the middle of January when the epidemic seemed to

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<sup>25</sup> Provincial Commissioner, Gambaga to CCNT 20.11.1918.

<sup>26</sup> Provincial Commissioner, North Western Province to CCNT 12.11.1918. Despatch No. 721/15/1918.

<sup>27</sup> Acting. District Commissioner, Tumu to Acting. DC., Wa 20.11.1918. Despatch No.307/6/1917.

<sup>28</sup> Medical Officer, Navrongo to Provincial Commissioner, North-Western Province 9.12.1918.

have run its course a total of over 20,000 deaths were reported in the northeastern and western sections of the North. The table below illustrates the extent of the deaths.

**Table 1<sup>29</sup> INFLUENZA EPIDEMIC AND DEATHS ARISING**

TOWN	APPROX. DEATHS
Narongo	4,046
Bawku	2,354
Gambaga	913
Lawra	3,706
Wa	2,613
Tumu	1,561
Zuarungu	5,715
Total	20,098

Smallpox has been another of the diseases that assumed epidemic proportions in Northern Ghana. Unlike other diseases, smallpox can be said, (with little doubt), to have pre-dated the declaration of the North as a Protectorate. Early traders and missionaries who visited Salaga towards the end of the nineteenth century left ample evidence of its prevalence. Between 1900 and 1950, yearly reported cases (though these were under-reported) of the disease in the North vividly shows that there was an admixture of incessantly small and mild eruptions and occasional but severe epidemics. In 1911 for instance only eleven cases were reported, two at Bole, eight at Lawra, and

<sup>29</sup> The total figure is an understatement. The deaths were certainly more than 20,908; children were not reckoned in a majority of cases. Several compounds refused to give the required information out of superstitious beliefs. The figures for Zuarungu, Bawku, Gambaga and Navrongo were taken from ADM 56/1/223 P.C., North Western Province to CCNT 15.3.1919; figures for Wa, Tumu, and Lawra see *Ibid* P.C., North western Province to Medical Officer, Wa 28.2.1919. Despatch No. 104/15/1918.

one at Wa.<sup>30</sup> Towards the end of in 1916, Wa again experienced a mild eruption.<sup>31</sup> However, in 1924-5, 1942 and 1947 serious epidemics occurred with reported cases exceeding 400. The worst experiences were those of 1942 and 1947 with 1,649 and 744 reported cases respectively. The epidemic of 1942 seemed to be a recrudescence on a larger scale, of a mild outbreak of the previous year which appeared to have shown signs of dying out. Its occurrence was so frightful that the whole of Northern Ghana was declared an infected area. But it was the eastern and western Dagomba, Navrongo, Mamprusi, Wa, Lawra, Tuma and Kusasi areas which turned out to be the areas chiefly affected. Not only was it widespread, it lasted almost a year, the last case reported in the early weeks of December.<sup>32</sup>

The outbreak of 1946 was as widespread as the previous major one. The first area to be hit by this outbreak was the Gonja district. As usual, it started during the early part of the year and persisted until mid May. The second phase of the outbreak started later in the year. On this occasion it hit Bawku, Navrongo and Tamale.<sup>33</sup> The 1947 outbreak appears to have been limited to the north-eastern sections, the major cases occurring in the neighbourhood of Navrongo, Zuarungu and Bawku.<sup>34</sup> From 1948 through to 1950, smallpox occurred though it never reached serious epidemic proportions. This was mainly due to the continuous vaccination activities of the medical field units (M.F.U.). The widespread prevalence of smallpox in Northern Ghana from the mid-1920s can be accounted for by the revolution in communication, particularly road transport. Hitherto movement of people was limited to short distances. With the

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<sup>30</sup> GCMSDR 1911 p. 37.

<sup>31</sup> ARNT 1916 p. 11.

<sup>32</sup> GCMSDR 1942 p. 1.

<sup>33</sup> GCMSDR 1946 p. 6.

<sup>34</sup> GCMSDR 1947 p. 4.

improvement in transport many more people interacted more easily, hence the disease spread quickly and more widely.<sup>35</sup>

Cerebro-spinal meningitis has been one of the diseases that assumed epidemic form in Northern Ghana. Unlike smallpox, cerebro-spinal fever was unreported in the North prior to 1906. The maiden reported occurrence of the epidemic in Northern Ghana was in March 1906 when its outbreak was reported among the Lobi-Dagarti, Sisala, and Grunshi areas of the north-west and western sections of the upper north. However, it was at Tizza, a settlement approximately fourteen miles south of Lawra that the epidemic turned out to be severest, as the settlement was almost deserted. The Chief Commissioner of the Northern Territories (CCNT) estimated that over 20,000 people died during the outbreak.<sup>36</sup> It ceased with the beginning of the rains, though it occurred during the harmattan season of 1907 in the Lobi, Dagarti, and Grunshi districts. This round of the scourge started apparently at Ulu, a small Dagarti settlement 20 miles south-east of Lawra. From this focus the epidemic seemed to have spread eastwards to Tumu, and then southwards to the surrounding areas. Though the fatality rate did not surpass the preceding epidemic, it was nonetheless enormous. Whole families died in a single day and whole villages were almost wiped out. Dr. Palmer who visited the infected areas in 1907, estimated the deaths to be over 8,000.<sup>37</sup> On January 1908 the epidemic appeared again at Lawra and its neighbourhood. From here, the scourge spread to the north-west, covering an area of about ten thousand square miles. The hardest hit areas in this marathon epidemic were Kokolobu, Lambussie and Tantua; the last village was almost completely destroyed. In its three-year plunder and infliction of

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<sup>35</sup> ARNT 1923-24 p. 16.

<sup>36</sup> Legislative Council Debates and Sessional Papers 1919-20 p. 4 (Hereafter LCDSP).

<sup>37</sup> A. E. Horn, "An Investigation of Cerebrospinal Fever in the Northern Territories of the Gold Coast in 1908" in Transactions of the Society of Tropical Medicine and Hygiene vol. II 1908-09 pp. 2-40; LCDSP 1919-1920 p. 4.

bitterness it appears the scourge was limited largely to the north-western areas of the Protectorate. The north-eastern areas seemed relatively unaffected. No cases appeared to have occurred among the European residents. Indeed it was among the local people that the epidemic exacted its toll.<sup>38</sup>

However between 1908 and 1918, cerebro-spinal meningitis seemed to have disappeared. Nonetheless, as an endemic disease sporadic cases indisputably appeared throughout the ten years' interval. But in 1919-20 an epidemic revisited northern Ghana. This dose of the epidemic knew no limits. This time it spread to Navrongo and neighbouring districts in the north-east. The 1919 epidemic was quite minimal, occurring largely at Lawra. The first reported cases were at the beginning of February, but with the advent of rains in April the epidemic abated. The total number of cases reported by Dr. Dowdall was 1041 out of which 986 deaths occurred.<sup>39</sup> In magnitude, the epidemic appeared scarcely to have reached areas around Tumu and Wa. The earliest known case of the 1920 epidemic occurred in the Tumu and Lawra districts of the north-west on 17th and 21st of January respectively. Containing the outbreak was out of the question in view of the fact that only one medical officer was left in charge of the whole of the north west, including Bole. Thus from the end of January to the beginning of February, the epidemic had spread throughout Northern Ghana. The main arteries for its spread were the many roads and paths that led to the north-east from the Tumu-Lawra area. In the northeast, towns like Navrongo, Sandema, and Bawku were flogged to submission. Notwithstanding its widespread nature, the epidemic appeared to have been less fatal, considering the death toll of the previous one. Dr. J.M. Dalziel, a senior sanitary officer who investigated the outbreak estimated the deaths to be

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<sup>38</sup> Horn, *op. cit.*

<sup>39</sup> LCDSP 1919-20 p. 7.

around 2850 only in the North Eastern and Western Provinces, including Bole.<sup>40</sup> After 1920, no further cases of the epidemic were reported in Northern Ghana until 1939 when over 800 cases were reported. In this particular case many of the victims were in the northeast.<sup>41</sup> Between 1940 and 1949 the epidemic consistently wreaked havoc with 1942 and 1943 recording averages of 308 cases and 142 deaths. In 1944 and 1946, recorded cases increased to 853 and 620 with 165 and 150 deaths respectively.<sup>42</sup> But the epidemics of 1947, 1948, and 1949 turned out to be the severest of the epidemics of the 1940s. This three-year long scourge recorded a combined total of approximately 13,887 cases, with 1,229 deaths.<sup>43</sup> A feature of the 1940s outbreaks was their widespread nature. Indeed, they affected almost all settlements in Northern Ghana but with changing areas of severity.<sup>44</sup> However, the north-western areas suffered most.

The plague epidemic that occurred in Ghana in 1908 and 1924 did not spread to the North. This was because of the effective control measures adopted by the health authorities to check its spread. What occurred in the north were three instances of unconfirmed suspected cases of bubonic plague. The first was reported at Tunga, a fishing village at Yeji, the second at Makango and the third at Wa in 1913, 1914 and 1921 respectively. In all these instances bacteriological and related investigations at Accra proved these suspicious cases incorrect. All the same measures analogous to those adopted in the 1908 epidemic were invoked to check the spread of whatever disease it was in view of its high percentage of death.<sup>45</sup> Between 1922 and 1950 no

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<sup>40</sup> *Ibid.*

<sup>41</sup> GCMSDR 1939 p. 1.

<sup>42</sup> GCMSDR 1944 p. 1; 1946 p. 7.

<sup>43</sup> Figures calculated from GCMSDR 1947, 1948; 1949.

<sup>44</sup> In the 1944 epidemic Wa and Lawra were the hardest hit areas, but in 1946 it was the Navrongo and Gambaga areas that were severely affected.

<sup>45</sup> The first death of the suspected 1913 outbreak occurred on the 29<sup>th</sup> July, three days after the symptoms were experienced. By August eight out of the eleven cases proved fatal. Provincial Medical Officer to Principal Medical Officer 31.8.1913. Despatch No. 210/13.

suspected cases of plague were reported, neither did any confirmed case of the epidemic occur in Northern Ghana.

Observation of epidemic outbreaks in the North suggests that prior to the 1920s outbreaks were isolated in nature; and was probably due to the minimal level of inter-village contacts. Movement of people was an important determinant of the rate of spread of epidemics; the faster people moved the faster epidemic spread followed. The main mode of transport of the people was by foot; horses were used but by Europeans. From about the 1900s, road building programmes formed part of colonial government's arsenal to "open up" the Protectorate. Indeed, by the first decade of the twentieth century hundreds of miles of roads were constructed which linked Kintampo to Lawra, in the north-western corner of Gold Coast. Other road networks radiated from Tamale, the capital of the dependency to the various administrative enclaves of the North. For the first time in the history of the Northern Territories, roads were opened practically ringing the districts of the Protectorate.<sup>46</sup> By the 1920s, these road networks were effectively used by trucks to convey passengers between towns. This rendered it possible for journeys hitherto made in days to be made in a matter of few hours. A clear consequence of the efficient and rapid movement of people was the spontaneous and widespread nature epidemic outbreaks assumed from the 1920s onwards.

Though climatic factors would have been responsible for the occurrence of some of the diseases in Northern Ghana, the unsanitary practices influenced the disease environment most. Most of the prevalent ailments were largely by-products of the revolting sanitary state of the North. By 1900, and even after, it was common to see towns littered with all manner of filth. The streets in particular were never cleaned. It

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<sup>46</sup> ARNT 1924-25 p. 15.

was not uncommon to see rubbish heaps in front of every single compound. Cattle and other animals were left to lie where they died. Designated and decent latrines were non-existent. Open spaces between compounds served this purpose. Water supply was unsatisfactory. Towns that were close to rivers relied wholly on such water. Others relied on rainwater stored in cisterns. Describing the nature of drinking water in Northern Ghana in 1890 Kling stated; “. . . we drunk avidly dirty water from puddles which were to be found in shady bush holes. . . .” with . . . "little white worms or little crab-like animals darting about as quick as lightning".<sup>47</sup> The unsanitary conditions and foul state of drinking water was compounded by over-crowding in wretched habitations with poor-to-no ventilation.<sup>48</sup> People were unconcerned with the revolting unsanitary state of the towns, leaving the task of scavenging on the shoulders of the vultures in the day and wolves, dogs, jackals, as well as hyenas in the night.

#### 1.4 TRADITIONAL HEALTH PRACTICES

A question that comes to mind is: in the midst of all these diseases what did the Africans of the North do (in their own way) to combat them in the absence of biomedicine? The way diseases were handled depended largely on the perceived cause. Traditionally, diseases and illness were attributed to two main causes; the natural (God given) and unnatural (human induced). In the first case the concept of disease is inseparably linked with religious beliefs. Unanimously, most communities of the North held a belief in a sky God with countless spirits under His command, some of which were assumed to be good while others were presumed malevolent. All happenings that seem to aid in the improvement of a person's material well-being were believed to be

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<sup>47</sup> Johnson, *op. cit.* acc. no. SAL67/1.

<sup>48</sup> The houses were constructed with swish, circular in form with cone shaped roofs.

due to the machination of the benevolent spirits. Occurrences that seem to incapacitate his physical and material well-being were held to be induced by the malevolent ones. A consequence of this was that many sicknesses, malaria not excluded, were regarded as punishment from the sky God via the malevolent spirits as a result of wrongdoing or so. It behoved the living to revere the ancestral spirits occasionally, in order to lubricate the path between them and the departed. Dereliction of this responsibility to the ancestors could lead to castigation of family members. Infringing taboos, committing adultery and lying under oath could also draw the wrath of ancestral spirits which would result in punishment. Leprosy for instance was seen among the Mamprusi and Frafra as a disease inflicted on people by the sky God.<sup>49</sup> In another dimension some Northern communities held on to widespread belief in the capability to invoke ill health on to others via mischievous schemes. Witches/wizards, sorcerers were the most pronounced means through which misfortunes could be invoked on perceived enemies. Witches were often blamed for health problems like epilepsy, lunacy and infertility among others. For instance, with magic that propelled them to fly, witches at Wa were capable, as it was believed, of causing the death of children by sucking their blood.<sup>50</sup>

Under the indigenous health system, the procedure for consultations, it appears, was judged by the character and gravity of the sickness. In cases of acute but less incapacitating diseases it was not uncommon for healers to be called to the domicile of the afflicted. It was however normal practice for ailing persons to visit the healers in their respective homes. Chronically ill and incapacitated patients, particularly lunatics, required admission in the healer's house until convincingly cured. There appeared to

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<sup>49</sup> PRAA-A ADM 56/1/159 Zuarungu Official Diary 1913; D.C., North Mamprusi to Acting. Commissioner, Northern Province 18.9.1925; Ag. Commissioner, Northern Province to CCNT 3.10.1925.

<sup>50</sup> ARNT 1899 p. 25.

have been no one designated point for treatment. Indeed some diseases were dealt with in public, others in private, yet others were dealt with in specially assigned areas of the town. Among these areas were: shrines, pools, isolated hills, forest and other related areas deemed therapeutically acceptable to the healer or medicine man. The making of diagnosis in a patient, as a logical prelude to treatment, was largely religious based. It entailed the consultation of the deities, the sole cause of the sickness as was presumed. Most often the consultation was undertaken with the assistance of a soothsayer or diviner.<sup>51</sup> In other cases diagnosis was based on experience of the healers with the symptoms shown to them. Modern diagnostic procedures like the use of the microscope were alien to the indigenous healers.

Treatment of diseases, like diagnosis, was magico-religious based. Among the supernatural techniques adopted to rehabilitate a diseased person was the offering of sacrifice to appease God and the ancestral spirits. The process of mollification was basically carried out by medicine men or healers, sometimes attached to shrines. One of such persons is reported to have been attached to a deity at Sherigu in the Zuarungu district. He was consulted by women who wanted to be mothers (and for other illnesses) drought, failure of crops and related matters.<sup>52</sup> These deities, it appears, were many in Northern Ghana. On this proliferation of deities, Northcott reported; "Every pagan has his fetish or object of peculiar veneration, to which he makes periodical offering and on whose assistance he relies in every relation of life".<sup>53</sup> Indeed, this measure of treatment was unanimous in the North, and it hardly required the use of drugs. Nonetheless, treatment by use of medicine was equally relied upon. These

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<sup>51</sup> These acted as paramedical staff believed to be in constant communication with the unforeseen forces.

<sup>52</sup> PRAA-A ADM 56/1/159 Zuarungu District Diary 1913.

<sup>53</sup> ARNT 1899 p. 24.

medicines were obtained largely from the bush and consisted of herbs, barks of trees, and grasses that were often bitter tasting. A potpourri of herbs, bark, shea butter and charcoal were used for poultices. The potency of native pharmacopoeia was largely determined by the bitterness and strength in smell.<sup>54</sup> In the treatment of smallpox for instance, a brew of the leaves of a shrub is placed on the scabs to reduce the suppuration. The remaining pocks were then treated with an extract of the Gimon tree to induce a dryness of the pocks.<sup>55</sup>

Besides the use of medicine as therapy, other forms of treatment were in the form of surgical operations, which of course was highly non-operative by nature. Surgery as it existed was limited basically to close reduction of fractures and dislocations. Medicine men at Navrongo were noted to be excellent setters of bones and dislocations.<sup>56</sup> The practice of medicine within the African set-up was not limited to curative measures only. Preventive measures were also used as a supplement. These measures essentially entailed the use of charms, amulets, talismans obtained from the medicine man. In Salaga, amulets sewn in leather and shoulder blades of a foal were hung over doors and miniature jaws were placed on the threshold to serve as protection against sickness and evil spirits.<sup>57</sup> In the north-eastern corner it was not uncommon to see hunters carrying charms for the same purpose.<sup>58</sup> The beliefs and processes associated with traditional medical system reveal at least one important feature of indigenous medical practices. The target in treatment was to get rid of the visible characteristics of the disease, and once that was done a patient was considered cured. This suggests that the aetiology of disease was absolutely unknown. Nonetheless a wide range of persons gained access to

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<sup>54</sup> Johnson, *op. cit.* acc. no. SAL18/3.

<sup>55</sup> A.W., Cardinall, The Natives of the Northern Territories of the Gold Coast: their custom religion and folklore (London:1925) p. 46.

<sup>56</sup> Ibid.

<sup>57</sup> Johnson, *op. cit.* acc. no. SAL35/2.

the various methods of therapy operating in the towns and villages. This was possible because of the decentralized nature of indigenous medical and health services. There existed numerous healers. At least every little settlement could boast of one; hence personal care was assured. Besides, payment seems not to have been a hindrance to obtaining therapy. While it was obvious that some services attracted payment, it appears this was affordable. Payment for the cure of barrenness required nothing more than a goat, fowl or a dog for sacrifice.<sup>59</sup>

A question that readily comes to mind is how the early visitors to Northern Ghana dealt with the disease environment, given the absence of European medical establishments. Available evidence indicates there has been no instance where the early visitors succumbed to the use of African therapy. It appears two methods were used. The first was that they carried along medical kits in their travels. Most of the missionaries who traversed these areas were noted for this. Theophil Opoku, a Basel missionary who travelled to Salaga on purpose of winning souls carried pills along in his journey.<sup>60</sup> A second method, typical of official visitors was the attachment of surgeons of expeditions and commissions who travelled these areas. In 1897 an expeditionary force sent to punish the people of Zacko had a P. J. Garland as its surgeon.<sup>61</sup> It is plausible that George Ekem Ferguson the Gold Coaster sent into the interior to make treaties with some chiefs had a medical officer in the fold of his commission of 1898.<sup>62</sup> This is because medical aid was unavailable in the towns further away from the coast. Although the disease environment of the North around this time

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<sup>58</sup> Cardinall, *op. cit.* p. 47.

<sup>59</sup> PRAA-A ADM 56/1/159 Zuarungu District Diary 8.10.1913.

<sup>60</sup> Johnson, *op. cit.* acc. no. SAL8/7.

<sup>61</sup> Illiasu Papers, Diary of expedition to the Frafra country, History Department, University of Ghana.

<sup>62</sup> Arhin, *op. cit.*

was yet to be known, it was axiomatic that malaria, the main killer of Europeans was present in the Protectorate as it was in the south of the country. It is therefore obvious that Ferguson's mission would not have excluded the services of a surgeon. However, what extant records as occur of this early period fail to show any evidence that some of these surgeons attached to expeditions declined to offer their medical services to the local people. Of course, such a gesture particularly if extended to the ruling class was sure to promote a cordial relationship between Ferguson and his entourage and the chiefs and people of the treaty making areas.

From spatial evidence it is clear that disease was the companion of the African of the North as it was with the rest of the country from time beyond recollection. This is not to suggest that other categories of disease (tuberculosis, gonorrhoea and syphilis) did exist but unrecognised by the local people prior to western influence. Other policies, like opening up the Protectorate through a network of roads and the introduction of transport was to cause a quick spread of disease and epidemic outbreaks. Lacking knowledge of the aetiology of disease, supernatural forces stood accused as architects of ill health and the gods in conjunction with herbs administered by herbalist restored health. Although European surgeons were present in the Protectorate around the 1890s and perhaps earlier, their services were mainly restricted to members of expeditionary forces. It was not until the early 1900s that the African population began to feel the presence of western medicine. The emergence and growth of this novel development forms the theme of the next chapter.

## **CHAPTER TWO**

### **CURATIVE HEALTH FACILITIES AND MEDICAL CARE**

Like most developments, curative health service facilities and medical care in Northern Ghana was generally subordinated to related developments in the Colony and Asante. The basic assumption underlying colonial administration was: every single colony, and for that matter division of a country, should be self-supporting. Northern Ghana was generally regarded as a benighted Protectorate, with no trade and little revenue. Consequently permanent infrastructural developments were directed at the south. In keeping with this attitude, and as a policy, government was only prepared to spend limited funds in the development of curative health facilities and medical care. This Chapter traces the development of health facilities and points out the bias in their provision, with particular reference to: hospitals, dispensaries, child and maternal welfare centres and leprosaria. The chapter also attempts to show the role of the local community in the provision of health facilities. Before that however, a brief review of the growth of the medical administrative set-up in the North shall be told.

#### **2.1 GROWTH AND ORGANISATION OF MEDICAL ADMINISTRATION**

The organisation of the Medical Department in the Protectorate was a simple one. Between 1900 and the beginning of 1910, the Department had no substantive head. Whichever medical officer was posted to the capital assumed the position of head of the Department. (It appears only senior medical officers were posted to the capital). The first medical officer to head the Department was probably Dr. Garland. He was the senior medical officer of the Northern Territories in 1900. Garland was followed by Dr. W. H. Jamison, Dr. Graham in 1904 and Dr. E. H. Tweedy from 1908, in that order. In

1910, the headship of the Department was given a new nomenclature, Provincial Medical Officer; and Dr. Edward Herbert Tweedy was appointed to fill that position. It can be said that, it was from 1910 that the Northern Medical Department had a substantive head. Dr. Tweedy was appointed medical officer in 1897. Seven years later he was made Senior Medical Officer; and Provincial Medical Officer in January 1910. In July 1911, Dr Tweedy was promoted Deputy Principal Medical Officer and Dr. James Arthur Clough was appointed Provincial Medical Officer to replace him. After Dr. Clough, came Dr. Ernest William Graham (appointed, October, 1914).

From the 1920s, the title of the administrative head of the Medical Department assumed a new nomenclature, Assistant Director of Medical Services. Dr. Francis Strachey Harper was the first to serve as head with this title in January 1921. But in 1953, the head of the Department was known as Principal Medical Officer. All these changes in nomenclature reflected similar changes in the Gold Coast Medical Department. Like other senior staff appointments, the Departmental head was appointed by the governor of the Gold Coast, but he was responsible to the Director of Medical Services in the performance of duties. His main duty was to coordinate the activities of the various medical officers and subordinate staff of the Department. In this capacity, the Assistant Director of Medical Services embarked on occasional tours of inspection. He was also the resident medical officer responsible for the European Hospital at Tamale. Because there was only one Senior Health Officer responsible for Asante and the Northern Territories, the Assistant Director of Medical Services was responsible for sanitary matters in the Protectorate.

## 2.2 HOSPITALS

Hospitals were essentially the basic curative health services institutions established by the colonial authorities to aid in reducing the incidence of diseases in Northern

Ghana. The first town to have a hospital in the North was Gambaga (The first capital of the Northern Territories). The hospital was a fenced enclosure and consisted of one ward of ten beds and two large enclosed verandas - one of which served as a convalescent ward. The hospital also had a consulting room, a mortuary, operation room, latrine and, quarters for the dispenser and dresser.<sup>1</sup> The establishment of hospitals in the North, at least in the early years, trailed the opening of outstations. Thus by 1920, all the eleven or so outstations opened possessed hospital facilities. But apart from the Tamale and Salaga hospitals, which were permanent constructions, all others were temporary 'bush' hospitals as they were known. These hospitals were built of 'swish' or sun-baked bricks and thatch-roofed, because of the policy of spending minimum funds in the areas.<sup>2</sup> By 1926 the Colony possessed no fewer than 23 excellent hospital facilities. While the Northern Territories contested favourably with Asante in terms of the number of hospitals in 1926, the quality of hospitals in latter was incontestable. Although both dependencies had eleven hospitals (including dispensaries) each, the number of beds including cots were 154 and 34 respectively.<sup>3</sup> Addae asserts that: " They (hospitals) were housed in superior structures, they had the best equipment and staff possessed operating theatres and carried out surgical operations."<sup>4</sup>

The adoption of the measure of providing "bush" health facilities was motivated, first by the difficulty in obtaining building materials. The distance between the North, and the coast (source of materials) was considerable. Vehicular transport, the only means by which the material could reach the Northern Territories, was scarce. Besides, their capacity was not large enough to carry large quantities of building material. Moreover the roads were poor-to-nil. Another, equally important, factor that influenced

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<sup>1</sup> PRAA-A ADM 56/1/419 Annual Report of the Medical Department Gambaga 1904.

<sup>2</sup> ARNT 1916, 1921, 1922.

<sup>3</sup> Organisation and Activities of the Public Health Services of the Gold Coast( Accra 1926) p.8.

<sup>4</sup> Addae., op. cit p. 61

the development of hospital facilities in the North was the lack of funds. Although the North possessed resources, these could not in the estimation of colonial authorities be obtained in economic quantities. Attempts were made to develop the cotton and sheanut industries, but both experiments failed. A direct tax, the maintenance tax was also introduced, but was short-lived. Not long after its introduction, governor Nathan ordered its withdrawal because he thought it was oppressive on the people.<sup>5</sup> That the colonial government was unprepared to spend a penny beyond that which was accrued in Northern Ghana is evident in a remark governor J. J. Thorburn made concerning the development of the North in 1912. He remarked that:

“ until the colony and Asante have been thoroughly opened up and developed, the Northern Territories must be content to wait their turn.”<sup>6</sup> Thorburn’s remark was not novel. Earlier than 1912 in 1899 Governor Frederick Hodgson pointed out that:

. . . as the trade value of the Northern Territories are not favourable. . . they possess no mineral wealth, it is destitute of timber and does not produce either rubber or kolanuts or indeed any product of trade value. . . I would not at present spend on the Northern Territories a single penny more than is absolutely necessary.<sup>7</sup>

The development of the North was compounded by the outbreak of the First World War in 1914, as whatever meagre funds accrued in the North was invested in the prosecution of the war. Indeed, as the Chief Commissioner was instructed; “ the object of government in the immediate future must be to reduce not to increase expenditure especially in the Northern Territories”.<sup>8</sup> Rather than maintaining the available ‘bush hospitals’, several of them were closed down. The status of hospitals remained unchanged well up to the mid 1920s. Brukum has pointed out that, the governors of the

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<sup>5</sup>PRAA-A ADM 56/1/34 Meeting between H.E the Governor and chiefs of Mamprusi, Dagomba, and Gambaga 13.04.1903.

<sup>6</sup> Quoted in ARNT 1912.

<sup>7</sup> R. B., Bening, “Colonial Development Policy in Northern Ghana 1898-50” in Bulletin of Geographical Association vol. 17, 1975 pp. 65-79.

<sup>8</sup> PRAA-A Acc No. 1303 Col. Sec. to CCNT 4.11.1914.

dependency were reluctant to develop the North because they were not mandated to do so. Northern political authorities were mandated to produce labour force needed in the south.<sup>9</sup>

When Guggisberg became governor of the Gold Coast in 1919, his policy was to upgrade the Tamale hospital to serve as the chief medical centre of the Northern Territories. He also intended (by policy) to improve the existing bush district hospitals and to build new ones in areas where necessary. These hospitals, as he envisaged, were to contain between twenty and fifty beds, well equipped with operating theatres and dispensaries. The district hospitals were to form the key medical centres in the districts.<sup>10</sup> As far as Northern Ghana was concerned, none of these envisaged dreams were realised at least by 1928 when he left office. It is possible that the prohibitive cost of building materials coupled with the rather high cost of transporting them to the hinterland did not make it possible for Guggisberg's policies to materialise. It is however clear that Northern Ghana was not Guggisberg's priority. The drive of Guggisberg was to undertake projects that brought in financial returns. So that his attention was drawn to developing transport, particularly railroad and harbour developments. Projects of this kind required very high capital cost. In the event no funds were left for pursuing social developments in the rural areas. The few social projects that engaged Guggisberg's attention were undertaken in areas of the Gold Coast that possessed financial promise. The North was certainly not part of these areas. Top priority was given to the Gold Coast hospital.<sup>11</sup>

Under Guggisberg's administration then, some hospitals in the Protectorate, remained in the state in which they were, prior to his accession. They consisted of one-

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<sup>9</sup> N.J.K. Brukum, The Northern Territories of the Gold Coast under Colonial Rule 1897-1956: A study in Political change p.10.

<sup>10</sup> Gold Coast Legislative Council Debates (Hereafter GCLCD) 1926-27 pp. 142-3.

<sup>11</sup> Now the Korle Bu Teaching Hospital. For details on the emergence of this hospital see Addae s. op. cit. pp. 67ff.

roomed dispensaries and dressing sheds. Other hospitals were worse still both in structure and equipment. Although Zuarungu had a hospital with room for six beds, there were no beds in the wards.<sup>12</sup> While the hospital buildings at Salaga were in good repair and well catered for, it had many bats in the roof of the theatre.<sup>13</sup> Other districts and stations either had no hospital facilities at all or for only brief periods. This was the situation at Navrongo and Gambaga in 1926 and 1929 respectively.<sup>14</sup> The appalling conditions of the hospitals appeared so serious because, it coincided with the steady increase in the population from the 1920s. By 1926, the population of Bawku and Lawra for example had risen to about 15,000. Navrongo district was estimated to have a population of 100,000 around the same time.<sup>15</sup> Coupled with this was the steady growth in confidence of the local people in European therapy. The result as should be expected, was the increase in hospital attendance, of both in-patients and out-patients. More often, hospital attendance reached levels which the available space of existing hospitals could not cope. In 1905, it was reported that the townspeople of the various stations in the dependency did not avail themselves of medical treatment offered by the government.<sup>16</sup> However in 1924-25 a total of 5,559 out-patients were seen at the Tamale, Wa, and Zuarungu hospitals. Approximately, 272 in-patients received treatment in these hospitals.<sup>17</sup>

Apart from the dilapidated conditions of the buildings and the question of space, frequent shortage of drugs and dressings was another problem that bedevilled the hospitals of the North, a rare condition in the Colony. It was noted in 1929, that, stocks of simple drugs, remedies and dressings at the stations of Bawku, Navrongo and

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<sup>12</sup> PRAA-A ADM 56/1/405 Acting. Assistant Director of Medical Services(ADMS) to Director of Medical and Sanitary Services(DMSS) 20.12.1927. Despatch No. 14/20/24.

<sup>13</sup> Ibid.

<sup>14</sup> PRAA-A ADM 56/1/405 ADMS to DMSS 4.2.1926; ADMS to DMSS 26.2 1929. Despatch No. 46/20/24.

<sup>15</sup> PRAA-A ADM 56/1/405 ADMS to DMSS 14/2/1926.

<sup>16</sup> ARNT 1905 p. 15.

<sup>17</sup> ARNT 1924-25 p. 13.

Gambaga were conspicuously low.<sup>18</sup> At Wa, there was an equally lamentable shortage of drugs and dressings. In the case of Wa, (1929) it was found that, none had been received since April 1925.<sup>19</sup> Interestingly, a few other hospitals possessed far in excess of their required medication. The store at Zuarungu was said to be “too full and the station overstocked with the majority of drugs”. Yendi was similarly overstocked with drugs.<sup>20</sup>

It was under these conditions that governor Slater assumed the governorship of the Gold Coast. Under Slater, Guggisberg's policy of the reconstruction of all hospitals in the North was not only maintained but received considerable attention. An important event which perhaps, influenced the prosecution of this policy was Slater's visit to the North in 1929. It placed the governor on a good footing to see things for himself and indeed contrast the state of hospital facilities in the Protectorate to those of the coast. Slater remarked:

The lack of hospitals in the Northern Territories is nothing but a scandal. There is only one hospital worth the name, viz., at Tamale. At Wa there is a so called hospital full of people sleeping on the floor, but the building was an ancient ramshackle one badly situated next to the noisy centre of town. At Lawra an old bush school building... here a totally illiterate but faithfully old retainer attends regularly every morning with lint to give a little elementary aid to persons suffering from sores etc. This is the sum total of the hospital facilities in a district with nearly 100,000 inhabitants.<sup>21</sup>

In the light of his observation, Slater immediately issued a special warrant for the erection of hospitals at Wa and Lawra. Thus beginning from 1930, when new hospitals were built at Wa and Lawra on Slater's orders, Northern Ghana began to witness the growth of hospitals with improved facilities (although not up to the standards of the Colony and Asante). The hospitals at Yendi for instance contained nine beds with capacity for twelve. It was adequately equipped with iron bedsteads, and indeed linen.

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<sup>18</sup> PRAA-A ADM 56/1/405 ADMS to DMSS 26/2/1929 Despatch No. 46/20/24.

<sup>19</sup> *Ibid.*

<sup>20</sup> PRAA-A ADM 56/1/405 ADMS to DMSS 20.12.1927. Despatch No. 14/20/24.

<sup>21</sup> PRAA-A ADM 56/1/405 A.E. ADMS to CCNT 3.5.1932; CSO 11/1/415 DMS to Governor.

Attached to the ward were a theatre, sterilising room and a consulting room.<sup>22</sup> At Navrongo a “war memorial” hospital was built from locally subscribed funds. The hospital contained eleven beds, with a layout largely similar to the Wa and Lawra hospitals.<sup>23</sup> It comprised a ward, operating theatre, administrative block, dispensers’ quarters and a mortuary.<sup>24</sup> The construction of the Navrongo hospital was not without controversy. According to the initial plan, it should have been built at Zuarungu. This was in view of the consideration that, Zuarungu was nearest to Bawku, a town without a medical officer. Navrongo was selected as the site mainly because the chiefs had volunteered to contribute £300 towards the hospital’s construction, an offer the governors of the dependency could not resist, given the background of the government’s policy of minimal spending in the Protectorate.<sup>25</sup> Under Slater, the Tamale hospital saw improvements; a new ward built with concrete and accommodation for 22 patients was completed in early 1930. Two water tanks with a total capacity of 20,000 gallons were erected to serve the hospital and following the introduction of electricity into Tamale in 1930, a powerful 1,500 candle power electric lamp was installed in the operating theatre.<sup>26</sup> In 1931, a laboratory block was added to the Tamale hospital. Thus it can be said that, by the middle of 1930, Slater had been able to prosecute, albeit partially, Guggisberg’s policy of constructing central hospitals in the districts of the Northern Territories.

Slater could however not proceed further because the period of his constructional works coincided with the slump in world trade. The price of cocoa, the mainstay of the economy dropped steeply. Cocoa prices dropped from £50 to £41 per ton in 1929. In

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<sup>22</sup> GCMSDR 1929-30 p.58; GCLCD 1931-32 p.46.

<sup>23</sup> GCMSDR 1931-32 p.39; 1932-33 p.39.

<sup>24</sup> PRAA-A CSO 11/12/19 Commissioner-NP to CCNT 24.11.1931.

<sup>25</sup> PRAA-A CSO 11/12/19 Acting. DMSS to Col. Sec. 21.11.1931.

<sup>26</sup> GCMSDR 1929-30 p. 58

1930, cocoa prices further fell to £20 per ton.<sup>27</sup> Similarly all other sources of revenue in the country experienced a downward trend in the early 1930s as illustrated in the table below.

TABLE 2 DECLINING REVENUE OF THE GOLD COAST IN THE 1930s<sup>28</sup>

SOURCE OF REVENUE	1929-30	1930-31	1931-32
Customs	£2,489,575	£1,735,198	£1,473,587
Licences	£215,901	£224,047	£118,823
Fees	£216,986	£235,894	£227,486
Railways	£31,724	--	--
Post and telegraph	£127,615	£119,585	£105,764
Sundry & extra-ordinary	£225,777	£284,494	£288,636
<b>Total</b>	<b>£3,337,578</b>	<b>£2,599,218</b>	<b>£2,284,299</b>

Against the decline, Slater reduced expenses. Development projects were terminated and social services were drastically reduced.<sup>29</sup> Although the financial position of the country had improved during the later 1930s, conditions of hospitals in the North continued to deteriorate. When governor Arnold Hodson visited the Protectorate in January 1937, he noted with displeasure the dirty state of most of the hospitals. At Bawku for instance, the hospital did not conform to Hodson's idea of hospital cleanliness. The governor blamed this on the indolence and lack of interest of the medical officer.<sup>30</sup> Navrongo was not different when M.G. Le Bas, matron of the Medical Department visited the hospital in February 1937. "The equipment", as Le Bas observed, "was in a terrible condition, great holes in the mattresses. The pillows were dirty and in a

<sup>27</sup> Gold Coast Annual Reports 1930 p. 18.

<sup>28</sup> Gold Coast Annual Reports 1931-32 p.70. The situation was compounded by losses in the Railway and Takoradi Harbour.

<sup>29</sup> GCLCD 1930 p.16; 1931 p.266.

<sup>30</sup> PRAA-A CSO 11/1/415.

terrible condition. The theatre furniture required repainting badly. . . very little or any equipment has been ordered for some time”<sup>31</sup>

An interesting feature of the development of health facilities in the North was that, up to 1937, the political administrators provided health facilities as and when the necessity arose. This often happened after a governor or senior government official visited the Protectorate. From late 1937, this crisis management approach in the provision of medical care was to change. Government resolved to provide hospital and other health facilities based on a plan. Whatever plans were to be drawn up were preceded by certain recommendations by Dr. W.J. McClintock the Assistant Director of Medical Services in Kumasi. In consultation with Dr. G.E. Craig (Deputy Director of Medical Services) two recommendations were made. First, that the type of hospitals in the North should be standardised: second, the equipment should equally be standardised, especially with regards to bedding. It was further suggested that, a small proportion of beds be set aside for “better class patients” Dr McClintock believed that if these suggestions were carried out they would result in “very much improved hospitals” in Northern Ghana.<sup>32</sup>

In keeping with the conviction of working with a plan, governor Arnold Hodson instructed the Director of Medical Service in consultation with the Chief Commissioner of the Northern Territories to consider the necessary medical facilities required. They were further to consider the order in which these facilities were to be provided, and the lines upon which government should grant financial and other assistance.<sup>33</sup> The recommendations of the collaborative work of the DMS and the Chief Commissioner followed closely the suggestions made by Dr. McClintock. No specific recommendations were made with regards to building more hospitals or expanding the existing ones. It was however found necessary to properly equip stations with limited

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<sup>31</sup> PRAA-A CSO 11/1/415 Report by Maud Godfryn Le Bas, Matron Medical Department 11.2.1937.

<sup>32</sup> PRAA-A CSO 11/1/415 Letter from ADMS(Kumasi) 10.3.1937.

<sup>33</sup> PRAA-A CSO 11/1/427 Col. Sec. to DMS 1937. Despatch No. 1554/30/186.

number of beds. These beds were for serious cases like pneumonia, and others, which in their estimation required skilled nursing. All other cases which required in-patient attention were to be handled in well-laid-out camps attached to the various hospitals.<sup>34</sup>

The provision of camps, as recommended, was largely influenced by the success achieved in this area by the Dagomba Native Authority. In 1935 the Dagomba Native Authority had built camps which could accommodate up to forty patients all together.<sup>35</sup> The innovation was further influenced by the gradual growth in the financial strength of the Native Authorities. To make native administration effective, native treasuries were introduced in 1936, (after the move had received the approval of the Secretary of State) and within three months the estimated revenue was exceeded.<sup>36</sup> The reason for the suggestions was to shed the financial burden of the colonial government in areas of the provision of wards, beds and subsistence. The suggestion also had the advantage of relieving congestion in the main wards which had limited space

Although the construction of camps appeared advantageous, the recommendation was not seriously carried out. Way had to be given to major developments in the 1940s largely under the administration of Alan Burns. Burns' policy regarding hospitals, was the building of additional wards in some of the hospitals and erecting new ones in places where none existed. Burns designed this policy essentially to reverse the "scandalous overcrowding" of most of the hospitals, particularly those in the rural areas. Well aware of the war and its consequences on the finance of the country, the governor warned that it was quite "unnecessary to building expensive hospitals". He proposed to obtain designs for relatively cheap forms of construction. This had the advantage of permitting the

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<sup>34</sup> *Ibid* These camps were to be well built houses of local materials and designed in styles in keeping with what the local people were used to.

<sup>35</sup> GCMSDR 1935-36 p.39.

<sup>36</sup> The estimated yield of the tax from ten Native Authority areas was £10,941. However the total collected by the end of the year was £19,144. an excess of almost 90%.

expansion of hospitals at reasonable cost.<sup>37</sup> But as Burns was to acknowledge in 1943, “it is clear... that the cost of these new hospitals is going to be much more than anticipated and, except perhaps in the case of one or two of the very worst, we cannot hope to be able to replace existing hospitals with new ones.”<sup>38</sup>

Committed to realising his plans, the governor sent a circular requesting medical officers in the various stations to report on the conditions of the country's hospitals. Responding to the circular, G. H. Gibbs, the then Chief Commissioner, decided that Wa hospital should be rebuilt. The reason for his choice was because he considered the population of Wa to be four times larger than the Krachi district.<sup>39</sup> Lawra, Navrongo and Bawku hospitals were considered “Worthless”, and were to be converted into health centres. Consequently, estimates were not made for the inclusion of these hospitals in the scheme of alteration of hospitals. Regardless of Gibbs’ recommendation, Yendi and Wa were equally left out.<sup>40</sup> The only hospitals included in the estimates for the Protectorate were: Tamale and Salaga African hospitals.<sup>41</sup> It appears two developments influenced the neglect of the North in the execution of Burns’ scheme. Dr. Johnston, who was assigned the task of visiting the various hospitals in the country delayed in touring the Northern Territories. The North had therefore to wait till he had completed his tour, which according to him could take a long time. A more important development was that, the proposal of the governor, as it stood, envisaged increase in bed accommodation. An effect of this increase was the requirement of additional nursing staff. But no such increase in nursing staff was possible. With the then existing bed establishment, it was estimated that the Medical Department was some 150-170 nurses

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<sup>37</sup> PRAA-A CSO 11/2/36 Governor to Col. Sec. 8.10.1942.

<sup>38</sup> PRAA-A CSO 11/2/36 Governor to the Col. Sec. 3.6.1943.

<sup>39</sup> PRAA-A CSO 11/2/36 CCNT to Col. Sec. 3.8.1943. This suggestion was based on the conviction that Krachi was close to Yendi. Thus, provision of a motor ambulance and building a small unit of six beds at Krachi to serve as a collecting centre.

<sup>40</sup> PRAA-A CSO 11/2/36 Ag. DMS to Col. Sec. 21.12.1944.

<sup>41</sup> PRAA-A CSO 11/2/37 The estimate of the two hospitals was £2,137.

short of the required strength to yield the standard ratio of one nurse to every three beds.<sup>42</sup>

It was not until the close of 1946, that a proposal was put forward for the building of a 60-bed hospital at Bolgatanga. This hospital was to become the second major hospital, but the most modern in the Protectorate at least in the 1950s. Preparations for the construction of this project began in 1943 with the appointment of a site board.<sup>43</sup> The board was entrusted with the duty of selecting a suitable site to measure approximately 1500 feet square. Two alternative sites were recommended by the board. The first was at Dopori-Tindengo, 13/4 miles north of Bolgatanga; the other was an area west of the Nangodi-Zuarungu road. The Dopori-Tindengo was selected finally as the more suitable. Bolgatanga was selected because it held promise of satisfactory water supply to the hospital if constructed: Bolgatanga was close to the Kuldan river and two other dam sites previously selected by Major G.J. Williams - geologist. The selection of the site received the approval of the governor.<sup>44</sup>

In 1948, tenders were called for the construction of the hospital. It was estimated at a cost of £60,000. Construction commenced that same year and was completed in 1950, but it was not opened until 1952.<sup>45</sup> A combination of factors caused the delay in the opening of the hospital. By 1950, water and electricity supply were not available on the premises of the hospital. Although the junior staff quarters had been built, accommodation for the medical officer and nursing sister had not started by 1950. Besides, the equipment to facilitate efficient operation of the hospital were non-existent. For instance, it was only in 1953 that X-Ray machines were installed and brought into use. The construction of this hospital fulfilled a much-felt need in the Northern

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<sup>42</sup> PRAA-A CSO 11/2/37 DMS to Col. Sec. 21.5.1945.

<sup>43</sup> PRAA A CSO 11/2/37 Director of Public Works to Ag. Col. Sec. 15.12.1943.

<sup>44</sup> PRAA A CSO 11/2/37 DMS to Col. Sec. 21.5.1945.

<sup>45</sup> GCMSDR 1948 pp. 6-10; GCLCD 1948.

Territories. The facility catered for one of the most densely populated areas in the Protectorate. Indeed, the hospital instantly became the busiest health institution next to Tamale.

From 1951 a programme involving the construction of new district hospitals was re-initiated and accelerated. A sum of £10,000 was included in the draft estimates of public works of 1951-52, for the building of a new hospital at Navrongo.<sup>46</sup> In 1952 contracts were awarded for the building of the Navrongo hospital. Hospitals at Yendi, Bawku, Wa and Jirapa similarly began. By 1954 all these hospitals had been completed. Although the hospitals were of varying sizes, they conformed to a standard pattern viz., general wards for male and female patients, a children and maternity block, isolation ward, theatre, outpatient block, administration, laundry and kitchen.<sup>47</sup> Indeed, it can be said that, Guggisberg's policy of regional and district hospitals was fully realised in 1954, twenty-seven years after he left office.

The spate of renewed development in hospital projects in the dependency from the mid 1940s was largely influenced by the political developments that emerged in the Protectorate in 1946: this was the creation of a Northern Territories Territorial Council (later called the Northern Territories Council-NTC). No sooner was this body formed than the council members in their debates began entreating government time and again to address the social and economic backwardness of the dependency. One of the main areas of concern was health. Indeed no session passed without health issues being raised. Issues on the water supply position in Krachi, the closure of the Kintampo School and the opening of the Bolgatanga hospital were raised during the seventh session of the council.<sup>48</sup> During the eighth session of the Council in December 1950, J.A. Braimah

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<sup>46</sup> A more comprehensive scheme was recommended to the government by the DMS at an estimated cost of £23,000.

<sup>47</sup> ARNT 1955 p. 77.

<sup>48</sup> Record of the Seventh Session of the Northern Territorial Council (Hereafter NTC) 18-21 July 1950 p.9-11.

demanded to know why the examination of children of the Native Authority School had ceased since 1946.<sup>49</sup>

But the event that was to increase the tempo of health service developments in the dependency was the C. P. P. government's desire to integrate the Protectorate to the Colony and Asante in preparation for self-government. In the opinion of the dependency's inhabitants, veritably enunciated by the NTC, the North was too backward to be ready for self-government. It was demanded that, the Northern Territories be developed to the level of the Colony and Asante before self-government was considered.<sup>50</sup> It was genuinely feared that Northern Ghana would forever lag behind the Colony and Asante. This was a threat that held the potential of undermining the hope for self-government and hence influenced substantially the accelerated growth of hospitals and other health centres in the 1950s.

A feature of the development of health facilities in the North in the 1950s was the practice of handing over the staffing and maintenance of the hospitals to the missionary bodies operating in the Protectorate. The hospitals at Navrongo, Damango, and Jirapa were put under the responsibility of the White Fathers Mission. The Salaga, and Bawku hospitals were run by the Basel Mission. The remaining ones Tamale, Wa, Yendi and Bolgatanga were staffed and maintained by the Health Ministry.<sup>51</sup> This arrangement appears to have been financially motivated. The growth of hospitals in the Northern Territories from the late 1920s to the mid 1950 is set out in the table below:

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<sup>49</sup> NTC eighth session 18-21 December 1950 p.9-10.

<sup>50</sup> Brukum, *op. cit.* p.332.

<sup>51</sup> ARNT 1955 p. 77.

TABLE 3 GROWTH OF HOSPITALS 1927-1955

YEAR	APPROX. No. of HOSP.	SOURCE
1927	4	GCMSDR 1927-28 pp. 89-90
1928	4	Ibid 1928-29 pp. 117-8
1929	5	Ibid 1929-30 pp. 183-4
1930	6	Ibid 1930-31 pp.
1931	6	Ibid 1931-32 pp. 86-7
1932	6	Ibid 1932-33 pp. 76-7
1933	6	Ibid 1933-34 pp. 81-82
1934	7	Ibid 1934-35 pp.
1935	7	Ibid 1935-36 pp.73-4
1936	6	Ibid 1936-37 p. 778
1937	7	Ibid 1937-38 pp. 85-6
1938	7	Ibid 193839 pp. 89-90
1950	--	-----
1953	---	-----
1955	9	ARNT 1955 p. 77

From the table, it can be seen that apart from 1927, 1928 and 1929, the number of hospitals generally remained static. The only significant differences between the hospitals of the 1930s and those of the 1950s were those of material composition, structure and style as well as size.

From the beginning of the 1910s the Africans were generally reluctant to avail themselves of western medical treatment. Medical reports of the period are replete with assertions by health officials and political authorities of the unwillingness of Africans to visit these health centres. For example in his report for 1905, the Chief Commissioner noted that the townspeople at the various stations did not “avail themselves to any great extent of the medical treatment supplied by the government.”<sup>52</sup> Unlike the coast where hospital fees contributed immensely to the reluctance of Africans to use modern health

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<sup>52</sup> ARNT 1905 p. 15.

facilities, this was not the case in the North. The maiden Hospital and Dispensary Fee Ordinance enacted by governor William Maxwell in May 1897 did not affect the Protectorate.<sup>53</sup> Ignorance and variation in concept of sickness more than any thing else were principally responsible for the local people's avoidance of modern health service facilities. The sick person, in the interpretation of the local people, was one whose health visibly hindered his capacity to work: thus as long as a patient could undertake daily chores, obvious disease symptoms were disregarded, until deterioration of health was severe and death appeared imminent. Also important in explaining the local peoples reluctance to utilize European health facilities is the fact that the local population had their own medical facilities before the introduction of western medical facilities. Therefore they needed time and evidence to persuade them to patronize the new unfamiliar facilities. Perhaps another explanation for the poor patronage of hospital and dispensary services was distance. Health facilities, as a rule were largely provided to cater for the European population who basically resided at some selected settlements of the Protectorate. Meanwhile many Africans lived miles away from the health facilities provided and as such the distance acted as a disincentive to attendance.

By 1908, tremendous improvements were recorded in out-patient numbers throughout the Protectorate. In 1915, as many as 2,226 out-patients offered themselves for treatment at the Tamale African hospital. Between 1934 and 1938, an average of 1600 out-patient cases were handled at Tamale.<sup>54</sup> This phenomenon, it should be pointed out was not limited to the hospital in Tamale alone; it was a general reflection throughout the Protectorate as illustrated below:

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<sup>53</sup> Gold Coast Ordinance 1897 pp. 34-35. The Ordinance classified the dependency under the zone of paupers and subject to free medical care.

<sup>54</sup> GCMSDR 1935-36 p. 39; 1938 p. 51. \_\_\_\_\_

TABLE 4: OUT-PATIENT HOSPITAL ATTENDANCE 1915<sup>55</sup>

TOWN	ATTENDANCE
Navrongo	349
Salaga	972
Bole	473
Lawra	217
Gambaga	589

Indeed, by the early 1930s, it became less difficult to persuade patients to attend hospitals for treatment, because people had developed confidence in European medication particularly, the efficacy of yaws therapy. The effect of the intravenous and intramuscular treatment used in the handling of this disease was so obvious that within a short period, patients became relieved. Increased confidence in European therapy so permeated the protectorate that some chiefs of the Southern Province relentlessly applied for medical assistance from the medical authorities.<sup>56</sup>

While out-patient attendance was improving gradually, the story of in-patient attendance was largely disappointing. Expressing this disappointment the Chief Commissioner declared in 1908: “It was still very difficult to make them understand the benefits they derive from being taken as in-patients into hospitals as they dislike leaving their homes and friends.” Indeed of a total attendance of about 603 patients at Salaga hospital in 1915 only 14 came as in-patients which was less than 3% of total attendance. The least said about Navrongo the better: While 349 out patients were seen no single case of in-patient was recorded. The reason for this state of affair is not far to seek. The local people declined being taken as in-patients not because they disliked leaving their

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<sup>55</sup> ARNT 1915 p. 10.

<sup>56</sup> GCLCD 1925-26, p. 174.

homes nor friends as opined by the Chief Commissioner. The Africans of the North generally abhorred the restriction normally imposed by the medical officers.<sup>57</sup> Hospitalisation was also feared because of seeming high death rate associated with it. Majority of the Africans attended hospitals after all traditional methods had failed and where ailments were in their advanced stages: this often resulted in death. Nonetheless, by the mid-1920 and for reason already stated, in-patient attendance improved. In 1924-25 for instance 229 patients were admitted at the Tamale African Hospital.<sup>58</sup> On the average between 1934 and 1938, in-patients attendance had reached the level of over 1,200.<sup>59</sup> At Yendi in 1930, the hospital was well patronised and the beds were exhausted.<sup>60</sup> At Navrongo where no single in-patient case was handled in 1915, over 150 in-patient were seen in the early 1930s.<sup>61</sup>

Although Africans attended hospitals and dispensaries as in-patients, they rarely stayed in the hospital long enough to be completely cured and discharged by the medical officer. The patients determined when they should be discharged and absconded unnoticed by the medical officer.<sup>62</sup> As would be expected, hospital authorities tried to persuade the Africans to stay by offering 'medical comforts' such as tinned milk, beef and other European foods in addition to the food patients received from their families.<sup>63</sup> This measure it appears, failed to halt the Africans attitude of absconding from hospitals prematurely and hence medical officers had to live with this attitude.

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<sup>57</sup> ARNT 1915 P.15.

<sup>58</sup> In 1925-26, this hospital really had vacant beds. GCLCD 1925-26P. 174; ARNT 1924-25 p. 13.

<sup>59</sup> GCMSDR 1935-36 P. 39; 1938 P. 51.

<sup>60</sup> Togoland report 1930 p. 45.

<sup>61</sup> GCMSDR 1932-33 P. 39.

<sup>62</sup> Togoland report 1923 P.31.

<sup>63</sup> Togoland report 1924 P. 64.

### 2.3 FUNCTIONS AND WORKING CONDITIONS OF MEDICAL OFFICERS

Apart from the poor structural state and equipment base of the early hospitals, the perpetual dearth of medical officers appears gravest. By the close of 1900 only one medical officer was in-charge of the whole Protectorate, a condition governor F. M. Hodgson described rather dismissively as inadequate. In a letter to the Secretary of State, Hodgson sought approval to send two or three more medical officers to the North.<sup>64</sup> By 1901 the medical duties of the Protectorate were performed by three medical officers. But it appears only two of them operated simultaneously. These were stationed at Gambaga and Wa. The location of the officers was significant. Although there existed relative peace in the Protectorate, there were exceptions. These exceptions were the Lobi-Dagarti settlements and the Nabrigo Hills, an area north-west of Gambaga. For this reason the Hausa Constabulary was stationed in these settlements. In 1901 a total of about 487 Constabulary were at Gambaga and Wa. The medical officers were thus stationed in these areas to take care of the health of the Hausa Constabulary and the few European staff.<sup>65</sup> Up to 1906, only three medical officers were stationed in the Protectorate. These were located at Gambaga, Wa and Yeji.

Between 1907 and 1913- a period under the governorships of Roger, Thorburn and Clifford- the number of doctors more than doubled to an average of eight.<sup>66</sup> A consequence of the rise in numbers of medical officers was a reduction of the doctor population ratio from 1:53716 in 1901 to 1:40, 423 in 1913, an improvement of about 25%.<sup>67</sup> An important development that accounts for the doubling in strength of medical officers was the outbreak of cerebro-spinal meningitis in 1906. As already pointed out, this was the first occasion in which the outbreak of the disease was reported. The speed

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<sup>64</sup> PRAA-A ADM 1/2/54 Governor to Sec. of State 11.8.1900. Despatch No. 300.

<sup>65</sup> PRAA-A ADM 56/1/37. Of the 487 Constabulary, 275 were stationed at Gambaga and 112 at Wa.

<sup>66</sup> Gold Coast Blue Book (Hereafter GCBB) 1907 p O 124-5; 1909 pp.O 129-30; 1910 p O 113; 1913 p.O 97.

<sup>67</sup> These ratios are based on calculations from the estimated population of the Northern Territories in 1901 and 1913 in the GCBB, 1902 p. S 1; 1913 p. S1.

with which the epidemic travelled and the rate at which deaths occurred perhaps sent signals to the political authorities of its possible spread to the south. It was obvious that, whatever facilities existed should be marshalled to exterminate the scourge before it spread southwards.

It is difficult to know the number of medical officers in the Protectorate between the outbreak of World War I and 1920. It is clear however that their strength was far below the figures for 1907, 1908 and 1913. In 1915 and 1916 for instance, there were no medical officers in charge of hospitals at Yeji, Wa, Bawku and Zuarungu.<sup>68</sup> In 1920, Tamale, Wa and Zuarungu appear to be the only hospitals in the Protectorate where medical officers were stationed. The reduction of the number of medical officers during this period was unquestioningly due to the exigencies of the war. During the war, doctors serving in the Protectorate were either seconded for military services or were requisitioned by the governor for services in other parts of the Colony. Though it was a countrywide measure, the brunt fell on the North because it was generally regarded as a “less important area.”

Beginning from 1929 there was an appreciation in the number of doctors. Ironically, it was in this period that tragedy befell the country’s finances. Indeed there was a general economic depression between 1929 and 1933. The effect of the depression was reflected in the gradual decline of revenue from £5,217,638 in 1927 to £2,778,055 in 1935.<sup>69</sup> The result was the adoption of cost-saving measures. One of these was the reduction of the number of doctors from 48 in 1929/30 to 36 in 1931/32.<sup>70</sup> Regardless of the depression and reduction of doctors, the strength of medical officers stood at an average of 8 in the Protectorate.<sup>71</sup> The relative stability in the strength of doctors in the

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<sup>68</sup> ARNT 1915 p. 10; 1916 p. 8.

<sup>69</sup> G. E., Metcalfe, *Great Britain and Ghana: Documents on Ghana History 1807-1957* (London:1965) p. 751.

<sup>70</sup> GCMSDR 1931-32 pp. 4-5.

<sup>71</sup> GCMSDR 1929-30 pp. 183-4; 1930-31 p. 140 ; 1932-33 pp. 76-7; 1933 p. 81 ; 1934 p. 67 ; 1935 p. 74-5; 1936 pp. 77-8; 1937 pp. 85-6; 1938 pp. 89-90.

face of the depression was due to the rise in attendance at hospitals. By this time the local people had gained much confidence in the medications provided by Europeans. The level of confidence was further increased when potent vaccines like norarsenobillon were used. Injections were favoured because they produced rapid relief. It seems the political administrators did not wish to lose the local people's confidence. In the midst of these developments, two options were open; either to maintain the force of doctors and consolidate the confidence of the inhabitants or decline to treat more than can adequately be dealt with. The government opted for the former. Indeed, according to one report it would seem a "...tragedy if after all the years of spade work during which we have endeavoured to impress upon a reluctant people the benefit of European medicine and just as we are beginning to get results, we now have to turn them away owing to lack of staff."<sup>72</sup> On account of the Second World War however, the number of doctors suffered reduction. But after the war in 1945 the strength of medical officers increased, steadily.

What functions did the medical officers in Northern Ghana perform and under what conditions did they live? One of the major tasks of the 'bush' medical officer, as they were referred to was the performance of clinical duties. In the absence of a resident specialist, the 'bush' doctor turned out to be 'a jack of all trades'. They also acted as medical officers of health of the districts in which they were usually stationed. In this capacity, they supervised the disposal of night soil, refuse, construction of latrines, siting of slaughterhouses, markets and town planning. Medical officers also performed administrative duties. They prepared and submitted instrument and drug requisitions for the hospitals and dispensaries. They were also responsible for the preparation of annual reports of the medical department of the district. On many occasions they acted as district officers in the absence of the commissioners. In 1916 for example, Walker-Leigh

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GCMSDR 1931-32 p. 9.

the District Commissioner, handed over Salaga district to Dr. Levers. Also, Dr. Duff acted as the District Commissioner of Bole in 1915. Similarly Dr. Ryan took over the Salaga /Yeji district from Mr. Halloway in May 1917.<sup>73</sup> The records indicate that at least every single medical officer who worked in the Protectorate once acted as District or Provincial Commissioner. Unlike the coast where medical officers despised acting as political officers because they lost income from private practice, a different picture was portrayed in the North. In the North medical officers were generally not denied the chance to private practice but a general lack of money and the policy of government to give free medical care, made the performance of such a venture unprofitable. Consequently doctors were often glad to act as District Commissioners since they received remuneration that augmented their purses. The adverse effect of this arrangement was that, medical officers who acted as Commissioners had little-to-no time to perform their professional task. They could hardly visit the dispensaries and hospitals. For instance Dr Duff had to spend the whole of his time in settling a dispute between the Yagbumwura and Bole chief, when he was acting District Commissioner of Bole in 1915.<sup>74</sup>

To make up for the perennial inadequacy of doctors in the North, the Medical Department resorted to an arrangement by which medical officers were also obliged to travel to the outstations to attend to patients who resided in areas without resident medical attendants. The difficulty associated with this measure was that, the distances between most towns were long.<sup>75</sup> Such distances were covered either by foot or carriage by hammock. It was however easy to travel throughout the Protectorate only in the dry

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<sup>73</sup> PRAA-A ADM 56/1/92 CCNT to Col. Sec. 19.1.1916; Acting. Asst. Commissioner to Commissioner Southern Province 1.12.1915; Ag. Provincial Commissioner Southern Province to CCNT 19.5.1916. In certain cases medical officers handed over to colleague doctors. Dr. Robert Whyte who acted as District Commissioner for Zuarungu in 1915 had taken over from Dr. C.L. Levers.

<sup>74</sup> PRAA-A ADM 56/1/92 Handing over Report, Bole District 24.11.1915.

<sup>75</sup> For instance, Wa to Tumu was 84 miles; to Lawra 53 miles; and to Bole 78 miles.

season. Apart from a few, most roads were usually flooded during the rainy seasons that rendered them unmotorable. This made it either impossible for medical officers to travel to other stations or caused delays, in the event that the doctor insisted on visiting outstations. In one of the rainiest period of 1945, Dr. B. B. Waddy (Medical Officer, Wa), was called to Lawra to perform a post-mortem on a woman. It took him more than four hours to travel the distance of fifty-three miles. Just as the abdomen of the woman was cut, it exploded. The explosion was not because Waddy was inexperienced in performing operations, but because he was unable to reach Lawra on time.<sup>76</sup>

The frequent travel of doctors ensured that emergency cases could not be attended to on time. In 1923, the Commissioner of the Northern Province was travelling to Wa on tour. At Nadawli the Commissioner suddenly got blinded in the right eye. He proceeded to Wa (Where a resident medical was stationed) to seek medical attention, only to be told that the doctor had travelled to Bole, a town of about 70 miles away from Wa.<sup>77</sup> Similarly, on a visit by the Commissioner of Northern Province to Gambaga in 1924, a Mr. Freeman reported an outbreak of measles in the town. A medical officer was sent for, but he came three days after the reported outbreak.<sup>78</sup>

Inadequate supporting staff compounded the plight of the doctors who worked in the North. Ideally, doctors were supposed to be supported by at least a nurse, dispenser and a dresser. But this was not the case in most hospitals in the North. Only doctors in hospitals like Tamale African Hospital and occasionally Salaga were fortunate to have the assistance of nurses and dispensers. A majority of them were assisted by “hospital boys.” These were expected to wash and clean hospital equipment, act as messengers and a general assistant in the performance of operations. Above all they were

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<sup>76</sup> B. B. Waddy, ‘A District Medical Officer in the North West Ghana’ Health in Colonial Africa during the Colonial period Sabben-clare, Bradley and Kirkwood (ed) Oxford press, New York, 1980 p. 163.

<sup>77</sup> PRAA-A ADM 56/1/118 Provincial Commissioner, Northern Province to CCNT 7.8.1923.

<sup>78</sup> PRAA-A ADM 56/1/118 Tour of inspection to Zuarungu, Bawku, and Gambaga by Commissioner, Northern Province 12.7.1924.

interpreters. In his last role, it is reported that, he was on duty throughout the day. Some doctors were compelled to employ additional assistants, who they paid from their own purses. Dr. Batchelor, one time medical officer at Navrongo paid for the services of an assistant.<sup>79</sup> Worst of all, doctors in the Protectorate lived under very abysmal conditions. While their counterparts in the Colony lived in decent houses, those in the North resided in shanty structures with leaking roofs, with near-to-no ventilation. On a tour of inspection in 1926, the Assistant Director of Medical Services, observed that; there was no “ . . . air in the Medical Officer's House, the temperature of which was 103, . . . And comparatively little in that of the District Commissioner, which is dark, ill ventilated and has insufficient roof space.”<sup>80</sup> Not able to cope with some of the conditions in the North, some doctors either refused postings there or asked for transfers after brief periods of service. Indeed as early as 1901, Dr. G. H. Taylor, assistant colonial surgeon resigned his appointment against the will of the Principal Medical Officer after serving in the Protectorate for a couple of months.<sup>81</sup>

#### 2.4 PROVISION OF DISPENSARIES

Dispensaries were the next set of health care units that engaged the attention of the government in Northern Ghana. Essentially, these health care units were designed to supplement the work of hospitals. They set out to deal with out- patient care, and were usually under the supervision of African dispensers, if one was available. The need for dispensaries arose because of the inability of existing hospital to reach the places outside the main towns. Hospitals in the North, like other stations, were sited in major centres

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<sup>79</sup> PRAA-A CSO 11/1/415 ADMS (Kumasi) 19.2.1937.

<sup>80</sup> PRAA-A ADM 56/1/405 Report on the Tour of inspection of the Eastern, Northern and Western stations in the Northern Territories 4.2.1926 p.4. The observation of the ADMS was based on his visit to Zuarungu.

<sup>81</sup> PRAA-A ADM 1/2/56 Governor Nathan to Sec. of State 26.11.1901. Despatch No. 558. In the 1930s the DMS complained of several doctors requesting for transfers from the North and other related bush hospitals to areas where their specialities could be put to practice. CSO 11/1/405 Circular by the DMS to the Medical Officers 16.7.1936.

where the European population resided. In this sense, they served only those people who lived close to the facilities. People living outside a certain radius of the hospitals, by reason of distance hardly if at all, gained access to them. Another important factor that influenced the construction of dispensaries was fiscal. The capital and recurrent cost required in the construction and maintenance of a hospital was quite enormous. The capital cost of the construction of a hospital, with an average number of four beds was approximately £50 in the mid- 1920s.<sup>82</sup>

The provision of these dispensaries up to the early 1930s was financed solely by the government with the local people providing labour.<sup>83</sup> Not many dispensaries were put up within the period because by policy dispensaries were located close to an area where a medical officer would be able to render supervision. Although meant for the rural population, these dispensaries preponderated in the areas already close to hospitals. To make it possible for doctors to visit the dispensaries, health authorities helped them with transport. For example, in 1928, Kusasi and South Mamprusi districts were visited by the medical officer resident at Zuarungu.<sup>84</sup> But with the persistent dearth of doctors they did not travel most of the time. Moreover, as noted earlier, during rainy season travelling was not feasible due to the bad nature of roads.

Another strategy employed by the Medical Department to reach out to the outstations, was to liaise with the various missionary bodies operating in the Protectorate. Among these bodies were, the White Fathers Mission-perhaps the first to offer curative health to the public -and the Assemblies of God. Needless to say, these mission bodies were already operating dispensaries in the various locations in which they had mission houses. Although the White Fathers Mission was headquartered at Navrongo, the

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<sup>82</sup> PRAA-A ADM 56/1/405 Report on Tour of inspection 4.2.1926.

<sup>83</sup> In certain instances, the dispensaries were built by the Political authorities of the Protectorate without assistance from the Medical Department.

<sup>84</sup> Togoland Reports 1928 p.34.

mission had dispensaries at Bolgatanga and Jirapa. The Assemblies of God similarly carried out dispensary work at Yendi. The initial relationship between the Medical Department and the Missions was for the former to assist the missions by supplying drugs and dressings. In 1918, the Medical Department arranged for the White Fathers to have instruction in medical duties at the Accra Laboratory and hospitals. This arrangement was based on a suggestion made by Dr. T. E. Rice, Principal Medical Officer, during one of his tours of the Protectorate. The measure had two advantages; the White Fathers were acquainted with the local people and they spoke the language fluently; they were versed in the intricacies of the mind of the local people. Because of these advantages, a course of instruction would increase the medical utility of the Fathers and solve the problems encountered in having to rely on interpreters. Another advantage of this strategy was that, it relieved the Medical Department from the trouble of having to pay wages to dispensers. In 1919, a formal request was made to the local superior of the White Fathers, Leonide. Although the superior was not against the measure, he declined to take a decision because “. . . Such a change of place of the missionaries is not the attribution of the local superior.” The matter had to be referred to the bishop.<sup>85</sup> A third, largely successful but problematic measure adopted in the mid 1930s to improve the health of the rural population, was to work through the Native Authorities. Native Authorities were established in the 1930s to oversee the general administration of the local people. This measure was in keeping with the British policy of indirect rule. To achieve effective administration, finance was required. This necessitated the creation of Native Treasuries for the collection of a proposed direct tax. Unexpectedly, the local people accepted to pay the tax without pressure. The result was an unprecedented rise in revenue. The table below illustrates this increase.

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<sup>85</sup> PRAA-A ADM 56/1/162 Leonide Barsalou to District Commissioner Navrongo-Zuarungu 30.6.1919.

TABLE 5 RISING REVENUE IN NORTHERN TERRITORIES 1904-1937

YEAR	AVERAGE REVENUE
1904	£12,475
1922-29	£12,319 <sup>86</sup>
1935-37	£34,700 <sup>87</sup>

The revenue collected, was divided into three heads; administration, capital works and developments. It was from the development fund that public health works derived its funding. Under the health scheme of government, the Native Authorities were made responsible for the erection of the required dispensaries while government's role was to provide qualified dispensers. The government did not allow the buildings to be constructed anyhow as dispensaries were to be constructed in areas and on sites selected by the district and administrative officers and approved by the Director of Medical Service. Two considerations guided the government in the selection of the locations. The first was ease of supervision. Although dispensers were generally well trained and proved efficient in the discharge of their duties, occasional advice was needed. Consideration was also given to the severity of certain diseases such as trypanosomiasis. This factor was important because, such a disease required prolonged treatment, and it was believed that when dispensaries were located close to these areas, patients would be encouraged by reason of accessibility to frequent them.

With funds readily available and the co-operation of the chiefs assured, the various Native Authorities completed the construction of the dispensaries as rapidly as the

<sup>86</sup> ARNT 1922-23 p. 15; 1923-24 p. 5; 1925-26 p. 5; 1926-27 p. 4; 1927-28 p. 4; 1929-30 p. 12.

<sup>87</sup> ARNT 1936-37 p. 56; 1937-38 p. 62.

Medical Department was able to provide dispensers. By the end of 1937, ten dispensaries had been opened in the Protectorate.<sup>88</sup>

TABLE 6 GROWTH OF DISPENSARIES, 1929-1950<sup>89</sup>

YEAR	APPROX. No
1927-31	6
1932	7
1933	8
1934-36	9
1937	10
1938-39	16
1942-43	18
1950	33

Although the progress in the establishment of Native Authority dispensaries was lauded by many and was highly recommended for emulation by the rest of the colony, it was not without difficulties. In certain instances, it was found that dispensers were inclined to assume more responsibilities than initially allowed them. Most dispensers were reluctant to refer cases beyond their capability to the nearest medical officer as required. Furthermore, the growth of dispensaries far outstripped the number of medical officers available, and some dispensaries were opened in areas beyond the reach of supervising doctors. This resulted in either less frequent visits or no supervision at all. Regardless of these complexities, the number of dispensaries in the North continued to grow so that by 1950 as shown in the table, the number had risen to thirty-three.

<sup>88</sup> ARNT 1937-38 p.70. The average cost of the erection of each dispensary was £300. GCLCD 1937 p.20.

<sup>89</sup> The figures for the various years were calculated from GCMSDR of the respective years.

A major problem of dispensaries was the continuous shortage of dispensers. From the inception of the medical department dispensers had their training at Accra. But because of the generally poor standard of education and indeed the small number of the local people who attended school, the recruitment of dispensers was increasingly difficult. The difficulty of recruitment was further exacerbated by the meagre remuneration paid to qualified dispensers.<sup>90</sup> The problem of the North was more critical in that, because of her poor living conditions dispensers avoided the Protectorate. The ideal solution would have been to train local people from the North. But this was not feasible either. Not only was it difficult to obtain literate indigenous people but also the instructors to train dispensers were either few or not available. For example in 1935, only one Dispenser's instructor was available.<sup>91</sup> The only persons who could have instructed dispensers in the North were the doctors. But they were few and constantly overworked. The inauguration of the nurse-dispenser scheme in 1930 could not help matters. By 1935 only 14 nurse-dispensers had completed their training, a number far below the expected 40 nurse dispensers targeted.<sup>92</sup>

In order to encourage dispensers to work in the Protectorate and other rural areas, Medical Department resolved to pay field allowance to dispensers who accepted postings to such deprived areas. This measure, introduced in 1935, was originally intended for dispensers in charge of village dispensaries. However it was later extended to dispensers who were in charge of hospitals, because of shortage of medical officers.<sup>93</sup> Although the measure attracted some dispensers, these were of the lower grade; most often third class dispensers. First and second class dispensers were often few and were in high demand in the Colony. Because dispensers were mainly local people from the coast, the majority of

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<sup>90</sup> See Addae *op. cit.* p.243.

<sup>91</sup> He was one Walter Dunlin .see Gold Coast Civil Service List 1935, p. 121.

<sup>92</sup> GCMSDR 1935 p. 35.

<sup>93</sup> PRAA-A CSO 11/3/39 Minute by Acting, DMS 24.11.1943; Minute by Col. Sec. 4.10.1946. the allowance paid was about £18 per annum in the 1940s.

them lacked interest in their work and the indigenous people of the Protectorate. For example in 1937, when a sick boy was sent to the Navrongo hospital on the instruction of the governor, the dispenser, J. O. Blankson, turned, him away although, he was admitted after he was thoroughly examined by the medical officer.<sup>94</sup> From 1938, the Medical Department was considering the training of Northerners at Tamale to play the role of dispensers.<sup>95</sup>

## 2.5 TREATMENT CENTRES AND DRESSING STATIONS

To supplement the work of Dispensaries, the Native Authorities also constructed treatment centres. These were mainly located in areas where dispensaries were not available. The buildings were similarly designed on the plans of the native dispensaries except that they were one room less. Grube, Bimbila, Yeji and Prang were among the first settlements in the North to benefit from this facility.<sup>96</sup> Though originally designed to be used by dispensers on periodic visits, the centres were later used by dressers as points of contact with local people. This development was based on observations made in the 1930s, that treatment of yaws and other related diseases could yield quicker and permanent results if the work of the dispenser was followed up by itinerant medical personnel. The policy, was for boys to be selected and trained at the Tamale African hospital. Among other things, they were taught to give injections for yaws, undertake simple dressings and above all to treat scabies and round worms. Upon completion of the course, the trainee dresser returned to his own area to work under the supervision of a medical officer. A six-week programme was then mapped out in a given area and arrangements made for each of these six selected villages to be visited once every week,

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<sup>94</sup> PRAA-A CSO 11/1/415 DMS to Governor 1937.

<sup>95</sup> For training of staff see chapter five.

<sup>96</sup> ARNT 1937-38 p. 71.

until the six expected injections of the appropriate vaccine were completed.<sup>97</sup> By 1938 only three African dressers operated in the Protectorate.<sup>98</sup> Within a short period of the introduction of the scheme, it yielded positive results. By September 1937, 886 new cases of yaws out of 1,170 received four or more injections at Wa by the dresser responsible for that area. Comparatively, only two out of a total of 455 received more than four injections within the same period at Wa government hospital.<sup>99</sup> A further advantage of the scheme was that, because the dressers were itinerant it enabled the medical department to see and treat most diseases particularly epidemics at their early stages of development.

The performance of the dressers was so impressive that the Director of Medical Services proposed the expansion of the scheme. In his proposal, he suggested that the dressers should be trained to vaccinate against smallpox and assist in popularising the use of quinine. Their training lasted 12 months in the African Hospital at Tamale. For a start the director proposed that two or three boys from each district should be selected. The director's proposals was fully supported by W. J. H. Jones, Chief Commissioner of the Northern Territories.<sup>100</sup> The proposed scheme of increasing the number and widening the scope of dressers was not pursued with vigour, hence not much was achieved. This was mainly because the number of trainees was not easily obtained in the North. Sufficiently educated boys were limited in supply. Indeed, before 1947, the government senior school (Tamale) was the only institution in the Protectorate where a higher form of education was offered. Only a few from the primary school had access to the Tamale school, the remaining graduated at standard III.<sup>101</sup> Between 1929 and 1938, an average

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<sup>97</sup> *Ibid.*

<sup>98</sup> Originally, four dressers were trained, but one was dismissed because he had no sympathy for his people. Many dressers could not be trained because there were few educated local people and limited training facilities in the Tamale Hospital.

<sup>99</sup> ARNT 1937-38 p. 72. The dresser for Dagomba obtained a return of about ninety percent.

<sup>100</sup> PRAA-A CSO 11/1/427.

<sup>101</sup> R. B. Bening, *A History of Education in Northern Ghana 1907-1976* (Accra:1990) p. 90.

of 2 pupils passed the standard III examination.<sup>102</sup> Besides, jobs as clerks which were less tiring and relatively more remunerating were preferred to itinerant duties.

In 1948, the concept of dressing stations received fresh attention from the Medical Department. These stations unlike the experiments of the 1930s were stocked with medicines provided by the Department. No prior plans were laid for the education of dressers before the scheme started. The arrangement the Medical Department resorted to was for the stations to be run temporarily by nurses of the Department. They were later to be replaced by Native Authority Dressers who had commenced training at Kintampo. The instructor of this school was Dr. Saunders.<sup>103</sup> In 1950, the school at Kintampo was closed down principally due to lack of an instructor. The dressers who had not completed their course were to be trained in the various hospitals in the districts.<sup>104</sup> From 1950, the policy was for dressers to be trained in the hospitals of the Protectorate for a period of 18 months.

## 2.6 MOBILE CLINICS

The introduction of travelling dispensaries formed part of the broad measures adopted by the Colonial government to reach the rural population in the North. This facility was introduced in the country on two separate occasions. It was first introduced in 1927 and subsequently in 1948. In neither of these occasions did the scheme last long. Between 1933-34 and 1951 the schemes were withdrawn respectively. As stated, travelling dispensaries were introduced with the rural population in mind. Although sedentary health facilities existed, these were few and located mainly close to district capitals. But because a majority of the population resided in the outskirts, distance

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<sup>102</sup> The average is based on computations from the Education Department Reports 1929-38.

<sup>103</sup> GCMSDR 1948 p. 9; GCLCD 1949 p. 35.

<sup>104</sup> GCMSDR 1950 p. 4. From 1950, consideration was also given to the recruitment of better educated men and to provide four years of intensive training. The fear was that, in future years these partly trained men may try to assume the title and dignity of a medical practitioner.

denied them of benefiting from the town-centred medical facilities. Furthermore, from the mid 1920s, there appear to have been a rise in confidence of the local people in European medicine. This resulted in increased attendance at such centres and created much work for the rather few medical officers. In 1924-25 the African hospitals at Wa, Tamale and Zuarungu were the only stations with resident medical officers. Given the size of the North, the number was woefully inadequate.<sup>105</sup> Thus the idea of travelling dispensaries was to lessen the pressure on the few doctors. Another important consideration which induced the introduction of the scheme was the low level turn-out for treatment of diseases like leprosy which required prolonged attention. However, it was noted that only 30% of cases actually yielded to repeated injections. In the late 1920 out of the many lepers under treatment of one Dr Dixey, only two returned regularly for review. Most of those who began treatment either returned irregularly or did not at all. The mobile clinics were largely to play the role of follow-ups in the rural settlements.

The first travelling dispensary started on 26 February 1927 in the North-Western Province of the Northern Territories. This dispensary was under the charge of Dr. G.F.T. Saunders. The organisation of the scheme was simple. The dispensaries were usually stocked with essential drugs. Using Tamale as the base, the mobile units visited selected villages once a week. Among the diseases dealt with by Dr. Saunders were yaws, leprosy, eye infections, respiratory conditions and minor operations. Within a year of the introduction of the scheme, impressive results were achieved. By the middle of 1929, more than 11,000 cases of various kinds of diseases had been seen and treated.<sup>106</sup> The result achieved by Dr Saunders were so impressive that, the medical department intended to convince the government to make grants for the provision of several more.<sup>107</sup>

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<sup>105</sup> ARNT 1924-25 p. 10.

<sup>106</sup> GCMSDR 1928-29 p. 42. Yaws dominated in the cases dealt with by the dispensary; 5700 patients were seen in 1931; 1929-30 over 5000 cases.

<sup>107</sup> GCMSDR 1927-28 p. 36.

By the mid 1930s the travelling dispensary system ceased to operate, mainly due to the economic depression. The depression essentially caused the reduction of funds available for medical services. Other factors that contributed to the withdrawal of the dispensaries were, bad roads, frequent mechanical break downs and high maintenance cost. The roads of the Protectorate were largely lanes constructed by the local people, and punctuated by ditches. Therefore, the conditions of the roads further deteriorated in the rainy season. Some areas could not be visited in the wet season.<sup>108</sup> As a result of the bad nature of the roads most of the vehicles broke down. For example, in 1929 the vans experienced two major breakdowns within an interval of a month. Not long after the fault was rectified by the transport department, it was reported that the vehicle required new bearings.<sup>109</sup> The spate of breakdowns initially did not deter the Medical Department from pursuing her rural outreach service. Arrangements were put in place to maintain the vehicles. Under these arrangements, the engineer, who was the transport officer and based in Kumasi was engaged to undertake periodic overhauling of all travelling dispensaries. The engineer was expected to check the dispensaries every six months.<sup>110</sup> Problems soon developed after the very first inspection visit by the transport officer. After completing the inspection the transport officer submitted a claim for the sum of £25.8.8 being travelling allowance for four days and a mileage allowance for 748 miles at 8d per mile.<sup>111</sup> The claim generated bitter exchanges between the transport officer and the treasurer. Indeed, in the view of the treasurer, the inspection was “needlessly high”. Though the claim was met, the arrangement of periodic inspection was discontinued.<sup>112</sup>

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<sup>108</sup> PRAA-A CSO 11/1/229 Memo from medical officer in charge of the Travelling Dispensary to DMSS 19.4.1929. Despatch No. 17/1/28/29.

<sup>109</sup> Ibid.

<sup>110</sup> PRAA-A CSO 11/1/229 Acting. Senior. Medical Officer to Engineer, Transport Officer 25.3.1930, Despatch No. 56/851/28-29.

<sup>111</sup> PRAA-A CSO 11/1/229 Acting. DMSS to Ag. Col. Sec. 10.9.1930. Despatch No. 1449/258/29/197.

<sup>112</sup> PRAA-A CSO 11/1/229 Acting. Treasurer to Col. Sec. 20.10.1930. Despatch No. cs 661/117/29.

Under governor Gerald Hallen Creasy, the scheme of using mobile dispensaries to reach the rural areas was re-introduced in 1948. This scheme was similar to the previous one in terms of organisation. The van was stocked with essential drugs and visited selected villages at weekly intervals. Unlike the 1927 scheme, the travelling clinics of the 1940s were under the care of trained African nurses and sometimes dispensers.<sup>113</sup> Though medical officers were preferred, they could not be spared on account of their acute shortage. Owing to constant breakdowns, due to the nature of bad roads, mobile dispensaries in the Protectorate could not keep to their regular schedule. The consequence of this was that maximum benefit could not be derived from their use. By 1952, the scheme was again withdrawn completely. An arrangement which supplanted the withdrawal of the mobile clinics was for Local Authorities to select men for training at government hospitals who would be employed at centres provided by the Local Authorities.<sup>114</sup>

## 2.7 'SPECIAL' MEDICAL FACILITIES

Some diseases in the Protectorate were given special and separate attention in terms of facilities, by the administrative authorities. Leprosy was one such disease. The existence of leprosy in the North pre-dated the British occupation. However it was only in 1913 that the disease began to gain recognition by the government and efforts were made to contain it. Generally, government's aim was to isolate lepers in specially designated settlements. The relatively late beginning of the policy of isolation was largely due to the fear of opposition from the local people. It was also because the incidence of leprosy was regarded as negligible by the government. Although lepers associated freely with relatives in their compounds, they rarely appeared at gatherings

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<sup>113</sup> GCMSDR 1948 p. 10.

<sup>114</sup> GCMSDR 1952 p. 361.

organised by the administrative authorities. For it was in these gatherings that members of the government would have had the opportunity of seeing them. The ignorance of the incidence of leprosy in the North was revealed in an observation made in 1913 by S.D. Nash, District Commissioner of Zuarungu. Nash asserted that; “ there are more victims in the country than I was aware of.”<sup>115</sup>.

The first important development towards the establishment of leprosy facilities was an initiative taken by the Chief Commissioner in September 1913. In a letter to the Commissioner of the North-Eastern Province, he requested that an enquiry be made through the chiefs to ascertain the attitude of the local population towards compulsory isolation.<sup>116</sup> As the enquiry was to reveal, the chiefs unanimously looked at the idea of isolation with favour. In the estimation of the chiefs, lepers were not capable of helping in food production. As such, they were regarded as burdens on their relatives.<sup>117</sup> Assured of the support of the chiefs, the next measure was to register all available lepers. This was to enable the government to have a clearer picture of the incidence of leprosy. By the end of December 1913, a total of over seventy-eight lepers were registered at Gambaga, Navrongo, Zuarungu and Bawku.<sup>118</sup> Further enquiries in 1925 indicated an increase of lepers in the North. Bawku alone registered more than seventy cases.<sup>119</sup>

Initially the administrative officers wanted to establish small African villages, to be entirely inhabited by lepers. These leper colonies, as envisaged were to have their own markets and farming lands. This policy had the advantage of ensuring that lepers lived within their communities. The measure could however not be implemented because, firstly, the scheme was not feasible in many of the districts because the District

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<sup>115</sup> PRAA-A ADM 56/1/159 Zuarungu Official Diary 14.10.1913.

<sup>116</sup> PRAA-A ADM 56/1/162 Ag. CCNT to Commissioner, North-Eastern Province 20.9.1913.

<sup>117</sup> PRAA-A ADM 56/1/159 Zuarungu Official Diary Dec. 1913.

<sup>118</sup> PRAA-A ADM 56/1/162 Commissioner, North-Eastern Province to CCNT 27.12.1913. The figure for Bawku was not stated, although registration was made. Besides the figures stated do not represent the total number of lepers existing in the North, as most of them refused to show up.

<sup>119</sup> PRAA-A ADM 56/1/162 District Commissioner (Bawku) to Commissioner, Northern Province 26.12.1925.

Commissioners did not consider the number of lepers so great as to merit the experiment. Second, most of the districts were overpopulated, with poor and limited farmlands. Besides, such a scheme would require special supervision by medical officers and other health workers. Through the initiative of Dr. Helen Hendrie, the first leper settlement was established in 1923 at Yendi. Hendrie was then the medical officer in charge of Yendi African hospital. The first lepers, thirty of them came into residence in November 1923.<sup>120</sup> Barely two years after Dr. Hendrie's initiative, it was realised that the settlement was too small to contain the available lepers. By December 1925 as many as 117 cases had received treatment from the asylum and approximately 500 untreated cases were known to be in the Yendi district.<sup>121</sup>

Ensured of good turnout, a campaign for the expansion of facilities was embarked upon. To begin with, Dr. Hendrie the architect of the leprosy colony suggested that more huts be constructed. This as was obvious called for additional capital and recurrent cost. Well prepared to avoid any further cost, the Chief Commissioner recommended the use of a trade school. (This school was to be abandoned for a new one at Tamale).<sup>122</sup> Besides saving costs, the Chief Commissioner's suggestion had two other advantages. First the abandoned school building had ample accommodation for lepers; second, there was extra sufficient land for purposes of farming. The latter advantage would facilitate the effort of making the leper colony self supporting. Although Dr. Hendrie favoured the Chief Commissioner's suggestion, the idea was objected to by Dr. F.S Harper, Assistant Director of Medical Services. Dr. Harper did not also favour the expansion of the existing leper colony either. Both sites, the Assistant Director explained, were near the town. As such it was likely to be a source of infection, given that the lepers mixed freely with the towns people. The Assistant Director preferred the acquisition of a new land

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<sup>120</sup> GCMSDR 1923-24 p. 37.

<sup>121</sup> PRAA-A ADM 56/1/405 ADMS DMSS 2.12.1925. Despatch No. 7/20/24.

<sup>122</sup> Ibid.

near the Kulpawn river and to utilise a sum of £72 allocated by the public works department (for minor works) to start the new building.<sup>123</sup> In 1927, Dr. F.S. Harper's view was implicitly supported by Dr. Philip D'Oakely, acting Assistant Director of Medical Services. Reporting on his tour of the Protectorate, Dr. Oakely remarked: "The leper colony is very much too near the Native Town being less than 100 yards from the nearest compound. The inmates of this leper colony apparently mix freely with the people, both in their houses and in the market."<sup>124</sup> By the beginning of 1930 and for reasons we are not told, the suggestions of the Assistant Directors had not received attention. It is possible however that, whatever plans the government had concerning the extension of the leper settlement were shelved because of the economic depression. The Director of Medical Services lamented that: "One must wait a return of financial prosperity before any important schemes can be considered."<sup>125</sup> Up to the beginning of 1930, leprosy cases were dealt with in the various hospitals and outpatient clinics. But the problem with this measure was that only lepers who were near stations where medical officers were resident could be attended to. But even in areas where there were hospitals, many of the medical officers went on frequent trek, which denied lepers of continuous treatment.

An important occasion which influenced the construction of, perhaps, the second main leprosarium in the North was the visit of Duncan Dixey, medical secretary of the British Empire of Leprosy Relief Association (BELRA) in 1930. Based on a report by Dr. G.F. Saunders, medical officer in-charge of the travelling dispensary, and his own observations, Dixey approached Monsignor Moran of the White Fathers Catholic Mission at Navrongo for assistance in establishing a leprosarium. Moran agreed to Dixey's suggestions but on one condition; that funds should be raised. In that same year.

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<sup>123</sup> *Ibid.*

<sup>124</sup> PRAA-A ADM 56/1/405 ADMS to DMSS20.12.1927. Despatch No. 14/20/24.

<sup>125</sup> GCMSDR 1930-31 p. 9.

BELRA made a grant of £150, an amount that was expected to cater for the building and equipping of a dispensary. The government promised a grant of £50 per annum for its maintenance.<sup>126</sup> The leper settlements at Yendi and Navrongo remained the only leprosaria in the Protectorate until the 1950s. In 1948, it was proposed that three leprosy settlements should be established to cover the entire country. Each of these was intended to have accommodation for 2000 patients under the control of a leprosy officer. In areas where leprosy was found to be more wide spread, the government would assist Native Authorities to construct leprosy villages. Supervision of these was to be by the nearest leprosarium.<sup>127</sup> In this connection, three leper settlements were established at Ankaful and Nkachina near Kpandai and Ho in 1951. The Kpandai settlement, the only major settlement close to the North was run by the World Wide Evangelisation Crusade. Yendi remained a minor settlement.<sup>128</sup>

The development of child and maternal health facilities in the North, like all other medical facilities commenced rather late. The case of the Protectorate was however not peculiar. Official attention was given to child and maternity welfare in the colony in the mid 1920s. However, unofficial work had begun by 1921. The opportunity occurred in 1924 to develop child and maternal health centres in the Protectorate when governor Guggisberg approved a plan proposed by Dr. Pirie. Under this plan, government was to launch a definite strategy for the foundation and subsequent amplification of infant welfare work throughout the country. Essentially, the plan involved the establishment of few large welfare centres in accessible locations. These were to be under the control of lady medical officers to be engaged by the government. Each welfare centre was to

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<sup>126</sup> GCMSDR 1929-30 p. 194. By the end of 1931 the buildings were completed. While working with the dispensary at Lawra-Tumu, Dr. Saunders saw 396 lepers, Dr. Gillespie, medical officer, Tamale had seen 213 cases by January 1930; 215 cases were seen at Zuarungu, Navrongo, Bawku, Kanjarga and Gambaga by Duncan Dixey.

<sup>127</sup> GCMSDR 1948 p. 8.

<sup>128</sup> GCMSDR 1951 p.13. In 1954 Pwaligu was selected as a site for the construction of a leprosarium in Northern. GCMSDR 1954 p. 82.

consist of a hospital and infant welfare centre. Among other activities, the welfare centres were expected to engage in a periodic inspection of school children, treatment of mothers and their children and to instruct African educated women in the work of health visitors. The foundation stone of Guggisberg's plan was laid in June 1925 by Princess Marie Louise.<sup>129</sup> In keeping with the plan, between 1924 and 1929 other government welfare centres were opened in some districts.<sup>130</sup> However, by 1930, the North had not felt any physical presence of Guggisberg's plans.

The first official attempt at the provision of child and maternal welfare facilities for the North was made in 1929. In that year the acting Director of Medical Services enquired into the possibility of building an infant welfare centre at Tamale. He further enquired into the practicability of getting a lady medical officer to take charge. The maiden efforts of the acting Director of Medical Services were dropped because of the non-availability of a lady medical officer; a problem the director was well placed to have known better.<sup>131</sup> By 1931 there were only eight women medical officers in the Gold Coast. This meagre number was highly inadequate for the Colony and Asante, the priority areas of the government. By September 1932, the number of women medical officers had dropped to only four.<sup>132</sup>

In 1932, a fresh initiative towards the inauguration of a child welfare centre was made. This fresh drive was due to the energetic and enterprising work of the then Assistant Director of Medical services in charge of the Protectorate, Dr. Percy Selwyn Selwyn-Clarke.<sup>133</sup> The start was made on the 15th September when a babies weighing clinic was opened. It was opened in a small room forming part of the laboratory of the

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<sup>129</sup> GCLCD 1926-27 p. 154; see also Addae *op cit* pp. 228-9.

<sup>130</sup> Among these centres were Sekondi, Shama, 1924; Kumasi in 1927; Cape Coast in 1928 and Ho in 1929.

<sup>131</sup> PRAA-A CSO 11/6/10 ADMS to CCNT 26.10.1932.

<sup>132</sup> Gold Coast Colony Civil Service List 1931 pp. 148-9; 1932 pp. 123-4. The four lady medical officers were: Margorie Carnsew Chappel, Beatrice Annie Sybil Russel; Cicely Williams and Mary Kathleen Lawlor.

<sup>133</sup> P.S Selwyn-Clark was appointed medical officer in October 1919. In 1924 he was promoted senior medical officer. By dint of hard work, he was promoted Assistant Director of Sanitary Services. In 1932 he

Tamale African Hospital. This clinic was staffed with a nursing sister and one African nurse. There were also two other European ladies who offered voluntary assistance while qualified medical guidance was given by the European medical staff at Tamale.<sup>134</sup>

No sooner had the clinic commenced than the question of adequate space emerged. Contrary to the expectations of the staff, the first session of the clinic attracted as many as fifty-nine babies. The second and subsequent sessions were not different. These sessions attracted an average of approximately fifty babies.<sup>135</sup> The area of operation gradually became too restricted to the extent that mothers and their babies had little-to-no shelter. The solution lay in either the extension of the existing clinic, the construction of a completely new welfare centre or decline to accommodate more than the facility could contain. It appears the first two options could not materialise because the development of the crisis coincided with the depression.

Unrelenting in his bid for securing the survival of the clinic, Dr. Selwyn-Clarke opted to use an abandoned building which housed the power station. In a letter to the Director of Medical Services, Selwyn-Clarke tried to convince the D.M.S. of the wisdom in the use of the power station. He wrote:

The disused powerhouse near by would serve as an excellent centre and is very conveniently situated. The house would lend itself to demonstrations in mother-craft and infant welfare apart from serving as a weighing clinic and the wall space is excellent for propaganda posters and material-personal and domestic hygiene infant care etc.<sup>136</sup>

Well aware of the financial plight of the country, Dr. Selwyn-Clarke hoped to elicit the interest of the members of the Junior Red Cross Organisation, until the finances of the country improved.<sup>137</sup> Up to 1939, the powerhouse served as the clinic.

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became the Assistant Director of Medical Services. A year later Dr. Selwyn-Clarke was promoted to Deputy Director of Health Services. See Gold Coast Civil Service List 1934 p. 128.

<sup>134</sup> PRAA-A CSO 11/6/10 ADMS to CCNT 26.10.1932.

<sup>135</sup> Ibid.

<sup>136</sup> Ibid.

<sup>137</sup> PRAA-A CSO 11/6/10 Minute by DMSS 15.11.1932; Col. Sec. to Ag. CCNT 22.11.1932.

By the end of 1939 the clinic had been moved to the O.P.D. of the African hospital, because the powerhouse was turned into an army store. The health authorities did not relent. To create room for the increasing rate of attendance, organisational changes were introduced. Each day of the week was assigned to a category of activities. Weighing clinics were held on Thursdays, while antenatal clinics were held on Fridays. All other cases requiring serious medical attention were referred to the medical officer. Further to this, the government midwives who conducted the clinics occasionally visited homes within the district. These visits were purposeful; to reduce the pressure on the regular clinics. Apart from the little space the O.P.D afforded, some medical officers objected to the holding of the clinics. Instrumental in this objection was Dr. H.C. Armstrong. The reason for his objection was that the arrangement created the impression that only sick children were to be brought to a hospital.<sup>138</sup>

Up to 1936 there had been little official extension of child and maternal welfare centres into the more rural districts of Asante. None of such facilities existed in the Northern Territories either. Indeed not even the subsidised midwife scheme introduced in the 1930s spread into the Protectorate. Of the 19 and 25 subsidised midwives operating in 1935 and 1936 respectively in the colony none practised in the Northern Territories.<sup>139</sup> The extension of child and maternal welfare work to the outskirts of Northern Ghana was pioneered by Mrs Griffith in 1935 at Savelugu. When Mrs Griffith left the Northern Territories, the work was carried on by Mrs Jones, wife of the then Chief Commissioner; William John Andrew Jones. In 1936, the heavy attendance in the centre necessitated the erection of a new building. This building was opened in January 1937.<sup>140</sup>

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<sup>138</sup> PRAA-A CSO 11/6/20 DMS to Col. Sec. 3.4.1945.

<sup>139</sup> GCMSDR 1936 p. 36 Table XX I. A subsidised midwife was a private midwife who received a monthly grant of £3 from government to enable her establish her self in private practice.

<sup>140</sup> *Ibid.*

The issue of constructing permanent child and maternal welfare centres in the Protectorate resurfaced in February 1945 when governor Burns visited the North. In his visit Burns was impressed by the need of child welfare facility at Tamale. In a couple of letters to the Director of Medical Services, the governor requested for consideration to be given to the matter.<sup>141</sup> But as it was later to turn out, the aspirations of governor Burns could not be realised largely on account, of shortage of human resource.<sup>142</sup> For a child welfare clinic to start on a proper basis, the Director of Medical Services estimated that a nursing sister, a health visitor, three midwives as well as clerks would be required. But the personnel base at the Gold Coast, particularly lady staff was too skeletal to meet the plans of Burns. The difficulty was more with the question of nursing sisters. Expressing his view on the issue of child welfare facilities in the North the Director of Medical Services noted:

. . . before developing maternal and child welfare services in Northern Territories as a general policy. . . an efficient and adequate organisation should be built up in Tamale to satisfy local needs and on the result of this pilot organisation the general policy for the Northern Territories be laid down.<sup>143</sup>

The problem of the North was more complicated in that, even the few midwives who could have worked there appeared reluctant. This was particularly so with the subsidised midwives. The reluctance of subsidised midwives was however justified at least on one ground. The remuneration of £3 monthly allowance paid to them was insufficient. For these midwives to subsist, there was the need to practice in areas where private practice paid, but the North was certainly not one of these areas. Northern Ghana generally held

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<sup>141</sup> PRAA-A CSO 11/6/20 Col. Sec. to DMS 10.2.1945; Col. Sec. to DMS 6.4.1945; Col. Sec. to DMS 21.5.1945.

<sup>142</sup> There appears to have been no problem with regard to erection of buildings because a simple two room structure will be suitable and was all that was needed, in the estimation of the DMS. Indeed, these structures were not beyond the capabilities of the Native Authorities. See PRAA-A CSO 11/6/20/DMS to Col. Sec. 25.6.1945.

<sup>143</sup> PRAA-A CSO 11/6/20 DMS to Col. Sec. 25.6.1945.

no financial leverage in view of the perpetual poverty of the majority of the local inhabitants.

From the mid-1940s, government was of the view that, the larger towns were adequately provided with sufficient midwives. Consequently, it was resolved that subsidies should be granted only to midwives who intended to practice in the smaller towns in the rural areas. The measure, it appears, did not deter newly qualified midwives from practising in the larger centres.<sup>144</sup> A significant step in the resolution of the dearth in midwives in the Protectorate was in 1953 when the St. Joseph Hospital, Jirapa, was completed. This hospital, a joint government/mission enterprise had a large maternity clinic and offered midwifery training.<sup>145</sup> By the end of 1955 when the old ramshackle hospitals in the Protectorate were replaced with permanent hospitals, child and maternity blocks were provided and welfare work undertaken in them.<sup>146</sup>

By and large, though the health of the inhabitants of the Northern Territories remained a problem in constant focus, efforts made by the government to handle them did not meet the realities of the health needs of the local people. It is evident that in the development of all facets of health service institutions the North was generally subordinated to similar development in the coast. This official neglect according to Kimble was partly deliberate and more importantly due to the lack of “exploitative resources” to attract private enterprise.<sup>147</sup> The Protectorate began coming to the lime light only from the 1950s when the administration of the Gold Coast was steered by Ghanaians and when members of the North gained access into the Legislative Assembly. Running parallel in development to the use of fixed outfits as curative centres was the

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<sup>144</sup> GCLCD 1946 p. 25 Governors address.

<sup>145</sup> GCMSDR 1953 p. 83. From the 1950s child and maternal welfare were provided in hospitals, clinics and in the Bimbila Health centre.

<sup>146</sup> ARNT 1955 p.77.

<sup>147</sup> David Kimble, *A Political History of Ghana 1850-1928* (Oxford:1963) pp. 533-4.

insistence by colonial authorities on mass disease eradication. What follows in the next chapter constitutes a discussion of development in this method of curative health.

## CHAPTER THREE

### POLICIES OF EPIDEMIC AND ENDEMIC DISEASE CONTROL

One of the main features of the disease climate of the Protectorate as has been noted was the recurrent spate of epidemic outbreaks and persistent endemic diseases. What follows is a discussion of the key policies set and the strategies mapped out by the colonial regime to control epidemics and the incidence of endemic diseases in the dependency.

#### 3.1 LIMITING THE SPREAD OF EPIDEMICS

The main policy designed to handle the recurrent outbreaks of epidemics in the dependency was that of limiting their spread. While the actual date of commencement of the implementation of this policy is not known, it was certainly in operation in the Protectorate before 1906 when the outbreak of cerebro-spinal meningitis(CSM) was first mentioned in the medical reports. The policy was however only rigorously applied during the 1906 CSM outbreak and thereafter. An important element in the effective prosecution of this policy was early notification. The medical and health authorities set out to achieve this through the assistance of the chiefs: it was the responsibility of village chiefs to notify the nearest medical officer of all cases of sudden deaths and their observation of increasing rate of mortality and illness. As evidence shows a few of the chiefs and headmen were alert and promptly reported any sudden deaths that occurred. For example the headman of Konyokwong was reported as "willing to do all in his power."<sup>1</sup> On the other hand the headman of Babile, in the Lawra district declined

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<sup>1</sup> PRAA ADM 56/1/177 Extract from the Lawra dairy from 22<sup>nd</sup> to 31<sup>st</sup> Oct., 1917.

to report the outbreak of sickness in his area. On investigation it was revealed that the unreported death occurred in the house of the headman himself.<sup>2</sup> The chiefs of Wa were similarly guilty of not reporting deaths in 1921.<sup>3</sup> Describing the attitude of the chiefs on this incident the medical officer, Wa noted that:

No attempt whatsoever seems to have been made by the chiefs and people to check the disease in spite of the severe lessons they had last year and I do not believe that, short of strictly policing infected villages the actual presence of an official in the village any attempt will ever be made by the people themselves or that any restrictions which may be put upon them with a view to checking of the disease are likely, short of the close supervision, to be carried out.<sup>4</sup>

The chiefs were not to blame for their inability to report cases of sudden death. They played the role of middlemen to relay reports from the local population to the medical and health authorities. Thus their ability to report depended largely on the co-operation of the local people. But as evidence indicates, the people even refused to report cases of death let alone illness. The medical officer of Navrongo, observed in the 1920s that the people “are very cautious about reporting illness” to him. While he admitted that the chief was co-operative and had been of great assistance, he emphasised the people’s general dislike of reporting any deaths.<sup>5</sup> At Buing it was noted in disappointment that “unless one marches very warily, there will never be reported any case at all”<sup>6</sup>

A combination of possibilities explain the attitude shown by the local people. The terrible nature of epidemics (when they occurred) particularly CSM and smallpox, beyond the fear it aroused, had a very strong social stigma. Most families sought to conceal the presence of such diseases among them for superstitious reasons. An

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<sup>2</sup> Ibid.

<sup>3</sup> PRAA ADM 56/1/267 Chief Commissioners informal dairy 1921-1930.

<sup>4</sup> GCMSDR 1921 p. 16.

<sup>5</sup> PRAA ADM 56/1/270 Informal dairy for Navrongo-Zuarungu District 15-21 March 1920.

<sup>6</sup> PRAA ADM 56/1/270 Informal dairy for Navrongo-Zuarungu District 15-21 Feb. 1921.

epidemic, like most sicknesses, was often regarded as the visitation of an omen from the gods for wrong doing. Added to this was the knowledge among the locals of the consequences, should suspicious cases of epidemics be made known to the medical and health authorities-- isolation. Isolation had many adverse effects: beyond causing the curtailment of the activities of the entire household, isolation of a person resulted in the termination of business with attendant grievous financial consequences for the affected families.

The procedure of disinfecting compounds attacked by epidemics appears to be one of the factors that encouraged the hiding of sick people. This had the potential of developing into an epidemic. Apart from spraying with disinfectant solution or sulphur, the burning of thatched roofs was another favourite measure of fumigation. No doubt, disinfecting had the potential of limiting the persistence of local infection as it helped to destroy several parasites of infectious diseases. Nonetheless, fumigation often resulted in the destruction of at least a room in a compound. Meanwhile, the medical and health officials appeared to be under no obligation to repair any damage caused. In 1913 when an outbreak of an epidemic suspected to be bubonic plague was reported at a village near Tunga, the infected huts were burnt without compensating the owners.<sup>7</sup> Similarly, in September 1921 when a fatal case was diagnosed clinically as bubonic plague in Wa, the entrance to the infected compound was sealed up, burnt and fluid disinfectants sprayed in the area without compensation.<sup>8</sup> Because of these reasons the local people continued to conceal illnesses and sudden deaths until 1945 when a change occurred. The cause of this change was accidental. During the outbreak of CSM in 1945, it was observed that majority of the cases which turned out fatal without any

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<sup>7</sup> Provincial Medical Officer to Principal Medical Officer 31<sup>st</sup> Aug. 1913.

<sup>8</sup> GCMSDR 1920-21 p. 15.

treatment normally survived for between two and six hours from the onset of the disease. It was observed that the few who withstood the disease, between twelve and twenty-four hours were normally seen in a state less responsive to treatment. To combat this situation (the short period between onset and death), the various chiefs and headmen were given tablets of sulphanilamide and the required dosage was explained to them.<sup>9</sup> An important benefit of this strategy was that rather than dying between two and six hours as was the situation, some people survived more than twelve hours, hence enough time allowed for a report to be made for further measures to be taken. Most importantly, a majority of the local people were inclined to report sudden illnesses to the chief because of the awareness that the latter had medicines in store which were capable of restoring or sustaining life. Thus from the mid 1940s cases of sudden death or illness were reported; the problem was how to control the spread of epidemics.

Isolation was one of the earliest and major prophylactic measures used in the fight against epidemics. The use of this measure in the Northern Territories was clearly not a novel experience. Indeed, isolation had been used in Europe in the 19th centuries. It had also been practised in the southern parts of the Gold Coast. Isolation, undoubtedly, was embarked upon largely to secure the segregation of cases when epidemic outbreaks occurred. It was observed time and again that during epidemic outbreaks there were instances of infection in one village being spread by a person visiting a relative in an uninfected village or an immigrant stranger introduced the infection. Indeed, it would have been difficult for the government to attempt the use of laws or related measures to dissuade inter-village interaction. It was however apparently less difficult in terms of financial and human resources to segregate suspicious cases of an infection from others.

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<sup>9</sup> PRAA ADM 5/3/56 Report on the outbreak of CSM in the Western N. T. 1<sup>st</sup> Jan. to 21<sup>st</sup> March 1945 p. 3.

Isolation camps in the Protectorate were generally built by the local people themselves with occasional assistance and supervision from officers of the Medical Department. The people of Tanchera willingly constructed an isolation camp in 1918 although it was only a rudimentary one. The camp was described as 'a small stifling grass hut with the entrance closed, excluding all fresh air and sunlight'<sup>10</sup>. As it turned out, patients were normally in a deplorable state. A patient, fourteen years old was seen rolled up in a mat much like a corpse awaiting internment in the camp at Tanchira. He was unconscious and nearly dead.<sup>11</sup> Other communities such as the Konyokwong, and Babile, also appeared ready to follow the advice of the colonial authorities on the construction of isolation facilities.<sup>12</sup> However it was not all the local communities that were easily convinced to construct such facilities. For example, when the people of Burifo were asked to consider constructing a camp, only a few (five compounds) of them turned up. The majority of the inhabitants particularly, a section called the Gbetouri, led by their fetish man, refused to perform any task related to the erection of an isolation camp suggested by the District Commissioner.<sup>13</sup> It is not clear why isolation was shunned by some of the local people. It is however possible that ignorance was an important factor. Another reason for this attitude which came up during the outbreak of cerebro-spinal meningitis in 1908 was that the patients so isolated ran the risk of being attacked in the night by wild beast.<sup>14</sup>

Although not uniform in design, isolation camps generally consisted of a group of huts for male and females, huts for camp attendants, latrines, incinerators and even burial grounds. To distinguish compounds of isolation camps from others, each camp

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<sup>10</sup> PRAA ADM 56/1/177 Extract from the Lawra dairy 22<sup>nd</sup>-31<sup>st</sup> Oct. 1917.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Horn, A.E., 'An Investigation of Cerebro-spinal Fever in the Northern Territories of the Gold Coast in 1908' TRSTMH, vol. 2 1908 p. 26.

was identified by the hoisting of a red flag on a post. Isolation camps in the North, it can be said, were self-contained villages. For obvious reasons camps were not manned by European officials; this was the responsibility of Africans. The camp at Burifo for instance had one Jatto, a hospital boy as an attendant, while one Alhandu, head scavenger was in charge of the camps at Konyokwong, Tugu and Tonchira.<sup>15</sup> On account of the small number of medical and health staff, no substantial medical attention was given to patients who had been isolated. For example, during the outbreak of smallpox in the North Western Province in 1917, the isolated patients were only sponged with warm water and given a dose of magnesium sulphate and a few grains of quinine.<sup>16</sup> This treatment appears to have been of some benefit in camps which were fortunate to be sited within reach of medical personnel. The local people's apathy towards isolation was partly caused by this state of affairs.

Isolation was not an effective means of controlling epidemics. As it were, the measure was ideal in containing local outbreaks. However when an outbreak ultimately became widespread isolation often failed to work. For instance when there was an outbreak of influenza in 1918-19 in the country isolation was tried with some success in Tumu. But as the epidemic exploded, isolation was "found to be useless."<sup>17</sup> At Lawra, the medical officer opined that the epidemic should be allowed to run its course because "isolation of inhabitants is not feasible"; although he recommended the maintenance of the measure in the constabulary lines because they were a concentrated group.<sup>18</sup>

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<sup>15</sup> PRAA ADM 56/1/177 Extract from Lawra dairy 22<sup>nd</sup>-31<sup>st</sup> Oct. 1917.

<sup>16</sup> *Ibid.*

<sup>17</sup> PRAA ADM 56/1/171 Acting District Commissioner, Tumu to Provincial Commissioner, North Western Province (Wa) 9<sup>th</sup> Feb. 1919.

<sup>18</sup> PRAA ADM 56/1/171 Acting Provincial Commissioner(S. D. Nash) to Acting District Commissioner, Lawra 20<sup>th</sup> Nov. 1918 despatch No. 739/15/1918.

As already pointed out the concept of isolation was not unique in the Protectorate. It had been practised around the coastal areas and in Asante but the camps constructed in the Protectorate differed at least in one respect from those in the coast. Camps in Northern Ghana were mainly temporary facilities, while those on the coast were by and large permanent. By 1914, for instance the towns of Accra, Ada, Keta, Saltpond, Obuasi and Kumasi were reported to possess permanent isolation hospitals.<sup>19</sup> The reason for this contrast is not far to seek: it was part of colonial government's policy of maintaining inferior structures in the Northern Territories because of the "meagre contribution" of the North to the finances of the country. It is also possible that the difficulty in inducing the local people of Northern Ghana to avail themselves of isolation facilities discouraged the medical authorities from erecting permanent camps. Nonetheless, these ephemeral grass huts appeared to have served the purpose well in the towns of the Northern Territories. Their use in the Protectorate was advantageous because they could easily be erected if the need arose.

One other measure advocated by the Health Department to control epidemics throughout the years was restraining the performance of funerals. Government was so concerned about funeral celebrations because as a social event cherished by the local population, funerals caused the congregation of people in large numbers from far distances. Besides, it was noted, time and again, that these celebrations caused congregants to remain undispersed for three or even more consecutive days depending on the sex of the deceased. Though it was known that cerebro-spinal meningitis, smallpox and influenza corpses were highly infectious, nevertheless the bodies were kept in tenements of usually one room until wakes were held. The authorities thought this decidedly dangerous. Thus in 1920-21 when CSM broke out in the Protectorate,

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<sup>19</sup> GCMSDR 1914 p. 45.

funeral customs and social visiting among houses and villages were barred in most of the infected areas.<sup>20</sup> But as the illustration below will show, burial custom was perhaps the most complicated of practices to abolish. On the occasion of the outbreak of CSM in 1945 funeral ceremonies were reported to have been banned at Wa. The Lobi community in the village of Kalaba deliberately flouted the ban. While the ban was in force, the Native Authority overseer, one Vena Dobo, reportedly heard several funeral ceremonies in process at the village of Kalaba. On investigation the overseer noted that a funeral dance was cheerfully in progress although the celebrants had intimated no deaths had occurred. Indeed, the village overseer was denied access even to their compounds. Not even the presence of the medical officer, Wa, changed the uncompromising stand of the inhabitants of the village. The local people persistently "refused all advise, reasoning and assistance." It was only with a display of force, initiated by the deputy Director of Health that the Kalaba community finally succumbed to discontinuing their funeral celebrations.<sup>21</sup> The explanation for the reactionary nature of the local population is not far to seek: death was not regarded as the end of life, it was as it still is an important social development which designated the transition of the deceased to the other world to continue life in spirit form. And for this transition to be flawless it was necessary for the performance of elaborate funeral rites; performances which could delay burial for a week or even more. Indeed, it was perhaps the desire to avoid confrontation with the medical and health authorities that the habit of concealing deaths gained currency in the Protectorate; a habit which forever caused incognizant spread of epidemics.

Restriction of traffic constituted yet another of the measures designed to control the

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<sup>20</sup> Legislative Council Debates and Sessional Papers, 1920-21 Dalziels Report, p. 14.

<sup>21</sup> PRAA ADM 5/3/56 Report on the outbreak of CSM in the Western N. T. 1<sup>st</sup> Jan. to 21<sup>st</sup> March 1945 p. 2.

spread of epidemic outbreaks. Around the 1910s, vehicular traffic was nearly non-existent in the Protectorate. The authorities therefore concentrated on the monitoring the movement of caravan travellers who were regarded as the most important in the dissemination of diseases in the Protectorate. The monitoring system designed was based on an observation of the characteristics of these traders. A peculiar feature of these traders was that their journeys were punctuated by rest periods usually in the villages and towns. To reduce the potential of the trader spreading any disease, District Commissioners erected caravanserais usually along the various trade routes; the purpose of which was to serve as resting points for travelling caravans.

By 1920, caravanserais existed in most of the larger towns and their use was encouraged by Dr. J.M Dalziel, senior sanitary officer who investigated the CSM outbreak of 1920-21.<sup>22</sup> While this measure held the potential of preventing the spread of infections of various categories by travelling traders, it was not well executed to derive maximum benefit. Most, if not all, of existing caravanserais were in disrepair. Dr. Dalziel described these as "small gypsy booths. . . . Their presence probably indicates a usual stopping place, and their structure is favourable to the spread of any form of communicable disease, especially if they are much patronized or crowded and long in use without renewal." Because of the poor physical state of caravanserais, travelling traders appeared unprepared to utilize them. In 1914 for instance, Moshie traders were reported to have refused to use the caravanserais; rather they preferred using rest houses because they were decent.<sup>23</sup>

From the 1920s, when vehicular traffic was gaining currency and traders were beginning to use them, a change in emphasis ensued: restriction of vehicular traffic

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<sup>22</sup> Legislative Council Debates and Sessional Papers 1920-21 Dalziels Report p. 15.

<sup>23</sup> Ibid.

received serious attention, although the use of caravanserai was not abolished. Under this restriction, cordons were often formed to either prevent the importation of infections or to restrict their exportation. During the 1920-21 CSM epidemic for example, pickets were placed on the roads leading to the south of the country from the North. Passengers from Bole and Daboya were denied entry into Kintampo; only those with goods were permitted to hold markets outside the purview of the pickets.<sup>24</sup> When CSM broke out in 1945, a complete ban was placed on all lorry traffic from either entering or leaving Wa. Similarly, all other outlets of the area of the epidemic were closed. Policemen were reported to have been stationed at Dikpi and Babili on the Lawra-Wa road, Hamile, Tumu, Kojoperi, Bulenga Sawla, Bole, Bamboi and Yapei.<sup>25</sup> The restriction of traffic was not effective as was expected by the authorities.

Although the movement of vehicular traffic was adequately checked by February 1945, pedestrians were able to evade the police by simply circling round barriers.<sup>26</sup> This evasion could not be effectively checked because there were many fordable points. Another problem encountered in the restriction of vehicular traffic was the issue of healthy carriers. This group of people were known to carry the disease without necessarily revealing any externally visible signs. The hunt for such carriers required thorough bacteriological work, but given the circumstances prevailing in the dependency it was impractical to perform such bacteriological works. Not only were bacteriological equipment unavailable, there was no pathologist in the Protectorate. Medical officers who could possibly have performed this task perhaps with improvised equipment were too preoccupied to go beyond their routine duties. The difficulty posed by healthy carriers is perhaps well illustrated by developments during the outbreak of

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<sup>24</sup> *Ibid.*

<sup>25</sup> PRAA A ADM 5/2/56 Report on the Outbreak of CSM in Western N. T. 1<sup>st</sup> Jan. to 21<sup>st</sup> March 1945 p. 2.

<sup>26</sup> PRAA A ADM 5/2/56 Report on the Outbreak of CSM in Western N. T. 1<sup>st</sup> Jan. to 21<sup>st</sup> March 1945 p. 16.

CSM in 1944-45 in the Protectorate. When this epidemic erupted, all lorries from Wa to Kumasi were inspected 'thoroughly' at the Wa police station before they were permitted to proceed. Regardless of the examination, a case of CSM was detected in Kumasi five days after their arrival. Subsequently, nine deaths were reported one of which originated from Wa. Indeed not even the introduction of the use of permits and a week's quarantine of passengers at Bole (before proceeding southwards) could prevent the spread of the epidemic by the healthy carriers.<sup>27</sup>

Besides isolation, the next important and relatively successful policy designed and applied by the medical and health authorities to subdue the canker of epidemics was vaccination. It appears vaccination was first introduced in Northern Ghana in 1909. Indeed, it was so effective that if it had been used before it would have been mentioned at least in part of Arthur Horn's report.<sup>28</sup> The reported use of vaccination in 1909 was to control an epidemic of smallpox which had commenced around the close of the previous year in the North Western Province of the Protectorate. Vaccination during these early periods was carried out by the few medical officers. Given their small number, and considering the size of the Northern Territories and the scattered nature of most of the communities it was impossible to vaccinate the entire population. Against this background the orientation of doctors was towards vaccinating persons with visible evidence of smallpox. Medical officers were made to undertake vaccination in the North because only few trained vaccinators were available in the Gold Coast. All of these were concentrated in the southern part of the country. Up to 1915 Kumasi appeared to be the most northerly point of the country where a full time African official

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<sup>27</sup> PRAA A ADM 5/2/56 Report on the Outbreak of CSM in Western N. T 1<sup>st</sup> Jan. to 21<sup>st</sup> March 1945 p. 2

<sup>28</sup> Dr. Arthur Horns was commissioned to investigate the outbreak of cerebro-spinal fever in the Northern Territories in 1908.

was employed to vaccinate.<sup>29</sup> The total number of vaccinators in the Gold Coast in 1920 for instance was nine, up to which date the Northern Territories had no permanent vaccinator stationed there. It was approximately in 1917/1918 that the first arrangements were made to despatch vaccinators in response to an epidemic outbreak. Two such vaccinators were despatched to work in some villages in the Lawra and Wa districts when smallpox broke out in 1918. During the outbreak of epidemic 10,459 people were vaccinated, 7489 of which were successful.<sup>30</sup> This arrangement did not permit the medical department to perform any systematic vaccinations in many of the towns on account of the size of the Protectorate. The work of the few vaccinators was made more complicated by the local people's practice of variolization, a practice that ensured the widespread dissemination of epidemics because of the far distances some of the people could travel for this practice. Indeed variolization has been blamed for many of the outbreaks of smallpox in Northern Ghana.<sup>31</sup>

From the 1930s, serious attention was given to the improvement of the number of vaccinators.<sup>32</sup> This was perhaps partly due to the acceptance by the medical authorities of the threat posed by certain illnesses, particularly trypanosomiasis hitherto regarded as less dangerous in terms of morbidity or mortality. Indeed, from 1934 political and health authorities became alarmed about the prevalence of trypanosomiasis. Thus in 1937, the trypanosomiasis campaign, under a special organization controlled by Dr. G.F.T. Saunders was created. Among the treatment measures used by this organization was the administering of intravenous tryparsamide injections. This mode of treatment

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<sup>29</sup> GCMSDR 1915 p. 15.

<sup>30</sup> GCMSDR 1918 p. 26.

<sup>31</sup> Variolization is a process where pus from an infected person was generally put into an incision on the wrist of a non-infected person to induce immunity.

<sup>32</sup> Prior to 1930s only three permanent and one temporary vaccinators were stationed at the Northern territories. The permanent ones were posted at Lawra, Zuarungu and Salaga.

necessarily required enough vaccinators of permanent nature. Consequently, commencing from the mid 1930s a number of assistant vaccinators were appointed. Probably for the first time areas such as Savelegu and the Bamboi Ferry had permanent public vaccinators in the persons of James Robert Mensah and Ossumanu Moshie respectively by February 1935.<sup>33</sup> To augment the number of vaccinators, Native Authority overseers were trained in the techniques of vaccination from the mid 1940s. The training of these vaccinators, was initiated by Dr. L.G. Eddey, medical officer of health, Tamale who had observed in the mid 1940s that epidemics were occurring at numerous scattered points in the Protectorate. Eddey's aim of training Native Administration overseers was therefore to counter the widespread nature of epidemics by the initiation of corresponding widespread vaccination campaign.<sup>34</sup> By 1950, and on account of the trypanosomiasis campaign and the effort of Dr. Eddey, the Protectorate had obtained adequate vaccinators to perform both routine and epidemic duties. At least vaccinations to combat epidemic outbreaks could be performed without the necessity of calling in vaccinators from the Colony proper or Asante.

While the issue of vaccinators was gradually waning with time and no longer a major problem in the Northern Territories, two other problems arose. They were the potency of vaccines and how to encourage the local people to willingly accept vaccination. Indeed the lanolated lymph prepared by the Lister Institute in England was effective in combating smallpox for instance provided the drug was satisfactorily stored. But this vaccine appeared to be of little value in the Northern Territories. The journey to the Northern Territories was so long that by the time the lymph was received

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<sup>33</sup>PRAA CSO 11/10/96 Deputy Director of Health Services to DMS 28<sup>th</sup> Feb. No. 368/805/65/1925; Deputy Director of Health Services to DMSS 11<sup>th</sup> Jan 1934 No.65/130/45/1939; Col. Sec. to DMSS 20<sup>th</sup> Jan. 1934 No. 276/33/11.

<sup>34</sup> PRAA-T NRG 8/13/5 MOH, Tamale to ADMS 17<sup>th</sup> Feb. 1946 No. 158/45/1934.

there its potency was lost. The consequence of this was obvious; most vaccinations, particularly of the earlier periods were largely unsuccessful. In 1911, one medical officer who conducted vaccination in the Bole, Lawra and surrounding areas obtained such bad results that he had to give up.<sup>35</sup> In that same year, the Provincial Medical Officer of the Protectorate, Dr. C.E.S. Watson gave up vaccination on account of disappointing results.<sup>36</sup> From the early 1920s however, successes in the level of vaccinations were made. This was most probably due to the use of dry vaccines supplied by the medical laboratory, Accra.<sup>37</sup> By 1930 the success levels of vaccinations ranged between 80 and 90 percent. During the outbreak of smallpox in 1930\31 as many as 188,463 people were vaccinated; all but a few were reported successful.<sup>38</sup>

A difficult problem that medical and health authorities faced was how to induce the local people to willingly accept vaccination. It was however not difficult to convince the few Africans from the coast working as administrative staff and the constabulary to be vaccinated. Unwillingness of the local people to accept vaccination is amply illustrated in an incident that occurred in 1917 in the Lawra district. In that year there was a reported outbreak of smallpox in the district and Dr. Whyte, the district's medical officer went on a tour of the area apparently with the view of finding out the number of people who had contracted the disease and to vaccinate where possible. When news of Dr. Whyte's vaccination trip reached Burifo, the people deserted the village. In 1920 the medical officer of Bawku complained bitterly about the reluctance of the people to present themselves for vaccination.<sup>39</sup> To safeguard against the local people's habit of avoiding vaccination governor Guggisberg passed an Ordinance making vaccination

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<sup>35</sup> GCMSDR 1911 p. 37.

<sup>36</sup> Ibid.

<sup>37</sup> By 1910 the medical laboratory in Accra had commenced the preparation of vaccines.

<sup>38</sup> GCMSDR 1930/31 p. 26.

<sup>39</sup> PRAA A ADM 56/1/270 Informal Dairy Navrongo-Zuarungu 15-21 Jan. 1920.

compulsory from 1924. Under this Ordinance powers were granted to public vaccinators to forcibly vaccinate persons who could not provide evidence that they had been vaccinated. Non-compliance indeed carried serious penalties.<sup>40</sup> However, in the application of Guggisberg's order it appears not all towns in the Protectorate were obliged to comply with the ordinance. As the application of the governor's order shows, and for reasons not given, not all the towns of North Mamprusi Province were included. Nor was the order applied in all towns within the western Gonja area. This was the bane of Guggisberg's order because towns which fell outside the purview of the governor's order risked no penalty for refusing to be vaccinated. Moreover, it meant that emergency vaccinations could not be performed in such areas because there was the need under such circumstances to bring such areas within the scope of the ordinance first.<sup>41</sup> From the latter part of 1932, the deputy Director of Health Services attempted circumventing this task by proposing the application of the vaccination ordinance to the whole Protectorate. His objective was for the Health Department to be able to deal instantly and legally with epidemics. The proposal was supported by Dr. Philip Oakley the then acting DMSS.<sup>42</sup> Earlier in August 1932, DMS, Dr. Duff and one Dr. H. O' Hara May had supported the proposal of Dr. Oakley.<sup>43</sup> It appears the Colonial Secretary did not favour the suggestion because he feared that the general application of the ordinance to the Protectorate would imply the operation of section 5 of chapter 182 of the ordinance as well. The regulation under this section and chapter implied that regardless of the existence of an epidemic all persons (except those specially exempted)

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<sup>40</sup> The Laws of Asante, the British sphere of Togoland and the Northern Territories of the Gold Coast pp. 314-315.

<sup>41</sup> PRAA-A CSO 11\10\83 compulsory vaccination order dd. 14th Nov. 193.

<sup>42</sup> PRAA-A CSO 11\10\83 Ag. DMSS to Col. Sec. dd. 21 Oct. 1932 No. 1583\36\32\8.

<sup>43</sup> PRAA-A CSO 11\10\83 DMSS to Ag. Col. Sec. dd. 12th Aug. 1932 No. 1245\36\32\5; Dr. H. O' Hara May to Col. Sec. dd. 10-8-1932 No. 205\3\27.

must present themselves for examination and possibly vaccination. The consequence of this, obviously was additional expenditure in terms of more vaccines and vaccinators and other related staff responsibilities which government preferred to defer.<sup>44</sup> Because of the fear of the potential rise in expenditure the Colonial Secretary avoided a blanket application of the ordinance. He favoured its gradual extension to some of the areas hitherto excluded. Consequently, from October 1932 and by orders of the governor, the Colonial Secretary's preference prevailed and vaccination orders applied to Wa and Lawra-Tumu districts of the Northern Territories.<sup>45</sup> In September 1932 the order was extended to the northern section under British mandate and the Gonja district.<sup>46</sup> In the 1930s, a re-organization of the districts in the Protectorate occurred. The Northern Province consisted of the districts of Mamprusi, Wa and Lawra Tumu, while the Southern Province was made up of Dagomba and Gonja districts. Owing to this re-demarcation, a situation arose where two different orders operated in certain districts making the position of such districts unclear. Thus in 1934, the acting Attorney General was compelled to invoke the suggestion earlier on made by the deputy Director of Health Services and which was turned down by the Colonial Secretary.<sup>47</sup> This time round the Colonial Secretary saw the wisdom in applying the vaccination ordinance to the whole Northern Territories. Consequently in May 1934 the vaccination ordinance was applied throughout the Protectorate.<sup>48</sup> Indeed it can be said that while from 1934 the health authorities in the Protectorate had the legal backing to forcibly vaccinate, the order did not induce any appreciable change in the response of the local people to

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<sup>44</sup> PRAA-A CSO 11\10\83 Memo for the Executive Council dd. 25\11\1932.

<sup>45</sup> PRAA-A CSO 11\10\84 Order by the Governor dd. 13th Oct. 1932.

<sup>46</sup> PRAA-A CSO 11\10\85 Order by the Governor dd. 1st Sept. 1932. The orders of 1932 revoked the earlier orders of 1920.

<sup>47</sup> PRAA-A CSO 11\10\85 Ag. Attorney General to Col Sec. dd. 9th April 1934.

<sup>48</sup> PRAA-A CSO 11\10\85 Order by the Governor dd. 16th May 1934: This Order applied to all persons who were within the limits of the Northern Territories of the Gold Coast including the Northern section of Togoland under British Mandate.

vaccination. What perhaps brought the change in attitude was the potency of some of the injectables.

Notwithstanding the outlined measures relied on by the health authorities, one significant factor which ensured that epidemic outbreaks could not be tackled as and when the need arose was the paucity of staff. While it constituted a problem of the country at large the paucity of qualified staff was more conspicuous in Northern Territories than any where else. The issue here was that before the few available staff could be marshalled the epidemic normally would have commenced widespread diffusion. Dalziel noted in his investigation of CSM in 1920 that:

with a reduction of medical officers in the three Provinces of the Northern Territories and with an inadequate staff of administrative officers in so large and important a territory, he would be an enthusiast or superman who could find time both to visit the whole of his district and to go much beyond routine duties as well<sup>49</sup>

This meagre staff base was not conspicuous in the early periods because epidemic outbreaks were principally restricted in nature and episodic. The effect of low staff levels began to show only around the 1920s when epidemics occurred simultaneously throughout the Protectorate.

### 3.2 FORMATION OF CONTROL TEAM

Against the background of the small staff numbers no permanent organisation of personnel to be specifically devoted to the handling of epidemics could be formed. Up to about the mid-1940s it became the norm during epidemic outbreaks, for the deployment of the medical officers and the available ancillary health staff to perform epidemic duties. When epidemics began to break out simultaneously assistance was sought from the constabulary and police force. Thus in 1914, when the outbreak of a

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<sup>49</sup> Legislative Debates and Sessional Papers 1920-21 Dalziels Report p. 15.

disease suspected to be plague was reported at Tunga, the constabulary assisted in checking the escalation of the disease.<sup>50</sup> To circumvent the situation of having to rely substantially on the constabulary and the police in the arrest of the epidemics, Dalziel made a number of suggestions. Among them were the appointment of a sanitary officer and a sanitary inspector. While the role of the sanitary officer to a greater extent would entail travelling throughout the Protectorate and instructing the local people on the necessary measures, the latter played the role of carrying out the instructions of the sanitary officer in the North Western Province. Besides, the sanitary instructor would relieve medical officers of the extra duties and above all during epidemics "his presence would guarantee the effectiveness of much that has to be left to natives without supervision." Aware of the difficulties involved in obtaining African sanitary inspectors from the coast, Dr. Dalziel offered two suggestions: the first was that a trial be made of a system of obtaining local men for a period of training subsequent to which they would be posted to work in their districts of origin. The second suggestion entailed the necessity of obtaining adequate intelligent young men who would be trained in the rudiments of controlling the outbreaks of epidemics and related duties. Indeed Dalziel strongly believed that if these proposals and suggestions were followed cases of epidemic outbreaks would be brought promptly to the notice of the authorities and a sort of staff reserve for duty during epidemics would equally be available.<sup>51</sup> Although Dalziel's suggestion appeared to be good it was not until the late 1940s that a combat-ready epidemic team was formed in the Northern Territories. The delay in implementing the policy does not mean that governors were unconcerned with Dalziel's suggestion. Indeed governor Guggisberg showed concern. Among the public

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<sup>50</sup> PRAA-A ADM 56\1\171 CCNT to Col. Sec. dd. 28th Jan. 1914.

<sup>51</sup> Dalziels Report op. cit. pp. 16-17.

health policies of government under Guggisberg was the plan to establish a standing organisation to deal with epidemics. Furthermore Guggisberg intended to organise campaigns that would eventually lead to the permanent eradication of the causes of epidemics.<sup>52</sup> A combination of factors led to the shelving of Dalziel's recommendations. The 1920s were not an ideal period for activating such recommendations because the country had just emerged from the First World War. Funds were not available to recruit adequate staff, as the implementation of the measure would require. While there were 25 vacancies available for medical officers in the early 1920s, funds could be provided to employ only five medical officers.<sup>53</sup> If funds were inadequate to recruit medical officers, the hub of the colonial health service network as it is revealed, the case of recruiting ancillary health and medical staff could be surmised. Before the country recovered from the effects of the war the trade depression of the 1930s had set in. This necessitated the reduction of staff and closure of some health stations.<sup>54</sup> To add to the financial woes of the country, the Second World War broke out in 1939.

It was approximately from the mid-1940s that conditions were ripe for the implementation of Guggisberg's policy of establishing a permanent outfit with a general aim of eradicating the causes of outbreaks of epidemics. This was under the initiative of governor Alan Burns. One important development which perhaps spurred Burns on was the simultaneous outbreaks of CSM and smallpox in Northern Ghana. In 1948 for instance, a simultaneous outbreak of CSM and smallpox in the Protectorate left behind in the eastern parts of the Northern Territories 11002 cases of meningitis and 651 cases of smallpox. Deaths recorded in this epidemic were 868 and 120

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<sup>52</sup> GCLCD 1926-27 p. 12.

<sup>53</sup> GCLCD 1921-22 p. 114.

<sup>54</sup> GCLCD 1931-32 p. 45.

respectively.<sup>55</sup> Coupled with this weird and frightening nature which epidemics had assumed, the financial conditions of the country were favourable. Revenue of the country which was £3,868,830 at the turn of 1940 had reached an unprecedented level of £7,171,618 in 1945-6.<sup>56</sup> Besides, by this date the treasuries of the Native Authorities had stabilised and funds were readily available for development projects. By the mid-1940s the southern sectors of the country had been adequately provided with basic health facilities. Thus in the estimation of governor Burns it was the turn of the people living in the remote villages.<sup>57</sup>

In 1947, the body that was to constitute a permanent outfit to effectively check epidemics was inaugurated. An event which caused the formation of this organisation was perhaps the outbreak of the smallpox epidemic in the Protectorate. This epidemic was widely spread and also lasted throughout the whole year, particularly in the neighbourhood of Zuarungu and Navrongo. On this occasion and for the first time 10 sanitary inspectors and five nurses were detailed to handle an outbreak in the Nangodi area. Another epidemic team consisting of a sanitary superintendent, two sanitary inspectors and two public vaccinators were despatched to Bawku.<sup>58</sup> These teams were ephemeral because they were disbanded at the end of every epidemic. The principal reason for this arrangement was because epidemics in their numerous forms were an episodic affair. It would therefore be improper to maintain a permanent body to control epidemics against the background of inadequate health staff in the Protectorate's health establishments. When campaigns against yaws and trypanosomiasis started in 1948 it was arranged for the team to be occasionally placed under the control of the medical

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<sup>55</sup> GCMSDR 1948 p. 7.

<sup>56</sup> Metcalfe *op. cit.* p. 752.

<sup>57</sup> GCLCD 1946 p. 4.

<sup>58</sup> GCMSDR 1947 p. 4.

officer of health during epidemic outbreaks.<sup>59</sup> This arrangement was significant at least in two respects: unlike previous arrangements other important health activities were not interrupted by the withdrawal of sanitary personnel for epidemic duties. From then on, several outbreaks of epidemics were dealt with at short notice thereby reducing the number of deaths significantly. The effectiveness of this arrangement is clearly illustrated by the maiden operation of the team when CSM broke out in 1949. Out of 9,081 cases, there were only 698 fatal ones.<sup>60</sup> By the closing years of the 1940s, the antidote for suppressing epidemics in their early stages had emerged; the problem at hand was how to maintain this organisation.

### 3.3 TRYPANOSOMIASIS AND YAWS CONTROL

Closely associated with the fight against epidemics of CSM, smallpox and influenza among others, were the problems of sleeping sickness and yaws. Unlike malaria, sleeping sickness and yaws (diseases prone to the local population) did not receive serious attention until the mid-1930s. This was particularly true of trypanosomiasis. It appears yaws began receiving attention probably in the 1920s. In 1923 for instance yaws patients at Yendi received treatment with N.A.B. This precedence given to yaws over trypanosomiasis was because of the apparent existence of the former in substantial numbers among patients in hospitals. Reports of the increasing incidence of yaws in the Protectorate were unanimous. The number of yaws cases reported in Yendi in 1923 was 1159.<sup>61</sup> In the late 1920s while 75% of cases seen at the Yendi dispensary were victims of yaws, the Konkombas of eastern Dagomba as

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<sup>59</sup> GCMSDR 1948 p. 7.

<sup>60</sup> GCMSDR 1949 p. 5; GCLCD 1950 p. 39: That is about 8%. Compare this figure to Dr. Dawdals estimate of cases and deaths of the CSM outbreak in the Northwestern Province of the Protectorate in 1919. Here of a total of about 1,041 cases 986 turned fatal-- nearly 95%.

<sup>61</sup> Togoland Report 1923 p. 31.

well as the people of Mamprusi were reported to be seriously affected.<sup>62</sup> Yaws was reported to be the most prevalent and wide-spread disease in the mandated territory.<sup>63</sup> Two important factors helped to expose the widespread incidence of yaws in the Protectorate. The potency of the drug used was one; the administration of novarsenobillon through intra-muscular injection and potassium iodide yielded marvellous results. Sores rapidly disappeared from the surface of the skin and large ulcers were reported to have healed within a short time. It was reported that the magic of novarsenobillon and potassium iodide so impressed the Konkombas that they became convinced the antidote of most diseases had finally arrived.<sup>64</sup> Consequently, it was common for patients to turn up for injections prior to the appearance of eruptions on the skin. The growing availability of fixed health facilities in the Protectorate helped to reveal the widespread incidence of yaws. Patients who usually walked a number of miles to obtain medical attention either had dispensaries in their villages or only had to walk a few hours to obtain medical attention. Once health facilities were accessible and treatment was efficacious the emergence of patients with yaws cases became apparent.

To a greater extent the Medical Department's policy on yaws was to eradicate it from the start. This was perhaps because in its most advanced form yaws was not only disabling it also caused a great deal of deformity to its victims even after it had been subdued. Consequently, it seriously affected the quality of labour force in the Protectorate. If the disease was allowed to prevail it meant that the government would lose much of its potential labour required for the cocoa and mining industries. Yet the policies designed to eradicate the disease in the 1920s and early 1930s were ineffective.

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<sup>62</sup> Togoland Report 1928 p. 35; 1930 p. 47.

<sup>63</sup> Togoland Report 1931 p. 44.

<sup>64</sup> Togoland Report 1924 p. 63.

It was the responsibility of the patient to approach the health authorities for treatment during the period. Going by the statistics of attendance to hospitals and dispensaries, this approach appeared encouraging. But most often patients applied for treatment only during the secondary stage of the disease. Worst of all one injection of norvarsenobillon brought such improvement that patients did not come for the subsequent doses which were necessary to ensure the extinction of the disease. In 1928-29 only an estimated 30% of yaws patients returned for the required repeated injections in the Protectorate for instance.<sup>65</sup> These developments obviously called for a review of tactics. Thus, rather than waiting to receive yaws patients in the hospitals and dispensaries, the strategy in the closing years of the 1930s was the obverse; taking treatment to the doorsteps of the local people. This was the significant role the Native Authority dressers had to play. After dressers were given basic training in injections, a six-week program of work was mapped out for each dresser in a given area. This program was designed such that a dresser visited his assigned area every six days until the course of the injection was completed.<sup>66</sup> The results were impressive. For example, out of 1,170 yaws patients under the treatment of the Wa dresser, 886 were reported to have received more than four of the injections; almost 76%. Comparatively, out of 445 new cases of yaws at the Wa Hospital in August 1937, barely two patients had received four injections at the close of September. In Gonja the dresser obtained re-attendance level of 90%.<sup>67</sup> While the dressers were not enough to undertake house to house treatment, the success of this pilot programme of taking treatment to the local people indicated to the Medical Department the role such a strategy could play in the long term eradication of yaws in the Northern Territories. The Chief Commissioner confidently

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<sup>65</sup> GCMSDR 1929 p. 42.

<sup>66</sup> ARNT 1937 p. 7.1

<sup>67</sup> Ibid.

predicted that: 'the continuance in an intensified form, of the present system of taking treatment to the people will result in the disease being stamped out within a comparatively short period.'<sup>68</sup> The enthusiasm of the Medical Department coincided with an upsurge of confidence of the local people in the efficacy of European medicine. It was however not until the mid-1940s when Burns was governor that the policy of eradication of yaws was intensified. The retardation in the progress of the mass eradication of yaws was principally caused by the war. As a result of the demands of the war a number of officers of the Medical Department were not available for routine health work. The staff of the Medical Department was further depleted by resignations and retirements.<sup>69</sup> Also the high cost of novarsenobillon, the drug that held the key to the extinction of the disease retarded the eradication of yaws. While its efficacy was not in doubt, it was reported in the 1930s that its price made it "difficult to cope with the number who submit themselves for treatment."<sup>70</sup>

When Burns took over in the 1940s, his desire was to "eventually eradicate this ubiquitous disease which is the cause of so much chronic ill health."<sup>71</sup> Undoubtedly aware of the demands of the policy, particularly the finances involved and indeed conscious of the growing yet limited revenues of the country Burns had to look elsewhere for funds to cater for the yaws campaign. Thanks to the Colonial Development Fund in 1943 a sum of £8,000 was obtained. Out of this fund Burns acquired and equipped a mobile dispensary. The use of the van was important at least in one regard; with a small staff a large proportion of the Protectorate could be covered with less difficulty. This would circumvent the perennial paucity of medical personnel

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<sup>68</sup> *Ibid.*

<sup>69</sup> GCLCD 1944 pp. 23-24.

<sup>70</sup> Togoland Report 1930 p. 47.

<sup>71</sup> GCLCD 1944 p. 25.

faced by the Health and Medical Department. Burns' campaign, both curative and preventive, commenced first in the Yendi district in an extensive form in 1944. Yendi was chosen as the maiden area of operation because yaws was reported to be extensively present in the district.<sup>72</sup> By 1946, the campaign had covered the whole Dagomba district, where surveys and mass treatment were undertaken. The team worked so relentlessly that in 1946 alone, over 20,000 yaws cases were seen and treated.<sup>73</sup> In January 1947 the surveillance of the campaign against yaws was amalgamated with a trypanosomiasis campaign hitherto ran by separate teams. Apart from broadening the hitherto independent teams the unification ensured not only the effective coverage of the Protectorate and maximum utilization of personnel, but also the two unpopular diseases were attacked for the first time simultaneously by a single team. Although governor Burns left the country by August 1947, his successor, Sir Gerald Creasy did not renege in the pursuance of his predecessor's policy. It can be said that Creasy was responsible for increasing the number of medical officers attached to the campaign from one to three which subsequently caused the decentralisation of their operations. Three centres emerged: Kintampo, Kumasi, and Gambaga.<sup>74</sup> The yaws and trypanosomiasis campaign metamorphosed into the Medical Field Units (MFU) in 1950. This change in nomenclature was meant to reflect the changed role of the team.<sup>75</sup> While the yaws campaign team and subsequently the MFUs made tremendous attempts at tracking down the incidence of yaws and progress reportedly being achieved, cases of yaws persistently lingered on. From 1944-45 when the yaws campaign was seriously pursued the eastern Dagomba district had been an area where consistent surveys,

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<sup>72</sup> GCMSDR 1943 p. 2.

<sup>73</sup> GCMSDR 1946 p. 7.

<sup>74</sup> GCMSDR 1949 p. 5.

<sup>75</sup> See Addae op. cit. for a detailed discussion of the operations of the MFU.

re-surveys and treatment were done. Yet the incidence of the disease remained very high. In a survey of eastern Dagomba in 1953, about 2925 cases of yaws were found.<sup>76</sup> Other districts which were believed to have been well catered for still had cases of yaws. Continual reports of cases were not because of lapses in the organisational network but principally due to the declining effectiveness of norvarsenobillon. Consequently, towards the end of 1953 treatment of yaws cases was modernised, with the use of penicillin. This drug was significant not only because of its efficacy but also in the drastic reduction in the number of injections required to exterminate the disease. Rather than having to receive injections weekly for two to three months, one single injection of procaine penicillin was henceforth administered as and when a survey was made. Indeed it was this wonder drug that eventually led to the eradication of yaws in the 1960s.

Although first mentioned in the annual report of 1903, trypanosomiasis was a well known disease in Northern Ghana before the inception of colonialism. From 1906 when sleeping sickness was first recognised by means of microscopy in a patient at Gambaga, yearly reports of the presence of trypanosomiasis were published. In 1909 for instance, only 5 cases of trypanosomiasis were reported to have been seen and treated.<sup>77</sup> In 1910 Dr. Beringer in a report on a tour through portions of the southern province revealed several cases of sleeping sickness. Many if not all of these cases were seen at a time the disease had reached its advanced forms.<sup>78</sup>

While the presence of trypanosomiasis was obvious, as to whether its presence constituted any danger to the health of the communities involved was in doubt,

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<sup>76</sup> GCMSDR 1952\53 p33.

<sup>77</sup> GCMSDR 1909 p. 39.

<sup>78</sup> Death often almost resulted. Cases were reported in Tamale, Wa, Lawra, and Gambaga in which attempts at treating trypanosomiasis patients ended fatally.

particularly up to around 1935. For instance, in a letter to the Secretary of State in 1928, it was reported that trypanosomiasis in all its forms was relatively unimportant.<sup>79</sup> In 1933, although the Assistant Director of Medical Services recorded an increase in the number of trypanosomiasis cases treated, he was not convinced that " human trypanosomiasis is such a serious cause of mortality and morbidity as to justify the diversion of large sums of money to eradicate it at the expense of other medical services needed by the inhabitants of the colony and its dependencies as a whole." Officers of the Health and Medical Department who had worked in the Protectorate did not share the opinion expressed by the Assistant Director. Some medical personnel pointed out areas where high mortality caused by trypanosomiasis had led to depopulation and abandoning of many settlements in the Protectorate. During his tours in 1910, Dr. Beringer, medical officer, Salaga had observed the existence of several vacant and ruined huts in Kulaw. Apparently this desertion was due to the migration of the people for fear of trypanosomiasis.<sup>80</sup>

In consonance with this conflicting opinion about trypanosomiasis, no elaborate policy was formulated to check the prevalence of the disease. Efforts at eliminating the disease were essentially directed at clearing of the bush around villages, fords and ferries within the vicinity of the tsetse fly. And because the personnel base of the Medical and Health Department was meagre the chiefs were often relied upon for the clearings, an activity they were less interested in on account of ignorance. In 1910 £4,000 was voted and specifically designated for preventive measures against sleeping sickness. Three special medical officers were appointed and assigned the task of finding the distribution of the disease and tsetse fly, because, as it was believed 'it will

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<sup>79</sup> ARNT 1937 p. 72.

<sup>80</sup> PRAA-A ADM 56\1\99; GCMSDR 1910 p. 46.

be extremely difficult to start a proper system of prophylaxis until the distribution of trypanosomiasis and *Glossina Palpalis* are more definitely mapped out.’’ But it appears the Northern Territories did not form part of the areas marked for the distributional study. For, of all the sleeping sickness hospitals set up as part of the campaign in 1910 the closest to the Northern Territories was erected at Kintampo.<sup>81</sup>

Attention was mainly devoted to the south: particularly Asante and Brong Ahafo areas during these early periods. This was because it was wrongly believed that the incidence of the trypanosome and *Glossina Palpalis* was higher in these two places than in the rest of the country. Though it was evident at least from the observation of Europeans stationed in the Protectorate that the true home of trypanosomiasis was Northern Ghana this could not be determined because of the disappointing number of health facilities and medical officers.<sup>82</sup> In the early periods the main means through which the incidence of trypanosomiasis could be determined was by hospital attendance. And because these facilities were few and located only in major settlements, accessibility was very difficult for potential sleeping sickness patients to avail themselves of the facilities. Also to explain the reluctance of potential trypanosome patients availing themselves of the use of health facilities was the little-to-no confidence the local people held for European medications for the disease. Reports of the handling of the few sleeping sickness patients who attended hospital suggest that medical officers were either ill-equipped to handle the disease or were incompetent. Out of the six trypanosomiasis patients seen in the various health centres of the Protectorate in 1909, five turned out fatal.<sup>83</sup> Under this circumstance, it was perhaps

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<sup>81</sup> GCMSDR 1910 p. 47.

<sup>82</sup> Addae *op. cit.* p. 343.

<sup>83</sup> GCMSDR 1909 p. 15.

thought reasonable on the part of the local people to conceal rather than expose cases of trypanosomiasis to the medical officers.

From the beginning of 1935, the hitherto optimistic view held about sleeping sickness gave way to a pessimistic one requiring urgent action. This was due to the gradual rise in the number of sleeping sickness patients attending hospitals and dispensaries.<sup>84</sup> The efficacy of the treatment received and the readiness to submit to it also encouraged people to attend hospitals. The table below shows the rising incidence of trypanosomiasis between 1935 and 1937. It also shows the areas in the Protectorate which suffered severely from it.

TABLE 7 RISING CASES OF TRYPANOSOMIASIS 1935-1937<sup>85</sup>

STATION	1935	1936	1937
Nakpanduri	1631	1165	735
Garu	-----	59	120
Lawra	1161	944	1242
Walewale	----	586	638
Gambaga	52	572	775
Bawku	194	274	286
Tamale	157	149	196
Wa	103	93	181
<b>Total</b>	<b>3298</b>	<b>3842</b>	<b>4173</b>

Against this background, in 1935 the then Secretary of State formed a team to survey the situation. It was to consist of a medical officer, an entomologist and other African personnel. The survey did not commence until mid-1937 mainly due to the

<sup>84</sup> By this date Governor Slater had masterminded the growth of hospitals and dispensary facilities: See chapter Two for details on this.

<sup>85</sup> GCMSDR 1937 p. 6.

difficulty of obtaining the services of an entomologist.<sup>86</sup> Contrary to expectation, the senior medical officer in charge of the survey team painted a picture which showed the gradual decline of trypanosomiasis. Generally the facts established by the team failed to indicate whether or not trypanosomiasis was rising. Referring particularly to the portions of the mandated territory of the Mamprusi district a definite conclusion was reached that the disease was static. Although the senior medical officer admitted that the Tumu-Lawra districts were areas where the prevalence of sleeping sickness was high he indicated that areas within the vicinity of Tamale and Navrongo were ironically free from the disease.<sup>87</sup> These observations clearly contradicted the statistics of the true incidence of trypanosomiasis revealed from records of hospital attendance illustrated above.

Based on the reports of hospital attendance, a definite policy regarding a fight against trypanosomiasis emerged in early January 1937. The policy which aimed at the total extermination of sleeping sickness was to be achieved through two main strategies: curative and preventive (simultaneously). Under the curative strategy provisions were made for the treatment of the disease not only in the available hospitals but also in the many dispensaries which existed in the 1930s. Attached to these facilities were camps carefully constructed and maintained by the various Native Authorities. The availability of the dispensaries close to most of the settlements ensured that treatment was brought nearer to the population. This arrangement was mainly responsible for the rising number of case incidence which appeared in reports of the latter part of the 1930s. A fundamental setback in the use of this strategy however was how to ensure that patients undertook the full course of treatment. Indeed, the

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<sup>86</sup> ARNT 1937 p. 73.

<sup>87</sup> ARNT p. 75.

medical experts indicated that completion of the course of treatment prevented any spread of an arsenic-resistant strain of trypanosome. Two measures were designed to ensure completion of treatment: the first, cleverly designed on the basis of the superstitious orientation of the local people was the suspension of 'fetishes' consisting of a small barrel of epsom salt over roofs of dispensaries. On arrival patients were made to stand within a circle marked on the floor of the dispensary. While touching the fetish the patient swore to persist in treatment until discharged by the dispenser. Apart from the dispenser of the Nakpanduri camp who is known to have relied on this trick no evidence of its application is shown in other areas though it is not unlikely that colleague dispensers practised the 'fetish' trick.<sup>88</sup> The second measure, an orthodox one was to enlist the support of the Native Authorities. Under a special arrangement with health authorities Native Authorities agreed to guarantee that once patients commenced the treatment of trypanosomiasis, they were obliged to complete the treatment without renegeing. It therefore became the sole responsibility of the Native Authorities not only to trace renegers but also to coerce them to complete treatment once started. While the Native Authorities were enthusiastic and anxious to discharge this responsibility fully, they faced the problem of how to reach infected people in the remote locations within their purview. It was in the face of this difficulty that Native Authorities were compelled to initiate and apply rules to the effect that patients risked being imprisoned for a maximum period of three months for failure to complete treatment.<sup>89</sup>

The second main strategy to eradicate the disease was a preventive one. It largely entailed a survey of the distribution of *Glossina Palpalis* and conducting experiments in

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<sup>88</sup> ARNT 1937 p. 74.

<sup>89</sup> ARNT p. 75; The fact that it was not obligatory for a patient to undergo treatment made nonsense of the institution of the rules.

selective clearing. The object of this was to render the habitat of the fly unsuitable for breeding. The first area to be surveyed in the Protectorate was the Kamba River area in the late 1930s. By mid 1940s, the Kamba River experiment had yielded dividend in the sense that the number of tsetse flies in the district had reduced tremendously. A corresponding reduction in sleeping sickness was reported among the population. Previously depopulated areas caused by the presence of the fly were similarly reported to have been re-populated by about fifty-two families. Many farms were recovered and grazing land made readily available.<sup>90</sup>

The success of the Kamba experiment appeared to have encouraged the medical and health authorities into the widespread application of the same technique throughout the Protectorate. Accordingly, from 1947 the trypanosomiasis campaign was united to the yaws campaign: these were operating concurrently and independently before this date.<sup>91</sup> In 1951 the trypanosomiasis and yaws campaigns metamorphosed into what became known as the Medical Field Unit (MFU). The MFU however did not concern itself with the task of reclamation of the derelict valleys depopulated by *Glossina Palpalis* as was the case of the early trypanosomiasis campaign. Besides research the MFU's preoccupation was the diagnosis and treatment of endemic diseases in general.<sup>92</sup>

The outfit that assumed the task of dealing with the important issue of reclamation of was the Department of Tsetse Control formed in 1949 with Dr. K. R. S. Morris, entomologist of the Medical Department as its director. The Department was initially headquartered at Lawra, but was later moved to Wa. By 1952, when Dr. Morris had retired and a Mr. F. A. Squire succeeded as director, many areas that had been nearly overrun by the fly were reclaimed. Apart from the extension of the reclaimed lands in

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<sup>90</sup> GCMSDR 1943 p. 2.

<sup>91</sup> ARNT 1947 p. 5.

<sup>92</sup> Addae op. cit. pp. 170-71.

the vicinity of the Kamba valleys, the Department of Tsetse Control also reclaimed lands in the Sielo-Tuni valley.<sup>93</sup> Here, about 250 square miles of land is reported to have been rendered healthy and habitable.<sup>94</sup>

The performance of the Department of Tsetse Control is well illustrated by this statement made in the report on the Northern Territories of the Chief Regional Officer in 1955 that:

Where once there was nothing but fly and tangled bush, healthy villages have sprung up, with extensive farms and sleek heads of cattle, for not only have the two riverine kinds of tsetse fly, *Glossina Palpalis* and *Glossina tachinoids* vanished from the scene, but the Savannah species, *Glossina morsitans*, . . . has also retreated.<sup>95</sup>

The simultaneous attack by the M. F. U and the department of tsetse control reduced the general incidence of sleeping sickness to exceedingly low levels. By 1955 only 347 cases were reported to the M.F.U, whereas in 1937 3,390 cases were reported.

It may be mistaken to concede though that the statistical decline of the level of sleeping sickness was solely on account of the organisational networks of the medical and health authorities and indeed the enthusiastic and willing nature of the personnel involved. The changed attitude of the local people towards western medicine and the willing co-operation of the chiefs and Native Authorities were significant in the tremendous reduction of the incidence of sleeping sickness. As stated elsewhere, from the late 1930s, the element of force which had been used as a tool of manipulating the local people was replaced by education and persuasion. Added to this was the resolute nature of the crop of medical officers and ancillary staff of the period, and the efficacy of medication and above all refined instrumentation and methods. All these variables combined to change the attitude of the local people from antipathy to cooperation.

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<sup>93</sup> This valley is a few miles south of Wa.

<sup>94</sup> ARNT 1955 p. 75.

<sup>95</sup> ARNT 1955 pp. 75-76.

### 3.5 ONCHOCERCIASIS

In the early 1950s the M.F.U included the eradication of onchocerciasis (River blindness) in their task. The microfilariae of *onchocerca volvulus* was first noticed in the Gold Coast in 1875 from an African. In 1906, when civil administration supplanted a military one and District Commissioners were posted to the Tumu district an abnormal rate of blindness prevailed. Then again in 1932, Dr. G.F.T Saunders in his usual rounds in the Protectorate noted the incidence of onchocerciasis. Saunders was by then fully preoccupied with the trypanosomiasis epidemic which continued to claim lives in the dependency. Following this, onchocerciasis was completely forgotten and nothing done about it until “rediscovered” in the mid 1940s by Dr. A. Ridley. Ridley was an army eye surgeon probably attached to a team involved in the recruitment of soldiers from Northern Ghana. In the course of his duties he noticed the association of deficient vision with onchocerciasis among the northern soldiers. An investigation was subsequently conducted by Ridley at Finsi (Wa district) and the result was published in 1945. The publication of Ridley’s findings coincided with the post-war dearth of medical staff and indeed, the devastating cerebro-spinal meningitis epidemic which was then sweeping the Protectorate.

By 1945 the incidence of onchocerciasis in Northern Ghana was beyond question; the problem was then the issue of finding its cause and the designing of adequate measures of handling it. Indeed it was not until 1953, thanks to the British Empire Society of the Blind, that Dr. Geoffrey Crisp an Entomologist successfully worked out the life cycle of *simulium damnosum*, the fly responsible for transmitting onchocerciasis. At the same time an investigation to find the possible prevention and cure of the disease was conducted by Dr. Frederick C. Rogers an Ophthalmic surgeon

and a companion of Dr. Crisp (Dr. Rogers conducted his investigation from a camp based at Navrongo and Crisp's work was based at Bolgatanga).

Meanwhile before the investigation of the British Empire Society for the Blind, experiments had commenced with the use of antrypol and banocide in the treatment of onchocerciasis by the government ophthalmologist. He eventually recommended the use of antrypol to the Medical Field Units (Banocide \ hetranyl ) was not considered as a drug for general use in the field without close and constant medical supervision because of its toxic side effect). Using antrypol the MFU immediately began experimental mass treatment in the Tumu District with positive results. Two events illustrates this: a hunter at Tumu who had been blind for over two years was reported to have resumed hunting after antrypol treatment. At about the same time, a man who arrived at Kintampo stone blind recovered after a course of antrypol.<sup>96</sup> The real opportunity for effectively treating onchocerciasis via a mass eradication campaign occurred at the close of 1954 when at a conference on onchocerciasis under the auspices of the World Health Organisation (WHO) delegates of Gold Coast realised for the first time the efficacy of nodulectomy both as a therapeutic and prophylactic measure. Although instruments for a nodulectomy campaign were secured, the lack of medical staff prevented the commencement of such a campaign against onchocerciasis. Mass campaign against onchocerciasis was further dented when the use of antrypol was stopped towards the close of 1955. Termination of its use was principally due to the reactions that normally resulted during treatment. On one such occasion, 98 reactions were recorded among a group of about 200 patients. These reactions were often difficult to handle because doctors were unavailable to monitor the administration of the drug. On the occasion cited for instance, the nearest doctor was reported to be 200

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<sup>96</sup> GCMSDR 1954/55 p. 46ff.

miles away.<sup>97</sup> Thus while the antidote to onchocerciasis was available, and the M.F.U was prepared to pursue a mass eradication campaign, the lack of supervisory medical staff to monitor treatment with a dangerous drug left the Medical Department in the lurch.

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<sup>97</sup> GCMSDR 1955 p. 29.

## **CHAPTER FOUR**

### **PREVENTIVE HEALTH**

Preventive health measures formed a significant component of the colonial government's arsenal for combating the disease environment which confronted them in Northern Ghana. Efforts at preventive health started at the very beginning of British official occupation of the dependency, although it was less elaborate in the early periods. This chapter sets out to explore developments in preventive health in two parts: the first part underscores the fundamental policies which appear to have guided the political and medical authorities in the area of general preventive health; the second part considers some of the specific but major preventive issues embarked on viz., disposal of excreta and refuse, water supply, housing and town planning and the regulation of cemeteries.

#### **4.1 EMERGENCE OF PREVENTIVE HEALTH POLICY**

Before 1910, when the sanitary branch of the Medical Department was established during the administration of governor Roger, preventive health issues were under the diffused control of the various medical officers who happened to be in the Protectorate. With the emergence of the Health Branch Department in 1910, a Senior Health Officer based in Kumasi was appointed to be in charge of both Asante and the Northern Territories. In that year the Provincial Medical Officer of the Northern Territories was also the Medical Officer of Health. Dr. Edward Herbert Tweedy was the first to assume this dual responsibility. However, as the population gradually increased, particularly that of Tamale, and the filth of the town was becoming evident, a health

officer and, later, sanitary superintendents, all Europeans, were appointed to take charge of sanitation and general preventive works.

Although not categorically stated, the preventive health policy of government was to concentrate on Europeans and the Hausa Constabulary. Surveillance was therefore limited to the European and Constabulary quarters. Pan latrines were provided for the use of Europeans and a few suitable sites for depositing rubbish were selected by the medical officers. The medical officers ensured that, rubbish was burnt at least once weekly. Other sanitary measures taken included the filling of holes and ditches most likely to be suitable breeding places of mosquitoes.<sup>1</sup> By 1900 the southern sectors of the country had reached a stage where towns had drains, roads, well-designed markets and sufficient public latrines.<sup>2</sup> One would have expected the application of residential segregation in Northern Ghana as it was in the south of the country. Residential segregation was a policy proposed by Dr. J. F. Easmon, the first Medical Officer of Health. The idea was to isolate European settlements from the malaria infested communities of the Africans thereby rendering it practically impossible for malaria infested mosquitoes in purely African settlements gaining access to the segregated areas. Serving as a cordon in between two communities was a no-building zone of about one quarter of a mile: a distance presumed to be long enough to pose a challenge to the African mosquitoes except the hardy ones. Not only was the *Anopheles* mosquito (identified as the principal transmitting vector) present in the Northern Territories but the reasoning that malaria was endemic and the African saturated with it applied to the dependency as well. Indeed, among the diseases the Europeans suffered

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<sup>1</sup> PRAA Accra ADM 56/1/419 Annual Report of Medical Department, Gambaga 31.12.1904 p.11.

<sup>2</sup> See Gale, T. S., "The Struggle against disease in the Gold Coast: Early attempts of urban sanitary Reform" *THSG* vol. 16 1995 p. 197. Yet it is significant to note that these towns of the colony which were receiving sanitary attention viz., Accra, Cape Coast, Sekondi and Axim were towns with a substantial population of Europeans.

from in the late 1900s, remittent and intermittent fever dominated. Of a total of 66 reported cases of a combination of sickness, 50 were malaria cases.<sup>3</sup> Although Europeans used mosquito proofing in their dwellings, segregation was not effectively applied as required. In a report on the health of Zuarungu in 1914, the medical officer noted that the European quarters were not adequately removed from African dwellings.<sup>4</sup> In a similar vein, the rising incidence of yellow fever at Bole in 1914 was blamed on insufficient segregation of European quarters.<sup>5</sup> Ironically, this was the year Europeans were moving from African settlements to reserved segregated areas in Cape Coast, Axim, Saltpond, Winneba, Kumasi, Tarkwa and Sekondi.<sup>6</sup> The policy and concept of residential segregation was not supported in the protectorate primarily because, its application would divorce the Europeans from Africans and make it more difficult to win the confidence of the local population.

Government was nonetheless not totally unconcerned with Africans. Sanitation in the villages and towns was delegated to chiefs and headmen. Chiefs were required to lead the towns people in weekly clean-ups, insist on the burning of rubbish in designated pits, the digging of pit latrines and, above all, they were expected to enforce the orders of doctors related to health in general.<sup>7</sup> Under rules made for the regulation of towns and villages in 1903 (the first of the kind in Northern Territories) chiefs and headmen were given the power to punish any person who did not comply with their orders on sanitation<sup>8</sup>. From time to time, government officials visited chiefs and headmen, with messages to impress upon them to be conscious of sanitation. For

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<sup>3</sup> ARNT 1908 p. 14 That is over 70%.

<sup>4</sup> GCMsDR 1914 p. 32.

<sup>5</sup> *Ibid.*

<sup>6</sup> See Addae, *op. cit.*

<sup>7</sup> PRAA Accra ADM 56/1/34 Meeting between the chiefs and headmen of the Northern Territories and Governor Nathan, 1903.

<sup>8</sup> PRAA Accra ADM 56/1/92 Handing over Report- Southern Province, march 1909. The first public health law in Ghana, the Towns, Police, and Public Health Ordinance was passed in 1878.

instance, sanitary issues formed the main theme of governor Nathan's discussions with some chiefs of the Protectorate in 1903. Nathan made it clear to the chiefs of Daboya that the people that suffered from a dirty town were those who live in it as " . . .they are liable to small pox which when it comes to a dirty town runs through it and kills many people."<sup>9</sup> Similar messages were given to the chiefs of Yagbum, Kpabia, Salaga and the headman of Zantana. This initiative by the governor was often complemented by efforts made by political authorities at all durbars held with chiefs to impress upon them the necessity of sanitation.

Regardless of the conscientising of chiefs and headmen on the implications of unsanitary conditions of towns on the health of the population, backed by the legal power to punish deviants, one thing was clear: non enforcement of rules. It is axiomatic that few of the chiefs were strong or had control over their subjects. The majority of the chiefs were rather weak. While the chief of Daboya for instance was "old and weak," the Tamale chief's influence over his subjects was not all that could be desired due to the "innate weakness of his character."<sup>10</sup> Other chiefs lacked confidence in the exercise of their power, perhaps out of fear of deskinment. As part of the policy of indirect rule, chiefs played an intermediary role between the political authorities and the local people. Unfortunately, apart from Dagomba, Wa, Mamprusi, and Gonja where the institution of chieftaincy was known, most parts of the Protectorate were conspicuous for the absence of " big chiefs." These chiefs in the opinion of Watterston, CCNT, were selected 'for their incapacity to make any one obey them.' Indeed, irrespective of the physical state of the person, once he had many cattle, demonstrating his ability to pay fines imposed on the local people, his election was

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<sup>9</sup> PRAA Accra ADM 56/1/34 Meeting between Governor Nathan and the chief of Daboya, April, 3 1903.

<sup>10</sup> PRAA Accra ADM 56/1/92 Handing over Report- Southern Province March 1909.

obvious.<sup>11</sup> To forestall the practice of electing weak people as chiefs, the political authorities began to appoint “suitable” chiefs, but this failed to change prevailing conditions. Appointed chiefs were at constant loggerheads with their subjects because the chiefs often went out of their way to prove themselves loyal subjects of the commissioners to the dismay of the local population who saw the giving of an order as alien practice. In most cases sovereignty over people was given to chiefs not in anyway entitled to it. An instance of this was the Bongo and Bolgatanga chiefs.<sup>12</sup> Village sanitation, being a novelty, was generally unpopular with many, if not all, of the local people.

What resulted from the non-enforcement of orders of medical officers is obvious. The accumulation of filth became the rule in many villages and towns. A report by Dr. Fritz J.A. Beringer, medical officer of Salaga during a tour through the centre and West Gonja districts in 1910 amply illustrates the state of sanitation under the regime of the chiefs. He said:

Excluding Salaga and Tamale, it may be at once said that all the villages passed through were dirty, whilst those of the beaten track of Europeans and out of the more frequented trade routes were disgustingly dirty with the accumulation of filth of ages. Huts mostly of the usually round type of this district, of swish with grass roof, containing human beings and animals, often indiscriminately mixed, were dirty and frequently little swept, compounds, were littered with rubbish and vegetable filth; whilst sweepings, broken utensils and all sort of rubbish were thrown over the walls or deposited a few yards beyond them... the open space is used for latrine purposes but frequently within a few yards of the compounds. Flies and other insects were in swarms. The dead are buried within the compounds.<sup>13</sup>

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<sup>11</sup> A. E. Watterson, ‘The Northern Territories of the Gold Coast’ in Journal of African Society vol. VII 1907-1908 pp. 344-373.

<sup>12</sup> Abstract Illiasu Papers.

<sup>13</sup> PRAA Accra ADM 56/1/99 Medical Report of a tour through the centre and west of Gonja with special reference to sleeping sickness 14.3.1910.

Clearly, the sanitary state of the Northern Territories in 1910 fits Fitzgerald's<sup>14</sup> description of Cape Coast in 1871 as "vast public privy and dunghill." Indeed it can be said that Dr. Beringer's report revealed that, if government wanted to have a healthy environment, a change of policy was needed.

From 1910, the health branch was born and the political and health authorities of the Protectorate complemented this development with the modification of policy. This was the application of force on the local people. Accordingly, further rules were made in 1910 and subsequently in 1921. Under the rules of 1910, it was deemed unlawful for wells or other receptacles for catching water to be left uncovered. Power was invested in Inspectors to forcefully enter and inspect any premises between the hours of 6 am and 6 p.m.<sup>15</sup> The 1921 rules, largely elaborations of the previous ones, regulated buildings and compounds, cemeteries, latrines, water supply. A fine not exceeding 40 shillings (in default of which prosecution was employed) was instituted.<sup>16</sup> Commencing from 1910, many yearly prosecutions were made in the Sanitary Branch Department of the Protectorate. The table below illustrates the magnitude of prosecutions between 1910 and 1920/21.

TABLE 8 PROSECUTIONS IN THE SANITARY DEPARTMENT. 1910-1920/21.<sup>17</sup>

Year	No. Prosecuted	No. Convicted	No. Fined	No. Imprisoned
1910	730	723	721	2
1911	276	274	274	--

<sup>14</sup> Fitzgerald was the London editor of the 'African Times.' He was instrumental in exposing the absence of sanitation in the Gold Coast. See Gale, *op. cit.* p. 187.

<sup>15</sup> Government of the Gold Coast Gazette 1910 pp. 865-66.

<sup>16</sup> Government of the Gold Coast Gazette 1921 p. 1094-8.

<sup>17</sup> The figures were extracted from GCMSDR 1910 p. 55; 1911 p. 57; 1914 p. 91; 1920/21 p. 54. Prosecutions continued into the 1940s and after. In 1940 as many as 919 local people were prosecuted in Tamale for various sanitary offences. See PRAA Tamale, NRG 8/3/120.

1914	367	350	249	--
1920/21	379	328	267	--

What is clear in this brief data is that prosecutions and coercion did not in any way make the local population deviate from the *status quo*. If it did, perhaps a drastic reduction in the number of persons prosecuted would have occurred. As can be seen, apart from the large reduction from 730 in 1910 to 276 in 1911, subsequent changes appeared negligible.

A striking feature of the management of sanitation up to 1934 is that punishment preceded education. No serious effort was directed at teaching the local people the essence of prevention of disease. The consequence of this was that officers of the health branch turned out to be regarded as pests rather than benefactors to the indigenous population. Sanitary inspectors were branded "Summer-summer" (Summons, summons) in obvious reference to the less persuasive methods they employed in their work.

A question which needs attention here is: why did the political authorities for a long time stick to the policy of confining sanitary improvements in the Protectorate to the headquarters of the various districts, and the few larger towns close to the main roads? Given the prevailing circumstances the policy could not have been otherwise. Apart from Tamale where there were two medical officers, the rest of the North was manned by an average of between four and five medical officers. Considering the tight schedule under which doctors worked and the vast nature of the Protectorate, the measure was inevitable. The pursuance of this policy was further motivated by the meagre funds voted for sanitation during the period. The insufficiency of funds is

exemplified in the expenditure allowed for sanitation in 1918, 1919 and 1921. In 1918 expenditure of £970 was allowed; £1,123 in 1919 and £1,711 in 1921.<sup>18</sup>

However, from 1935 there was a major change in policy which sought to vigorously extend sanitary supervision to areas other than those within the vicinity of the district headquarters. It was impossible, with safety, to stick to the principle of “pinpoint” sanitation, allowing the villages and outskirts of towns to worsen in sanitary standards. It was perhaps apparent that if such a measure were maintained, the guarded areas of the district capitals risked repeated infections from the outskirts. Two strategies were resorted to. The first of these was stimulating the interest of Native Authorities and enlisting their co-operation by entrusting them with responsibility for supervising the control of sanitation. The second measure was to avoid the use of coercion as much as possible by educating the local people to appreciate the benefit of sanitation and the observation of rules. L.J. Mothersil, Assistant District Commissioner, (Navrongo) stated that:

A solid foundation of education in the desirability of and necessity for sanitation must be laid down upon which to build in the future and at the same time the people must be taught methods by which they will not lose by adopting it. There is no question at present of imposing harsh penalties for neglect of sanitary overseer’s instructions. . . . The people must first be taught what to do and the value of doing it. . .<sup>19</sup>

Nonetheless, coercion was kept in the background to be used, and indeed was used, when necessity demanded it. The change in policy was formally introduced in April 1935 and many, if not majority of the medical officers, immediately implemented the new policy. Because of the paucity of sanitary overseers, the medical officers began

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<sup>18</sup> Gold Coast Blue Book 1918 p.c.14; 1919 p. c.14; 1921 p. c.14.

<sup>19</sup> PRAA Accra CSO 11/14/208 L. J. Mothersil to CCNT dd. 2.8.1934 Despatch No. 301/6/1928. S.F. 6 p. 2.

implementing the policy by carefully training illiterate men in simple sanitary methods.<sup>20</sup>

The involvement of the Native Authorities in sanitation and the training and use of illiterate sanitary overseers resulted in the tremendous improvement of the sanitary conditions of some of the districts. The improvement was particularly conspicuous in the provision of sanitary structures. In 1936 the Mamprusi Native Authority spent £70 in the provision of sanitary structures while the Wala Native Authority similarly constructed six permanent pit latrines at a cost of £60.<sup>21</sup> There was also an improvement in the supervision of sanitation within the confines of the respective districts. All Native Authorities had a reasonable number of village overseers who took charge of supervisory work. Above all, there were changes in the attitude of the local population and the chiefs towards sanitary measures. Many people were beginning to realise the essence of sanitation and to understand its purpose. Nonetheless because of the lack of skilled assistance as the village overseers lacked adequate skill, haphazard development of sanitary structures became the rule.

Thus the question of co-ordinating the various sanitary works embarked upon by the Native Authorities became a basic problem of preventive health work in the dependency. Up to the early 1940s harmonisation was effected by periodic visits of the various districts by the Senior Health Officer. As already stated, this officer was based in Kumasi. Each medical officer was also a medical officer of health.<sup>22</sup> In principle medical officers were expected to be in constant touch with the Senior Health Officer for guidance but this could not be done because, the medical officers were few

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<sup>20</sup> PRAA A CSO 11/14/208 Dr. C. W. Vaughan to L. J. Mothersil 12.5.1934 Despatch No. 46/n/34; ARNT 1936-37 p. 95.

<sup>21</sup> ARNT 1936-37 p. 94.

<sup>22</sup> Except at Tamale where a full time medical officer of health was stationed.

and consequently had tight work schedules in the districts. Nor could the senior health officer visit the Northern Territories as frequently as required. This was principally on account of the rather meagre funds voted for transport.<sup>23</sup>

In 1938, attention was drawn to the question of supervision and coordination of preventive health activities. This subject was prominent in a proposed policy statement presented to the government jointly by the Director of Medical Services and the Chief Commissioner of the Protectorate. A combination of options were suggested. It was suggested first, that the Senior Health Officer should be permitted to undertake more frequent tours of inspection to discuss local problems on the spot and give guidance. It was further suggested that a reliable sanitary superintendent should be stationed at Tamale. The Director of Medical Services proposed the elevation of the status of medical officer of health (Tamale) to “Superintendent of Sanitation of the Northern Territories”, a measure favoured by the Chief Commissioner, W.J.A. Jones.<sup>24</sup> To provide for the efficient execution of any sanitary measure decided upon, the D.M.S. further suggested the posting of Sanitary Superintendents, one to the north-eastern part of the Protectorate and another to the north-west. The D.M.S.’s suggestion was based on the conviction that, the arrangement could offer skilled assistance to District Commissioners and medical officers.<sup>25</sup>

A complementary proposal by Dr. W.M. Howell, deputy Director of Health Services, conceded the necessity for a sanitary superintendent for the Northern Province of the Protectorate. Dr. Howell’s proposal however conflicted with the

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<sup>23</sup> PRAA Accra CSO 11/1/427. Medical and sanitary facilities in the Northern Territories dd. 15.7.1938.

<sup>24</sup> PRAA A CSO 11/1/427. The superintendent of sanitation was to perform this role in addition to his ordinary duties as a medical officer of health for an allowance of £72 per annum.

<sup>25</sup> PRAA A CSO 11/1/427. The ultimate aim of the DMS was to have three sanitary superintendents in the Northern Territories: One at Tamale, one at Bawku for the North-east and a third for the North-west.

D.M.S.'s suggestion that the medical officer of health, should act as such in addition to his normal duties. Drawing on his experience as medical officer of health Tamale, Dr. Howell explained that, for the services of a medical officer of health in general charge of sanitation in the Protectorate to be of value, it was necessary to travel. This requirement was viewed as an impossible task by Dr. Howell because there was already ample work for a medical officer of health at Tamale and neighbouring districts.<sup>26</sup> By 1941, against the odds of the war, the problem of sanitary supervision was temporarily solved. By this time, three medical officers of health and three Sanitary Superintendents were available in the Protectorate. It appears however, that they were later withdrawn, as the war intensified, because by the mid 1940s, only one Sanitary Superintendent was available in the North.<sup>27</sup> Up to 1951, the difficulty of senior level supervision still persisted. It was however not so obvious as it was in the periods preceding 1930 because sanitary overseers were being provided from the sanitary training school at Tamale.

Although there were changes of emphasis in the approach to preventive health, no change of policy occurred. Policy remained as it was in the mid-1930s, preventive health being the exclusive preserve of Local Authorities. It was stated in the 1951 development plan that:

.... there is a pressing need for the improvement of health in the rural areas and it is hoped that local authorities will play an increasingly important part in rural health work and thus enable rapid progress to be made in the next few years. Ultimately, responsibility for all local health services must be transferred to the local authorities. . . the central government providing assistance with finance and the training of staff.<sup>28</sup>

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<sup>26</sup> PRAA A CSO 11/1/427, Deputy Director of Health Services to Senior Health Officer, Asante and Northern Territories dd. 7.1.1938. Despatch No. 93/7/1918.

<sup>27</sup> PRAA Tamale NRG 8/13/7 MOH (Northern Territories) to CCNT dd. 2.8.1949. Despatch No. 807/9B/34.

<sup>28</sup> The Development Plan, 1951 p. 18.

In a letter to the Chief Regional Officer in 1952, the acting Permanent Secretary of the Ministry of Health and Labour opined that direct intervention by central government, in the matter of provision of sanitary works would lead ‘...local Authorities to lean too heavily on the central government for the performance of functions properly their own.’<sup>29</sup>

#### 4.1 DISPOSAL OF REFUSE AND EXCRETA

The disposal of excreta and refuse became one of the major preventive health problems in the North which received much attention of the medical, and subsequently, health branch department. Prior to the inception of British rule, the local population stuck to rudimentary methods of disposal of refuse and excreta. Rubbish was heaped just a few metres away from compounds to form middens. Other forms of debris were left scattered all over the surroundings of the villages. Designated points for excreta was unknown to the local inhabitants. Any part of the village or town except areas too close to compounds was deemed appropriate for the disposal of excreta. In a conversation with the governor of the Gold Coast in 1903, the chief of Daboya told the former that it was customary to deposit excreta in any part of the village.<sup>30</sup> On his visit to Salaga in 1884 David Asante observed that great stretches of the town was ‘nothing but middens and rubbish heaps, half the ground in different places is to a great extent fouled by men and beast.’<sup>31</sup>

Though the colonial administrators detested the local people’s mode of refuse and excreta disposal and wished its discontinuance, no sophisticated alternative methods

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<sup>29</sup> PRAA Tamale NRG 8/13/7 Acting. Permanent Secretary (Ministry of Health and Labour) to Chief Regional Officer, Northern Territories dd. 23.7.1952. Despatch No. RX 10.

<sup>30</sup> PRAA Accra ADM 56/1/34 Meeting between Governor Nathan and chief of Daboya dd. 3.4.1903.

<sup>31</sup> Marion, *op. cit.* Acc. no. SAL 118/1.

were offered. Pan latrines were supplied for the use of Europeans. These were emptied at least twice a day. For the rest of the local people, pit latrines were dug and enclosed with mats during the dry seasons. In the rainy periods, the long grasses which grew around the pits served this purpose.<sup>32</sup> It seems there was no rule that guided the provision of pit latrines. Consequently, by 1910 pit latrines were in use at Bole, Gambaga, Salaga and Wa. A fundamental problem associated with pit latrines was that they could not be designed to last permanently. The pits easily became full, were demolished and new ones constructed year after year. In 1910, as many as 15 pit latrines were destroyed and new replacements erected at Bole.<sup>33</sup> Further, it was quite a difficult task to dig deep pits in many places because of the nature of the soil. The ideal thing to do perhaps was for the administrators to provide public pan latrine systems in the town.<sup>34</sup> The measure appeared less feasible because pan latrines required frequent removal and cleaning. Though labour was abundant, the health branch budget was too skeletal to permit the remuneration of the necessary labour force. The management of pan latrine was indeed a heavy task. The contents were removed and emptied in trenching grounds, necessarily of some distance from the latrines. Apart from Tamale where carts and bullocks were in use, thanks to the veterinary department, head loading was the rule in other stations.<sup>35</sup> Constant water supply was also required to allow washing of pans. While water constituted no problem in the rainy season, it was not easy to obtain during the dry season.

For the disposal of refuse, a sort of homemade distracters were provided in several

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<sup>32</sup> PRAA Accra ADM 56/1/419 Annual Report of the Medical Department, Gambaga 1904.

<sup>33</sup> GCMSDR 1910 pp. 94-5.

<sup>34</sup> Comparatively by 1910 more than 20 towns in the Colony used pan latrines; and by 1925, numerous pan latrines existed in the Cape Coast and Asante; there were about 104 at Accra, 74 at Kumasi and 50 at Sekondi.

<sup>35</sup> PRAA Accra ADM 56/1/405 ADMS to CCNT dd. 14.11.1925. Despatch No.6/20/24.

of the towns in which Europeans were stationed. But in the towns and villages not under European supervision efforts were made to enforce the burning of rubbish. Because compulsion rather than education often reigned, burning was seldom adopted except at the instigation of Europeans. Most local people habitually stuck to heaping rubbish along the periphery of towns and villages.<sup>36</sup> While it was not so much a problem to induce the local population to burn debris, pit latrines, it appears, were rarely used by the majority of Africans. That this was the case is obvious; indeed pit latrines at their best were fly nurseries. Notwithstanding that some of the latrines were lidded and fly trapped, it was common for people to refuse replacing lids provided. The hovering of flies rendered the use of pit latrine facilities uncomfortable. By the turn of 1930s, emphasis was beginning to be placed on the desirability of establishing the principle of grouping latrines and incinerators at designated places. The assumption which guided this principle was that persons carrying refuse most likely needed to make use of the latrine.<sup>37</sup>

From the mid-1930s, pit and pan latrines were being gradually replaced by septic tank latrines.<sup>38</sup> It appears, this type of latrine was in use in the Protectorate earlier than 1930; these were few and located principally, at schools, missions and hospitals. This facility was limited because, it required special attention and perhaps not regarded as practicable. Besides, the provision of many of them would require larger funding than the case of pit and pan latrine systems. From 1945, systematic effort was made toward the provision of septic tank latrines throughout the North. A suitable type of latrine was designed to match prevailing conditions of the North. This design was in the form

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<sup>36</sup> GCMSDR 1914 pp. 42-3.

<sup>37</sup> GCMSDR 1931-32 p. 26.

<sup>38</sup> Septic tank latrines were devised by A. L. Otway, MOH Sekondi but were allowed for public use first at Labadi and Teshie.

of a double unit, comprising 20 drop holes and capable of accommodating 600 people per day. The estimated cost per double unit was £500.<sup>39</sup> Like most post-1930 programmes, it was not proposed that government should wholly finance the capital expenditure of the septic tank latrine programme. Government initially resorted to an arrangement by which Native Authorities would provide half of the capital requirements from their own resources and the other half was provided by central government.<sup>40</sup>

Meanwhile, a schedule of the required septic tank latrines in the Protectorate was prepared by the Medical Department in 1945. Under the schedule, a total of 178 latrines were earmarked to be constructed. Below is the distribution of the facility.

TABLE 9 SCHEDULE OF SEPTIC TANK LATRINES IN 1945<sup>41</sup>

Town	Estimated Population	Required Number
Gambaga	1,251	2
Walewale	2,297	4
Nakpanduri	369	1
Navrongo	24,312	41
Bolgatanga	8,100	14
Wa	8,000	14
Bawku	18,000	30
Tamale	18,000	30

<sup>39</sup> PRAA Tamale NRG 8/13/4 Circular by Colonial Secretary, H .L. G. Gurney dd. 3.4.1945. Despatch No. 16/45.

<sup>40</sup> Ibid.

<sup>41</sup> PRAA Tamale, NRG 8/13/14 Circular by Colonial Secretary, 3<sup>rd</sup> April 1945, Despatch No. 16/45. The total number required and distribution was arrived at by dividing the estimated total population of the Protectorate by 600.

Savelugu	6,000	10
Salaga	3,200	6
Kumbungu	3,400	6
Prang	4,800	8
Yeji	800	2
Tolon	1,800	3
Diary	1,800	3
Pong-Tamale	2,000	4
<b>Total</b>		<b>178</b>

By November 1949, not many septic tank latrines had been constructed; not even a quarter of the impressive schedule of required latrines were in existence. Fiscal factors were the most important which militated against the provision of that facility. Given the estimated cost of £500 pounds per one 20 drop septic tank latrine and the financial base of the Native Authorities, and indeed, the other commitments of the local body, the task was simply beyond the capability of the traditional authorities. The fiscal factor was further exacerbated by the withdrawal in 1949 of central government's initial commitment to offer Native Authorities half of the capital cost. The commitment was withdrawn apparently because government realised that the arrangement was most likely to drain huge sums of money from the development grant; the very reason why government placed Native Authorities in the centre stage of developments in sanitation.<sup>42</sup> Another factor which retarded the growth of septic tank

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<sup>42</sup> PRAA Tamale NRG 8/13/4 Acting Colonial Secretary to CCNT dd. 5.4.1945. Despatch No.3721/S.F. 12/127.

latrine was a condition given by government that, the total requirement of latrines for any settlement be erected and brought into use at the same time. The condition was designed on account of the fear that, any number short of the total requirements would not stand the test of time; they would be overused and inevitably break down. Though the measure was well intended, it was beyond the means of the majority of the Native Authorities to proceed with the installation of septic latrines from their own resources.

From 1949, measures were being put in place to quicken the growth of latrine facilities. The first of these was the re-institution of the grant to Native Authorities by governor, Charles Noble Arden Clarke. A second measure, which was rejected, was a suggestion made by the Chief Commissioner of the Colony resident in Cape Coast. His suggestion was that, the building regulations under the Towns Ordinance be amended to make it obligatory for provision to be made for latrines in private homes. Though the Director of Medical Services appeared to be in favour of the suggestion, he doubted its practicability, particularly with the case of low-income groups. He objected to the proposal to compel owners of existing houses to provide such facilities because a majority of such houses possessed no space to embark on such conversions.<sup>43</sup> Another objection came from the Chief Commissioner of the Protectorate. He vehemently opposed the suggestion and argued that no single town of the Northern Territories had reached the stage where provision of latrines in dwelling houses could be made obligatory. He argued that not even in Tamale, the centre of administration was the proposed measure feasible.<sup>44</sup>

The decision to re-introduce the grant coincided fairly well with the growing purse of the Native Authorities and culminated in the proliferation of septic tank latrines in

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<sup>43</sup> PRAA Tamale NRG 8/13/4 DMS(R. L. Cheverton) to Chief Commissioner of the Colony, Cape Coast dd. 15.12.1949 Despatch No. 55/45.

<sup>44</sup> PRAA Tamale NRG 8/13/4 CCNT to DMS dd. 31.1.1950. Despatch No.0096/73

the North from the early 1950s. By 1952 as many as 14 septic tank latrines were available at Yendi.<sup>45</sup> But most unfortunately, several of the latrines were rarely inspected or even washed. They were often seen overloaded and became breeding grounds for flies. Apart from irregular supervision, many of the facilities appear not to have been constructed to set plans. Population figures seem not to have been given any serious consideration either; most of the Native Authorities constructed the toilets without expert advice from the Public Works Department, neither were medical officers of health consulted for advice. In 1952, serious consideration was given to devising measures to check the uncontrolled growth of latrines. Under rules made by the medical officer of health, it was illegal for any body to build septic tank latrines without the health officer's prior consultation. Type plans were hence to be strictly adhered to.<sup>46</sup> To ensure the efficient operation of latrines and minimum-to -no nuisance, it was insisted that they should not be used by more than the estimated daily number of persons (600).<sup>47</sup> The measure was necessary if the collapse of latrines was to be avoided. Alternative designs and styles of latrine were thought of in 1952. In that year government considered the construction of automated flushing water-borne septic tank latrines. This however failed to materialise because water was not available in sufficient quantity. Although government was poised to abolish the pit latrine system, these still existed side by side with septic tank systems and indeed the pan latrines.

Following at the heels of development in sanitary structures was the search for an ideal method to dispose of excreta and other waste. In the period up to the early 1930s,

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<sup>45</sup> PRAA Tamale NRG 8/13/17 Acting ADMS, Northern Territories to DMS dd. 16.1.1952. Despatch No. NT 36/61.

<sup>46</sup> PRAA Tamale NRG 8/13/17 MOH to District Commissioners dd. 20.11.1951. Despatch No. 6B/44.

<sup>47</sup> PRAA Tamale NRG 8/13/17ADMS to CRNT dd. February 1053. Despatch No. 36/88.

excreta from pan latrines, as stated elsewhere was carried by employed local labour and emptied in trenches designed for the purpose. Towns in which prisons were located, like Tamale and Zuarungu relied on prison labour. The disposal of excreta from pit latrine was rather simple and less costly. It was a practice, when drop holes became exhausted for the pits to be condemned and new ones constructed elsewhere. In 1927, the ADMS suggested the extensive use of mechanical transport in place of labour. No serious consideration was given to this probably because of cost.<sup>48</sup> In 1935, a new system of the disposal of excreta and organic refuse was evolved. It originated from the Agricultural Department of the Protectorate and was supported by the health authorities. By this system, compost was formed through the mixture of partially digested sludge and effluent obtained from septic tank and pan latrines and organic refuse. The mixture was then rotted down in shallow pits for between three to four weeks. The maiden experiment was carried out in Tamale at the central school.<sup>49</sup> A few months later, and after the first trial was successful, another experiment was carried out in the African hospital at Tamale.<sup>50</sup> Other small scale experiments were tried at Yendi, Lawra and in Bawku. In the case of Bawku, compost system remained to be the only method relied upon for disposing of effluent and organising refuse in towns.<sup>51</sup>

The use of composting was too slow to develop in the Protectorate but held promise in two ways. The system served as an antidote to fly breeding, a problem which had consistently bedevilled the previous modes of disposal of excreta and waste. The danger of fly breeding was minimal because, the method generated sufficient heat

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<sup>48</sup> PRAA Accra ADM 56/1/295 Minutes of meeting of the Northern Territories Public Health Boards at Tamale dd. 20.9.1927.

<sup>49</sup> ARNT 1937-38 p. 79.

<sup>50</sup> Ibid.

<sup>51</sup> PRAA Tamale NRG 8/3/69 Annual Reports(sanitary) 1938-39 p. 27.

in the process, capable of destroying helminth ova and the larvae of flies. Besides, the resulting compost was found to be of high manurial value and was utilised by the local people to improve the fertility of lands that were approaching exhaustion. This was more important in the densely populated areas of the Protectorate where land was not sufficient to permit shifting cultivation. By 1940 the demand for compost had risen because many farmers were beginning to appreciate the effect of compost in increasing crop yield.<sup>52</sup> Although water carriage sewerage system was introduced in 1923 and gained wide spread currency in some private homes in Accra and other towns through the years, no such development appears to have occurred in the North.<sup>53</sup> It can be said that, up to 1950 and perhaps after, compost method of disposal of excreta and refuse remained unchanged in the North. As stated in the preceding discussion, it was in 1952 that consideration was given to the possibility of constructing water-bone septic tanks. But the lack of water caused the idea to be shelved.

#### 4.1 PROVISION OF CLEAN WATER

The provision of adequate and clean water constitutes one of the general measures the colonial Medical Department used to reduce the development and spread of certain diseases. Prior to the inception of colonial rule in Northern Ghana, rainwater was the main source through which the local population obtained water for all purposes in the raining season; water from this source was often trapped from the grass roofs and stored in cisterns. Apart from rainwater, the local population equally relied on surface water: streams, lakes, rivers, ponds and wells. Some of the communities, like Gambaga relied also on spring water. Although wells were in use, these were not as

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<sup>52</sup> PRAA Tamale NRG 8/13/120 Health Branch Annual Reports 1940 p. 6.

<sup>53</sup> Addae, *op. cit* p. 140.

deep as those of today. For instance, the wells in use at Salaga were described as shallow funnel-shaped holes.<sup>54</sup> Deep wells were not in use largely because the local people lacked the requisite skills and suitable tools to handle the characteristically solid earth of the dependency.

Generally, except spring water, water from all the above sources was of unsatisfactory quality. Although rain water could be regarded as pure on account of its distilled nature, it was loaded with impurities of all kinds: from the grass roofs from which it was trapped and perhaps the smoke-laden atmosphere of the Protectorate. The least said about surface water the best. Water from this source was commonly exposed to physical and bacterial contamination of all sorts. Salaga in 1888 was reputed to have had the worst drinking water in the whole Volta area. Apart from its unwholesomeness, it appears the supply of water was only adequate during the rainy season. Between the month of November and March, water supply was generally scarce. Apart from the Volta River and a few of its tributaries which offered water perennially, all other rivers and ponds were dry. The implications of the state of water is clear; polluted water was responsible for many of the endemic conditions which endangered the health of the local people. Dracontiasis reigned supreme among the cases of endemics caused by drinking foul water. This disease was widespread in Northern Ghana.

When the British officially occupied the Protectorate in the early 20th century, two problems confronted them. The provision of not only adequate and sustained supplies of water but also ensuring its wholesomeness. Generally the question of securing adequate water was tackled first. This aspect occupied the attention of the political authorities up to approximately 1930. But between 1900 and 1910, concern was more

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<sup>54</sup> Johnson, *op. cit.* acc. no. SAL/18/2.

in seeing to the adequate supply of water for Europeans. Consequently, wells were dug close to the residences of Europeans in the Protectorate. Nonetheless wells were provided for the use of local people except that these were few and not as deep as those for Europeans. At Gambaga for instance, water level in wells of the local people became very low early in March.<sup>55</sup> On a tour of some parts of the Protectorate in March 1910, Dr. Fritz Beringer observed that water was generally scarce, prompting the African population to travel miles for it.<sup>56</sup> Although measures adopted by the political administrators could have been racially motivated, it was largely influenced by the absence of enough funds in the protectorate. It has been stated time and again that revenue generated from the territory was minuscule and most of it was expended on the opening up the area through programmes of road networks. Experts capable of handling wells were also absent.

After 1910, the supply of water to the Africans began to receive serious attention from the Gold Coast government. In that year, and for the first time, £500 was voted for the “improvement of water supply at outstations.” Arrangements to facilitate the improvement was made with the Director of Public Works, who was expected to help with skilled labour.<sup>57</sup> By 1927, vote for water had reached approximately £2,500, an increase by about 400%. There was however, no uniform provision of wells throughout the various areas. Sinking of wells was left entirely to the discretion of the District Commissioners. They were required to determine the needs of their districts and to request for the necessary funds from the Chief Commissioner. This arrangement offered an opportunity for the proliferation of wells in the Protectorate,

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<sup>55</sup> GCMSDR 1904 p. 27.

<sup>56</sup> PRAA Accra ADM 56/1/99 Medical Report of a tour through the centre and west of Gonja dd. 14.3.1910. Interestingly this situation has not been solved, a majority of the people still travel miles to obtain water.

<sup>57</sup> PRAA Accra ADM 56/1/89 CCNT to Acting. Colonial Secretary dd. 17.7.1909.

but many of them yielded little-to-no water. By the end of Guggisberg's administration, the Lawra-Tumu district had as many as 19 wells.<sup>58</sup> Similarly, Wa and Bawku had an adequate number of wells while Navrongo, had as many as 50 wells. These excluded seven others reserved for Government officials and another three for the White Fathers Mission.<sup>59</sup>

Other communities seemed not to have benefited from the well sinking programme of the government. Zuarungu was one such community. By 1929, this settlement had only two successful wells; both of 17 feet depth. Two wells sunk in 1928 collapsed.<sup>60</sup> Three wells sunk at Han in 1923 also collapsed.<sup>61</sup> Villages like Kologu suffered worse experiences. Here three wells were sunk in 1923 to the depth of 45, 36, and 33 feet respectively without finding water.<sup>62</sup>

The basic problem associated with the sinking of wells was the lack of experts and devices capable of locating areas of adequate water. Time and again, the political and health authorities had recommended the necessity of experts to deal with well sinking. Around 1928 Dr. H.O'Hara May called on the government to make provision for a special staff of four engineers who were experienced in the construction of small water supply schemes for settlements with population figures ranging between 500 and 5000.<sup>63</sup> Similar calls had been made earlier in 1920-21 by Dr. Alexander, Senior Sanitary Officer.<sup>64</sup>

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<sup>58</sup> PRAA Accra ADM 56/1/306 D.C Lawra-Tumu to Acting. Commissioner, Northern Province dd. 15.2.1929.

<sup>59</sup> PRAA Accra ADM 56/1/306 D.C Navrongo to Ag. Commissioner, Northern Province dd. 7.5.1929.

<sup>60</sup> PRAA Accra ADM 56/1/306 D.C. Zuarungu to Ag. Commissioner, Northern Province dd. 1.3.1929.

<sup>61</sup> PRAA Accra ADM 56/1/306 D.C. Lawra-Tumu to Commissioner, Northern Province dd. 27.2.1924; ADM 56/1/118 D.C. Lawra-Tumu to Commissioner, Northern Province dd. 9.4.1923.

<sup>62</sup> PRAA Accra ADM 56/1/306 Ag. Commissioner, Northern Province to CCNT dd. 22.2.1924.

<sup>63</sup> GCMSDR 1928-29 p. 37.

<sup>64</sup> GCMSDR 1920-21 p. 31.

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<sup>59</sup> PRAA Accra ADM 56/1/306 D.C Navrongo to Ag. Commissioner, Northern Province dd. 7.5.1929.

<sup>60</sup> PRAA Accra ADM 56/1/306 D.C. Zuarungu to Ag. Commissioner, Northern Province dd. 1.3.1929.

<sup>61</sup> PRAA Accra ADM 56/1/306 D.C. Lawra-Tumu to Commissioner, Northern Province dd. 27.2.1924; ADM 56/1/118 D.C. Lawra-Tumu to Commissioner, Northern Province dd. 9.4.1923.

<sup>62</sup> PRAA Accra ADM 56/1/306 Ag. Commissioner, Northern Province to CCNT dd. 22.2.1924.

<sup>63</sup> GCMSDR 1928-29 p. 37.

<sup>64</sup> GCMSDR 1920-21 p. 31.

These calls yielded results in 1936 when Arnold Hudson was governor. In that year investigation into water supplies in the Protectorate was started by the Public Works and Geological Departments. The main aim of the combined effort was to assess the feasibility of sinking wells in areas of the North where the shortage of water was most acute. On completion of the investigation by the Geological Survey Department, various schemes were to be formulated, upon approval of which supplies would be commenced under the control of a Northern Territories Water Board.<sup>65</sup> In April 1936, the investigations had been completed and government decided to establish a water supply section of the Geological Department. A scheme for the construction of 2167 wells and 28 dams within five years suggested earlier by the deputy director was to be followed. The total expenditure involved in the scheme was £30,000. In their bid to get the work expedited the Mamprusi and Dagomba local administrations pledged to supplement the vote by £800 excluding the payment of the salary of an additional foreman. Indeed in 1937, the two Native Administrations and the Gonja provided a total amount of £4,500 which formed over 50% of the sum available for actual construction.<sup>66</sup>

The establishment of the water supply division marked the opening of a new epoch in the history of water supply in the Protectorate. By the end of 1939, many new wells were dug, old ones improved and a new dimension, the impounding of dams, emerged. Savelugu and Yendi were among the first towns to benefit from the use of dams.<sup>67</sup> In areas where it was difficult to locate suitable well sites and where the population was

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<sup>65</sup> GCMSDR 1935-36 p.5; 1937 p.27. No traces of the existence nor operation could be found. This suggest either the Board was not established or if it were, it played no significant role in water supply.

<sup>66</sup> ARNT 1937-38 p. 81.

<sup>67</sup> GCMSDR 1939 p. 5; PRAA Tamale NRG 8/5/69 Annual Report(sanitary) 1938-39 pp. 25-6.

not sufficient to warrant the provision of a dam a subterranean cistern was provided.<sup>68</sup> Alongside the provision of wells, the water supply section of the Geological Survey Department offered training in the techniques of constructing dams and wells to some selected men of the Native Authorities. This aspect of the work of the Geological Survey Department was significant not only because it speeded up water supply works; it was also important in the sense that it aided in the provision of wells and dams in some small villages outside the purview of the water supply section's operations. Principally on account of the out-break of the Second World War, the water supply section of the Geological Survey Department could not proceed further than it had done before the commencement of the war. During the course of war the work of the department was limited to the maintenance and repair of existing supplies.<sup>69</sup> By the end of the war, it was clear that the improvement and extension of water supply had not received the deserved attention and hence remained an outstanding need of the Protectorate.

The period between 1944 and 1950 saw changes and improvement in the provision of water supply. The principal change was administrative. The responsibility for supervising the provision of water was assigned to a newly formed temporary Water Supply Department and, later, to the Department of Rural Water Supply. The new body was initially intended to be temporary because, it was estimated that most of the minor but important water works it was to deal with would be completed within a period of seven years. However, no sooner had the department commenced activities than it became obvious to governor Burns that progress would be slow. Indeed,

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<sup>68</sup> ARNT 1937-38 p. 82. The subterranean cistern was known popularly as the biliga by the local people. This technology was not new; it was known before the local peoples' contact with the British.

<sup>69</sup> GCMSDR 1943 p. 6.

qualified men and the necessary materials and equipment were yet to be available.<sup>70</sup> The new organisational set-up was not required to deal with major schemes of any kind. It was essentially responsible for the provision of adequate water to “villages and rural communities.”<sup>71</sup> The major schemes were reserved for the Public Works Department.

In many respects the activities of the new body was not any different from the previous body, the Geological Survey Department. The sinking of new wells and the desilting of old ones became its major pre-occupation. Nonetheless, by all standards, the wells sunk by the newly constituted body were an improvement upon those provided in the earlier periods. The wells of the mid-1940s were deeper and protective walls were erected to raise the opening above ground level. This development was significant because it prevented rainwater and other running water from draining into the wells. Because explosive devices were employed, many of the wells were over 50 feet deep. In parts of the Protectorate where the ground was shale and mud stone, and seemingly unsuitable for wells, small shafts of 60 feet were sunk and adequately shaped at the base to form storage wells.<sup>72</sup> This was an improvement of the ‘biliga’ hitherto constructed in the 1930s. It could be said that by the close of 1950, Northern Ghana was adequately provided with wells. The table below illustrates this:

TABLE 10 GROWTH OF WELLS 1946-1950<sup>73</sup>

<b>District</b>	<b>1946/47</b>	<b>1947/48</b>	<b>1948/49</b>	<b>1949/50</b>	<b>Total</b>
Mamprusi	16			20	36
Gonja	6	33	-		39

<sup>70</sup> GCMSDR 1944 p. 6.

<sup>71</sup> PRAA Tamale NRG 8/8/6 Memo by the Governor on the new water supply Department, Colonial Secretary to CCNT dd. 20.4.1944. Despatch No. 3673/149.

<sup>72</sup> Report on the Department of water supply 1947-48 p. 4.

<sup>73</sup> Report on the Department of Water Supply 1947-1948 p. 4; 1948-49 p. 2; 1949-50 p. 2.

Dagomba	105	86	80	21	292
Kete Krachi	-	12			12
<b>Wa</b>					
Wala sub district	87	-	-	-	87
Tumu sub district	-	41	1		42
Lawra sub district	79	37	6	-	122
Total	293	209	87	41	630

As the above figures indicate, in pursuit of its programmes, the department of water supply was principally confined to the Dagomba, the Lawra and Tumu sub-districts. It was not deliberate. They appear to have benefited minimally from the 1930s well sinking programme because of the impermeable nature of the grounds. Thus, when the water programme commenced after the war with the necessary equipment it was only logical that preference be given first to the areas where the water problem was severest.

As part of its programme of improving access to water supply, the department embarked on the construction of reservoirs. Reservoirs were constructed, mainly in the Tumu, Lawra, and Wa areas. Given good rainfall, these reservoirs could hold enough water to safeguard against long spells of drought in the dry season.<sup>74</sup> Wary of the danger of contaminating the catchment areas of reservoirs, draw-offs were fitted, cattle watering provided and the catchment areas were adequately fenced.

The first town in the Northern Territories to obtain pipe borne water supply was Tamale, in March 1932. Prior to this, supply of pipe borne water was strictly confined to important towns of the Gold Coast. By the beginning of 1927 however, it became evident that pipe borne supply was a necessity in the Protectorate. It was necessary because, the supply of pipe borne water at Accra, Sekondi, Takoradi and Winneba had

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<sup>74</sup> *Ibid.* All the six reservoirs had water carrying capacities ranging from 2,500,000 to 23,800,000 gallons.

brought beneficial effects to the health of the people by way of decrease in infant mortality and water borne disease.<sup>75</sup> Indeed water borne diseases predominated in cases seen at the Tamale African hospital in 1930; the highest of these being guinea worm, enteritis and dysentery. Other areas in the North equally demonstrated a similar trend. Pipe borne water supply was necessary also on account of the rising population and the attendant potential risk of contamination of existing water resources. According to the census of 1921, Tamale had a population of about 3,901. From then on, Tamale town developed rapidly reaching an estimated population of 12,000 by the beginning of 1930.<sup>76</sup> Tamale was also considered first because complexities in administration had caused the increase of European population in that town. Although the need for pure water in Tamale became a source of anxiety for the political administrators in the Protectorate, it was clear from pronouncements made by governor Guggisberg that the North was to remain without piped water until after 1932 when Kumasi and Cape Coast had been catered for. In his address to the Legislative Council, Guggisberg intimated that, “. . . the places requiring these supplies are so numerous, and the construction is so costly, that a reasonable time is needed. Government was incapable of undertaking more than the completion of those of Cape Coast and Kumasi in the next five years.”<sup>77</sup>

While it is evident that large sums of money were required to provide pipe borne water, the finances of the Gold Coast were not in so bad a state as to preclude Tamale from obtaining adequate pure water. From 1919-20, there had been a consistent increase in revenue (except in 1921; revenue in that year was £3,016,520 reaching

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<sup>75</sup> These towns had pipe borne water supply by 1925. See Addae *op. cit.* p. 133.

<sup>76</sup> Gold Coast Blue Book.

<sup>77</sup> GCLCD 1927-28 pp. 121-2.

£4,116,442 in 1925-26.<sup>78</sup> In each of the years, (except 1921-22) surpluses ranging from £500 to over £900,000 were recorded.<sup>79</sup> It is therefore obvious that reasons other than fiscal motivated Guggisberg in his programme of water supply. As stated in the preceding chapter with reference to the governors' hospital construction policies, he was more interested in improving towns of commercial merit. This is evident in Head IV of the ten-year development programme.<sup>80</sup>

When Ransford Slater became governor in July 1927, the scheme of providing Tamale with pipe borne water supply was seriously pursued. Preparations for the scheme commenced in 1929. Slater had anticipated that provision would be made in the estimates of 1930 financial year for the project. But from 1930, and on account of the depression, the financial position had undergone a complete change, necessitating government to exercise rigid economy. During the period of the depression the available financial resources of the country were largely reserved for the completion of works to which government had already committed itself. Under such circumstances, Slater had a genuine case to defer the scheme. Ransford Slater and G.C. Du Boulay (Acting Governor in 1930) did not defer the Tamale project.

Slater sought assistance from external source. In May 1930, an application was sent through the then Secretary of State to the advisory committee of the Colonial Development and Welfare Fund. Government requested a sum of £40,000 (estimated capital cost of the scheme); £20,000 as a direct grant and the other half as a direct loan. Government pledged to refund the loan in five annual instalments with an interest (as fixed by the advisory committee), beginning from the date of completion of the

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<sup>78</sup> GCLCD 1927-28 p. 168.

<sup>79</sup> Ibid.

<sup>80</sup> GCLCD 1927-28 pp. 265-6, 273; Provision was made for only Accra, Sekondi, Winneba, Cape Coast and Kumasi.

intended supply scheme. Contrary to the wish and expectations of Slater, the committee declined to consent to any free grant towards the scheme. It recommended that the whole cost be met by a loan to be repaid within ten years. The loan was not to attract any interest for the first three years, but subsequently it was to attract an interest rate of 5% per annum.<sup>81</sup> These terms were accepted by government, and on the 26th March 1932, the Tamale water supply was inaugurated by the Chief Commissioner of the Protectorate.<sup>82</sup>

Until the late 1940s, Tamale remained the only town in the Protectorate with pipe borne water supply. The other towns relied mainly on wells and reservoirs. The scheme for the provision of pipe borne water in the rest of the North commenced in the mid 1940s. It was inaugurated and pursued by governor Alan Burns. In 1946 approval was given for the construction of piped supplies at Pong-Tamale and Bolgatanga; a year later another one was approved for Yendi. It was not until 1951 that these schemes were completed and clean water supplied. A common factor appears to have militated against the early completion of the schemes: the difficulty of obtaining the required plants and materials. The plants and material necessary for the Bolgatanga and Pong-Tamale were ordered in 1946. By the end of 1949 some of the items had not yet arrived. Work on the Yendi water supply for instance was delayed because the pressed steel tank service reservoir which had been ordered had not been received. Several factors motivated and aided Burns in the prosecution of his Northern water supply scheme. By the beginning of the 1940s, the concept that the North constituted a burden and drain on the resources of the south had gradually been discarded. Way was given to a more pragmatic attitude to the Protectorate. The

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<sup>81</sup> Minutes of the Legislative Council and Sessional Papers, 1930-31: Despatches relating to the Tamale water supply scheme pp.4-8.

<sup>82</sup> PRAA Tamale NRG 8/8/1 Programme for the opening of Tamale Water Works dd. 26.3.1932.

change in attitude is evident in a statement made by the governor in the Legislative Council in 1946.

Everyone in the Colony, in Asante, in the Northern Territories and Togoland, pays taxes in one form or another, and it is not fair on the people in remote villages and in the country districts that taxes they pay should be used to provide special amenities for the inhabitants of Accra, Kumasi, Cape Coast, or Sekondi. The citizens of the four municipalities expect certain amenities and they are entitled to them - but not at the expense of other tax payers, most of whom have no amenities at all. Money raised by general taxation, direct or indirect, must be spent for the general community and not to provide special amenities for the citizens of the four largest towns.<sup>83</sup>

Burns' water supply scheme in the North was therefore seen as part of his desire to distribute amenities in the Gold Coast fairly.

Complementing the general change in attitude towards rural areas was the favourable financial conditions of the country immediately after the Second World War. From £3,734, 438 in 1939-40, the revenue of the Gold Coast had shot up to £7,171,618 by the middle of 1946. In 1949-50, revenue had further risen steadily to £198,106,495.<sup>84</sup> Indeed with funds readily available, nothing could stop Burns in extending pipe borne supplies to the North. A third important factor was the assurance of recouping the capital outlay and maintenance cost from the beneficiaries of the supplies. It appears the institution of a water rate at Tamale in the early 1930 attracted resistance from the local people. It was interpreted as an extra tax. To go round this, in the 1940s the water tax was incorporated into the ordinary tax local people paid and were familiar with. Thus rather than pay a water levy and a tax separately, the latter was slightly increased to include the water levy. This feat assured the government of recouping the capital invested in piped supplies with relative ease. As revenue continued to increase, subsequent governments followed Burns' programme although with difficulty.

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<sup>83</sup> GCLCD 1946 p.4.

<sup>84</sup> Metcalfe, *op. cit.* p. 751.

## 4.2 HOUSING AND TOWN PLANNING

One aspect of preventive health in which the colonial government was fairly successful was housing and town planning. However, the notion of housing and town planning as understood by the British was alien to the people of the North. The housing centre of the North consisted of compounds which stood among patches of farms and grazing land. Covering the patch of land within the compounds were a network of winding foot paths of approximately 18 inches wide. The compounds basically consisted of a set of round rooms constructed of swish with either conical thatched roofs or flat swish roofs. Though there were openings which served as windows, these were designed for purposes of securing light into the room and not for ventilation purposes as the openings were too small to serve as adequate ventilation inlets. Closely associated with poor ventilation as a feature of the local architecture was overcrowding in compounds. In fact each of the compounds could contain between 12 and 20 round huts of about 11 feet in diameter and as many as six persons on average lived in each hut.

Unquestionably these structural designs and arrangement of dwellings constituted breeding ground for germ multiplication and hence epidemic outbreaks. The cerebro-spinal fever germ, menigococcus was particularly known to thrive favourably under conditions of poor ventilation and overcrowding. This germ multiplies conducive in the nose and throat. Under overcrowded and poor ventilation condition congestion is caused in the mucous membrane of the nose and throat and the germ becomes easily transferable under these conditions; its virulence increasing as the germ is transferred from one person to another. (This is why it had the character of sweeping whole families). The issue of poor ventilation and overcrowding was becoming complicated

with the increase in population and consequently growth of towns. Indeed the growth of towns and population under the traditional architectural designs and styles coupled with unorganised arrangement of structures posed serious health problems.

To a great extent the measures pursued by the colonial administration to curb the prevailing situation were legislative in nature and directed towards creating an adequate sanitary environment. The first of these legislative measures was passed in 1908. In that year, rules were made by R.A. Irvin (then acting Chief Commissioner) with particular respect to the regulation of Tamale township. Under the rules, it was an offence for houses to be built without permission obtained from the Provincial Commissioner. Sites and plans of buildings similarly required the Provincial Commissioner's approval. A committee comprising the medical officer, inspector of works and the chief of the town was formed. It was assigned the task of conducting special inspections of towns and Zongos once a month to ensure that the set rules were adhered to.<sup>85</sup> The rules were principally designed to be applied to Tamale in principle, but copies of the building permit used in Tamale were circulated to most of the towns in the Protectorate as a measure to ensure uniformity. Salaga and Yeji for instance were obliged to adhere to the established rules in 1909.<sup>86</sup> The question of the architectural design and structure of buildings had been seen and known by government since the inception of British colonial rule in the Protectorate. Furthermore, powers were given to the governor as early as 1902 to make laws capable of safeguarding the Protectorate in whatever dimension. Why did the political authorities have to wait until after nine or so years before rules were made to control buildings? The explanation is clear. The traditional designs were not seen to pose any

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<sup>85</sup> Gold Coast Gazette Jan.-June 1909 p. 92; PRAA Accra ADM 56/1/92 Handing over Reports, Southern Province, March 1909.

<sup>86</sup> PRAA Accra ADM 56/1/92 Handing over Report, Southern Province dd. March 1909.

serious health problems initially. It was the outbreak of the cerebro-spinal meningitis epidemic of 1906-1908 that alerted government to the implications of the existing building designs of the traditional population. C.S.M. as it was discovered, occurred indoors and not in the open air like smallpox did. In effect the epidemic largely exposed the weaknesses of the indigenous design of houses.

Though the rules of 1908 were well intentioned, and indeed purposeful, it is apparent from records that some towns hardly, if at all, adhered to them. Yeji, a town in the Southern Province, was one such town noted for wilfully disregarding the set rules.<sup>87</sup> A possible cause of non-compliance of rules was the method employed in enforcing adherence. As indicated, in the earlier periods of colonial administration persuasion and education hardly formed part of the tools designed to enforce compliance; the rule of prosecution prevailed. The local people were not made to understand why the construction of buildings had to be controlled. Granting that the use of force was ideal, the penalty meted out for non-adherence appeared mild as offences under the rules were under the jurisdiction of the chief. Poor supervision also caused the ineffective operation of the rules. The interval of inspection (once a month) allowed for the inspection committee was long. Moreover, the members constituting the committee, particularly medical officers, were pre-occupied with tasks far in excess of the duties of their office. Nonetheless, defective though these rules proved to be, they paved the way for the institution of more imaginative measures in subsequent years.

Noticing the ineffectiveness of the supervisory network set to police the application of sanitary rules, a new sanitary committee was formed in May 1913. This body had

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<sup>87</sup> Ibid.

the Provincial Commissioner as its president, with the Provincial Medical Officer, sub-inspector of works, and commandant of the Northern Territory Constabulary (N.T.C) as members. The task of this committee was not so different from the previous one. It was assigned among other things the duty of approving sites for building and supervision of the construction of roads in the towns and cantonments. Unlike the 1909 committee, the sanitary committee of 1913 met once a month to deliberate on important issues of relevance to town planning. By 1916 however the committee had become defunct.<sup>88</sup> The cause of the collapse of the committee is not told, but it is possible that the frequent transfer of officials of the Northern Territories was a contributory factor. Transfers were particularly common among the ranks of senior officers like medical officers and commissioners. Most stayed not more than two years. Coincidentally, the medical officer was responsible for taking and keeping minutes of the sanitary committee. Under such circumstance and as was obvious, his transfer might have stalled monthly meetings. It is equally likely that the commencement of the First World War in 1914, a year after the committee was formed contributed to its demise. During the war, it could be said that, about 50%, if not more, political and medical officers were either drafted into the fighting forces or withdrawn to augment the staff of the Colony.

The next important development in housing and town planning in the Protectorate occurred in July 1921, when Arthur James Philbrick was Chief Commissioner. In that year a set of new rules to be applied in the whole Protectorate were passed. Under them specific attention was given to the required distance between detached buildings as well as collective compounds. Emphasis was placed on the necessity of providing drainage outlets for each detached house or compound. All these were under the

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<sup>88</sup> *Ibid.* Handing over Report, Southern Province dd. 15.4.1919.

surveillance of the chiefs and headmen and not a committee as prevailed in 1909. The rules further empowered the Chief Commissioner to lay out streets and open spaces, where no buildings were to be constructed.<sup>89</sup> The rules of 1921, like the previous one, were influenced principally by the widespread outbreak of the cerebro-spinal meningitis in 1919/20 and guided by the recommendations of Drs. J.M. Dalziel (senior sanitary officer) and Dowdall, who investigated the 1919 and 1920 outbreaks respectively. Dr. Dalziel declared that:

The Social and domestic habits of a people cannot be altered in a generation either by Statute, precept or example. The unhygienic type of dwelling, to which they are accustomed is not likely to be voluntarily replaced by any thing better, nor can they be expected voluntarily to adopt even that most elementary reform and first step towards civilization, viz., the removal of domestic animals from the dwelling, much less to build houses reasonably open to the air. The only form of education in sanitary matters which might be apprehended by them would be sanitary rules and by laws gradually applied.<sup>90</sup>

It can be said that up to the passing of the rules of 1921, the Gold Coast central government did not play any significant role in the development of housing and town planning. All the measures resorted to were initiated by the political and health officials resident in the North. Indeed, considering the budget within which the authorities operated at the time, and given the paucity of town planning experts, it is only obvious that no substantial progress could be made.

Towards the end of 1921, when Guggisberg was governor, central government began to see the necessity of housing and town planning schemes in the Protectorate. In his ten-year development plan, Guggisberg gave prominent attention to town and housing planning. The governor noted: "In practically every town of any size the necessity for improvements in sanitation brings with it the demand for considerable

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<sup>89</sup> The Laws of Asante, The British Sphere of Togoland and the Northern Territories of the Gold Coast p.266.

<sup>90</sup> Minutes of the Legislative Council and Sessional Papers p. 7, 18.

alterations in buildings and streets”, a demand Guggisberg described simply as unlimited. The policy Guggisberg followed was to concentrate efforts on those towns whose rapidly growing population caused grave dangers of epidemic.<sup>91</sup>

One of Guggisberg's main measures was the formation of Health Boards. The first of these was the Central Board of Health. It was headed by the Principal Medical Officer with the director of public works, secretary of works, senior sanitary officer and the superintendent sanitary engineer as its other members. It was mainly an advisory body assigned the task of initiating discussions and suggesting measures considered desirable for the general benefit of the colony. Among the range of issues the board was empowered to discuss was town planning and housing. In particular the board was expected to consider plans for “large or important buildings” but more importantly, plans for buildings intended to be adopted as standard plans for the country.<sup>92</sup> In October 1920, Guggisberg approved the appointment of Provincial Boards of Health, in the Colony, Asante and the Northern Territories. The Northern Territories health board had the Chief Commissioner as president. Other members were the Provincial Medical Officer, junior sanitary officer and the principal engineer. This board was responsible for the roles assigned to the central board in the Protectorate. The formation of these provincial boards did not lead to the dissolution of sanitary committees; these were maintained but subordinated to the provincial board and worked in complement.<sup>93</sup>

It appears the work required to be done in the North on housing and town planning could not be handled effectively by a single board centred around Tamale on account of the vast nature of the Protectorate. Consequently in 1921, the Provincial Board of

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<sup>91</sup> GCLCD 1920-21 pp. 46ff.

<sup>92</sup> Gold Coast Gazette July-Dec. 1920 p. 1219.

<sup>93</sup> Gold Coast Gazette July-Dec. 1920 p. 1396.

Health was renamed Northern Territories Central Board of Health and two other provincial boards were formed: one for the Southern Province and the other in the Northern Province. Each consisted of the Provincial Commissioner, as president, the medical officer and an engineer of Public Works Department. These two provincial boards were specifically assigned the task of selection of sites for government stations, designing of layouts of the station buildings, water supply, streets and roads.<sup>94</sup>

A significant achievement of the boards was the survey and layout of some towns. Tamale was the first town to be surveyed and laid out. By 1929, layouts had been made in the Moshi Zongo and Tishugu areas. A small township containing all schools was carved out on the ridge to the north of the Tamale town.<sup>95</sup> Considerable progress was also made in laying out of roads.<sup>96</sup> Layouts were also made in Bawku, Savelugu, Bolgatanga, Lawra, Wa and Bole by 1938. Another area of improvement which emerged under Health Boards was housing design. Indeed by 1925, the type of houses built in the North, particularly Tamale were gradually changing in design and structure. Houses were largely oblong with many windows replacing the hitherto round and ill-ventilated ones.<sup>97</sup>

From the beginning of the 1940s, through to 1950 and after, government continued to guard against congestion in towns. Existing township rules were modified to suit changing conditions and the boards were enlarged and continued to operate as the major bodies responsible for decongestion. A town planner was appointed for the first time in the 1950s for the North.<sup>98</sup>

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<sup>94</sup> PRAA Accra ADM 56/1/295 Government memorandum on town layout and building designs in the Northern Territories dd. 5.7.1921.

<sup>95</sup> This is known as Educational Ridge where almost all the institutions of higher learning are located.

<sup>96</sup> GCLCD 1927-28 p. 131; GCMSDR 1929-30 p. 45.

<sup>97</sup> PRAA Accra ADM 56/1/64 ARNT 1925-26 p. 16.

<sup>98</sup> PRAA Tamale NRG 8/13/20 Draft order by the chief Regional officer dd. 30.8.1952. By 1956, a detailed building regulation of 32 pages was designed by the Tamale Sanitary Board.

Though impressive, on the average, developments in housing and town planning layouts were not without odds. One major shortfall in development of town decongestion measures was that the layout did not extend to pre-existing congested area. Extending layouts to such areas was a potential source of rancour. It would mean that the existing houses would have to be demolished. And as poverty was a general feature of most inhabitants of the Protectorate, unless government offered to reconstruct, rebuilding would constitute a heavy and unbearable task for the local people granted that decongestion of such areas was a necessity. Against this background, town and housing layouts were meant for only new settlements.

#### 4.3 CEMETERIES AND BURIALS

The regulation of cemeteries and burials was one of the preventive health problems colonial government took seriously in the Protectorate. Except for a few towns, designated areas to serve as cemeteries were not popular in the Protectorate prior to European settlement. What seemed a universal phenomenon was for the dead to be buried within the enclosures of the various compounds in graves which appeared to be shallow. It was also common in most settlements in the Protectorate for a single grave to be used for multiple burials through the years. While different reasons account for these burial systems religious interpretations dominate. The concept was that, the dead still formed part of the living family. As such it would perhaps amount to disassociating the dead from the living if buried in locations outside the confines of the compound. Another explanation for this custom is that, local people wished to protect the dead from being desecrated by hyenas and other animals which habitually, exhumed and devoured corpses as these were deposited in shallow graves. This culture of burial was a potential source of epidemic outbreaks.

Professor Simpson was among the first to draw government's attention to the necessity of registering deaths and controlling burials in 1908. Simpson observed that, with the indigenous culture of burials, government was denied the necessary information required in determining the eruption of infectious diseases or the treatment of an epidemic. He warned that as long as the defect was not rectified and continued to persist there was the danger of epidemics acquiring such a firm foothold that even the most sophisticated and rigorous measures could not contain them.<sup>99</sup> Not much attention was given to Simpson's advice, because the strength of health personnel in the Protectorate around 1908 could not undertake such a task. From 1910, measures were gradually put in place to control burials. One of such measures was instruction to the local people to bury the dead in the bush well away from the villages. Yeji and Kulaw are examples of towns given such instructions by Dr. Fritz J.A. Beringer (medical officer, Salaga) in 1910. The medical officer however declined to insist on the use of the measure in some towns because " . . . it was thought useless, on a first visit, to insist on too many, to them, sanitary novelties."<sup>100</sup>

Nonetheless, by mid-1914, some towns had laid out organised cemeteries. Tamale and Salaga had cemeteries even before February 1914. By this date, a new African cemetery was opened to replace one that was exhausted at Tamale. A new cemetery divided into plots was also opened at Bole.<sup>101</sup> No force seems to have been used for the layout of cemeteries, neither was it obligatory for all burials to be made within the confines of the designated cemetery layouts. Hence some local people, particularly

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<sup>99</sup> PRAA Accra ADM 56/1/11 Simpsons Report on Plague in the Gold Coast 1908.

<sup>100</sup> PRAA Accra ADM 56/11/99 Medical Report on a tour through the centre and west of Gonja dd. 14.3.1910.

<sup>101</sup> PRAA Accra ADM 56/1/124 Tour of inspection in the Southern and North-western Provinces of the Northern Territories dd. 19.7.1914; PRAA Accra ADM 56/1/167 Provincial Medical Officer (F. Harper) to CCNT dd. 12.2.1914. No. 35/21/1914.

chiefs, refused to bury in these designated cemeteries to the dissatisfaction of the medical authorities. One such medical personnel who expressed displeasure was Dr. Harper, Provincial Medical Officer. Dr. Harper observed, in September 1914, that the chief of Tamale and others had a “legitimate desire to bury their dead in places other than the ordinary cemetery.” He wondered why no rule existed to deter them from proceeding with this practice. He was also surprised that the Towns and Public Health Ordinance No. 13 of 1892 was not applied in the Northern Territories. Dr. Harper called on the Chief Commissioner to invoke his powers under the Northern Territories Administration Ordinance and to make rules applicable to cemeteries. The Provincial Medical Officer demanded that the rules if made should have a wider application to include Yeji, Salaga, Yapei, Daboya, Bole, Wa, Lawra, Tumu, Gambaga, Bawku, Navrongo and Zuarungu.<sup>102</sup>

In October 1914, the Chief Commissioner, acted on Dr. Harper’s wish and accordingly set rules which made the provision of cemeteries by chiefs obligatory. In default, chiefs could face a penalty of a fine not exceeding £5. Under the rules, any other person apart from chiefs who buried or caused to be buried corpses outside designated cemeteries was liable to a penalty not exceeding imprisonment for two years.<sup>103</sup> All the rules received the government’s approval except “rule six” (The rule making it obligatory for chiefs to bury in cemeteries). The Colonial Secretary did not see the wisdom in applying this rule in view of the fact that by native customs, some local people, particularly the Wala, Lobi, Dagaaba and Gurunshi, buried their chiefs’

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<sup>102</sup> PRAA Accra ADM 56/1/167 Acting, Provincial Medical Officer to CCNT dd. 5.9.1914. Despatch No. 202/10/14.

<sup>103</sup> *Ibid* Rules as regards to cemeteries in Northern Territories dd. Oct., 1914. Even today few chiefs are buried in cemeteries in the country.

eldest son and head wife inside the chiefs' compound.<sup>104</sup> The Colonial Secretary's doubt was confirmed in findings of a study of the possible reactions of the local people to the rules. As the findings revealed, not only was the custom of burying in compounds or close to compounds nearly universal, but also that the chiefs were very unwilling to have the custom restricted. In the opinion of District Commissioner, Lawra, if it were insisted on, there was the likelihood of the increase in the concealment of sickness and deaths, indeed, the basic reason for which control of burials was necessary. Nonetheless, under rules made in 1921 to guide chiefs, provisions were made for the regulation of burials except that the rules appear not to have been enforced.<sup>105</sup>

Another important measure used to control burials and cemeteries was the Births, Death and Burials Ordinance of 1891. Under this ordinance central government was empowered to layout public cemeteries. This ordinance was first applied in the Northern Territories to Tamale and Salaga in 1929 and subsequently over the years to the other towns. From the late 1940s sites were carefully selected in the various districts for cemeteries and by the beginning of 1951 the ordinance had been applied to many towns and "public cemeteries" were created. Other categories were the "chiefs cemetery" and "private cemeteries." While any ordinary person could bury a relative within the precinct of the public cemetery, the facility was specifically designed for the non-aboriginal population living in the Protectorate. To ensure that the required depth of graves was adhered to, sextons, and gravediggers were employed and paid by government. Provision was also made for the periodic maintenance of cemeteries.<sup>106</sup>

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<sup>104</sup> PRAA Accra ADM 56/1/167 A.R Slater( Col. Sec.) to CCNT dd. 16.11.1914. Despatch No. 10126/M.P 19882/14.

<sup>105</sup> Laws of Asante, The British Togoland and The Northern Territories of the Gold Coast p. 266.

<sup>106</sup> PRAA Tamale NRG 8/1/334 Principal Registrar of Births and Deaths and Burials to Col. Sec. dd. 18.3.1948. Despatch No. 884/22/41.

One major problem the central government had to contend with was the maintenance of public cemeteries. A recurring reason given by the chiefs and headsmen for the burial of corpses in compounds was the wish to protect these corpses from the desecration by wild animals. To allay this fear and to encourage the use of public cemeteries government expended funds in providing fences around each public cemetery. However, as the cemeteries were growing gradually government was beginning to show reluctance to bear the increased costs. In 1927 for instance government could not provide £280 required for the fencing of three cemeteries at Tamale because revenue generated from burial fees could not salvage the situation.<sup>107</sup> During 1933-34, £60 was spent on maintaining the Salaga cemetery, whereas revenue for the period amounted to just £14.14.<sup>108</sup>

From 1935, political officers were beginning to consider other options of financing the cost of cemeteries. The first and indeed definite option which gained attention was the relinquishing of the responsibility to the Native Authorities. The suggestion, it appears was first proposed by the District Commissioner of Gonja in October 1935 with reference to the Salaga African cemetery. By this arrangement, the District Commissioner felt "Government would save money."<sup>109</sup> The medical officer of health, Tamale who perhaps held a clear picture of the implication of the handing over of cemeteries to Native Authorities, did not regard this measure as feasible at the point in time.<sup>110</sup> Although no explanation is given, it is possible that the medical officer took into consideration the fact that the Native Authorities were still in the teething stage of their development, thus perhaps piling so much responsibilities on them could lead to

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<sup>107</sup> PRAA Accra ADM 56/1/167 DDSS to DMS dd. 30.11.1927. Despatch No. 4552/66/1927.

<sup>108</sup> PRAA Accra ADM 56/1/167 District Commissioner, Gonja to Acting. CCNT dd. 21.8.1935. Despatch No. 510/91/1935.

<sup>109</sup> *Ibid.*

<sup>110</sup> PRAA Accra ADM 56/1/167 MOH, Tamale to CCNT dd. 28.10.1935. Despatch No. 266/7/1934.

the renegation of public cemeteries or even the premature extinction of the local bodies. But in 1948, the principal registrar of births, deaths and burials insisted that the control, administration and maintenance of cemeteries be handed over to the local bodies. For the second time, the suggestion was rejected by the Chief Commissioner who was supported by the Colonial Secretary. Rebuffing the suggestion, the Chief Commissioner intimated:

I consider that, as the financial commitments of Native Administrations have very much increased in the past few years, and as they will inevitably continue to increase even if no further functions are assumed by them, the Native Administration should now confine their activities more and more on developmental activities.<sup>111</sup>

This resolution was maintained until around 1951-52 when Local Authorities assumed the responsibility of establishing and maintenance of public cemeteries.

Thus mainly on account of the allocation of insufficient funds to the Protectorate governors could do nothing but limit sanitary surveillance to the European and constabulary enclaves. The kingpins of sanitation in the areas other than European settlement were the chiefs and headmen, but because they were weak and not respected by the local population, chiefs failed to execute their task efficiently. This necessitated the institutionalisation of force as a means of maintaining sanitation in the Protectorate. This measure did not yield any dividend either as the number of sanitary offenders continued to increase yearly. In the mid-1930s, a change of policy ensued to systematically educate the local people about the necessity of maintaining a decent environment. This policy change coincided with the emergence of Native Authorities who eventually became the main facilitators of the new policy as government gradually transferred the handling of sanitary matters to these bodies.

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<sup>111</sup> PRAA Tamale NRG 8/1/344 Ag. CCNT to Col. Sec. dd. 23.8.1948. Despatch No. NT. 0288/19(2).

## CHAPTER FIVE

### MEDICAL AND HEALTH STAFF TRAINING

This chapter deals with the training of health and medical personnel and the evolution of training facilities. For obvious reasons the development of training facilities of medical officers and dispensers does not form part of this discussion.<sup>1</sup> What is of concern here is, in the main, training of sanitary overseers and inspectors, nurses and midwives. From the beginning of the Medical and Health Department in the North to approximately the mid 1930s no training facility of substance had been established. Health and medical staff of all categories who worked in the North were mainly Europeans and Africans of southern extraction who had been trained in the colony.

Why it took the government so long to begin the training of Africans from the Protectorate is not difficult to surmise. The first is that it was thought unnecessary to establish such training facilities here. It may be recalled that medical and health policy had been designed essentially for the European population, the few clerical staff and the Northern Territory Constabulary. As such it was thought that the staff trained from Accra could adequately meet such requirements. Even if government had resolved to provide health training facilities, no trainer could have been obtained for the purpose. Sanitary superintendents like nursing sisters were barely adequate for the Colony. The third consideration that perhaps explain why no provision was made for training facilities was paucity of trainees. The basic qualification pursuing any course in health service was a standard VII certificate. However, this calibre of pupils was practically

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<sup>1</sup> Facilities for the training of this calibre of staff was mainly in Accra. No evidence of their training in the protectorate could be found.

non-existent. Indeed between 1929 and 1937 the average number of pupil who had passed the standard VII examination was only eight; not even an adequate number of them could be obtained for training in Kumasi and Accra.<sup>2</sup> Above all the funds provided by central government to meet expenditure in the Protectorate to cater for training facilities was by all standards minuscule.

### 5.1 TRAINING OF SANITARY INSPECTORS

By the mid-1930s it became apparent that the provision of training facilities could no longer be held up, particularly the training of sanitary staff. This had been necessitated by the opening of stations that made the health task difficult for the few available health and related personnel. It had also become the policy around this time to extend health care to the general African population-the serious implementation of which would require additional staff. Besides, the policy of using force had given way to that of persuading the local population through education. Indeed, effectively educating the local people required not merely augmenting of health staff; it also meant recruiting staff of Northern extraction who understood the languages of the dependency and could be used to overcome the communication gap which hitherto existed between the coast dominated paramedical staff and the illiterate local population.

The need for sanitary staff was so urgent that some enthusiastic medical officers began to train personnel locally on their own. One of such doctors was Dr. G.W. Vaughan, medical officer of Navrongo. With the support of Mothersil, Assistant District Commissioner (Navrongo), a week's course was given to boys to prepare them as sanitary inspectors. The course was largely practical oriented and involved only an

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<sup>2</sup> R. B. Benin A History of Education in Northern Ghana 1907-1975 (Accra: 1990) p. 91

hour of theory on the necessity of pit latrines, emphasising the danger of hookworms and their spread. The practical aspect involved the actual construction of pit latrines under the supervision of one Mr. Osei, then the mosquito inspector. The medical officer was careful not to overburden trainees with complicated explanations and therefore the course did not cover the construction of water supplies and control of mosquito larvae. Explaining the wisdom of this measure, Dr. Vaughan noted: " I feel that more will be gained by establishing one aspect of sanitation at a time than by expecting them to be fully fledged sanitary inspectors at one fell swoop."<sup>3</sup> No rigorous admission requirements were deemed necessary. Chiefs from the surrounding villages without compulsion were required to send a man each for training. Because of these precautions the chiefs were not averse to the programme although some appeared keener than others. When the course commenced only twenty-two trainees were obtained from twenty-six chiefs. On completion they were provided with a "badge of office" and employed as sanitary overseers by the Native Authorities on a monthly salary of 7/6d.<sup>4</sup>

Although the Chief Commissioner lauded the training scheme and wished other districts of the Protectorate adopted it, it appears the scheme was not adopted anywhere else in the Northern Territories. Most of the districts continued to rely on village overseers trained by the senior health officer in Kumasi. The scheme was not adopted because of the lack of keenness and interest of the medical officers in the surrounding districts. It is possible that fiscal problems were also responsible for the non-adoption of the scheme. By 1935, a year after the scheme commenced, Native Authorities were

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<sup>3</sup> PRAA-A CSO 11/14/208 Dr. Vaughan to Assistant District Commissioner (Navrongo) dd 12 May 1934 46/N/34.

<sup>4</sup> Ibid.

in their embryonic stages; as such only a few of them had enough resources. In Navrongo itself where the scheme originated, it appears the very training given by Dr. Vaughan was the last.<sup>5</sup>

The principal reason why Dr. Vaughan's experiment was allowed to die was the commencement of a school for the training of village overseers at Tamale in 1938. This school was built to include a hostel by the Public Works Department at a cost of £1,200 with the funds provided by the Native Authorities. It was run by a part-time teaching staff and offered an initial six-month's course. This was followed by refresher courses lasting between one to two months from time to time.<sup>6</sup> Candidates to the school were generally of poor educational standards, principally due to the paucity of standards VII boys from the schools of the Protectorate. The unpopularity of health work and indeed the less attractive prospects offered by the Native Authorities drove the best candidates to other more lucrative and comparatively more attractive jobs. In 1939 the school turned out 19 sanitary overseers for the various Native Authorities of the Protectorate. The number dropped to 16 in 1940.<sup>7</sup> The school was constructed principally to aid in the implementation of government's policy of gradually appealing to the conscience of the local people about the need for sanitation rather than resorting to brute force which yielded no visible dividend. For the effective education of the local people it was deemed expedient to use people of Northern extraction who understood the nature of the local people better than Europeans and Africans of southern origin. On account of uniformity and ease of training the Director of Medical Services, Dr. Duff favoured the training to be done at Accra. However, trials revealed

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<sup>5</sup> There has been no reference to the continuation of the scheme after 1934 in the records.

<sup>6</sup> GCMSDR 1935-36 p 28; 1938 p 38.

<sup>7</sup> GCMSDR 1939 p 7; 1940 p 8.

that Accra and Kumasi were not good for boys from the North because they were looked down upon by people at the coast.<sup>8</sup> By the late 1930s, sanitary staff requirements appeared adequate as regards Africans. For example Gambaga alone had four African sanitary overseers while Yendi had three.<sup>9</sup>

Regardless of the benefits derived from the training programs, it appears the school was closed down by 1947. Two reasons account for this. Firstly, there was the absence of a training officer. Mr. N. S. Elliot, sanitary superintendent who had commenced the training program was withdrawn from the protectorate. The closure of the school was also motivated by the contention that the Native Authority sanitary overseers served no useful purpose.<sup>10</sup> From 1947, the Northern Territories Territorial Council began advocating the re-opening of the school. Members of the council argued that it was important to have trained persons to teach the local people good hygiene and sanitary habits. It was further contended that the existing sanitary overseers in the protectorate were few. The council questioned the wisdom in importing sanitary overseers from the Colony when "these people from the south" do not know the languages of the area. The use of locally trained overseers who understood the language and perhaps the culture was deemed a better option.<sup>11</sup> Well aware of the dearth of standard VII certificate holders, the council suggested the admission of lower standard boys until enough standard VII pupil were available. Although the Chief Commissioner was in favour of the arguments of the council and commended the suggestion regarding the temporary admission of pupils below the level of standard VII, he warned: "...I don't want you to go with the idea that being a

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<sup>8</sup> PRAA-A CSO 11/1/427 Note on the Medical and Sanitary facilities in the Northern Territories 15 July 1938 p 6.

<sup>9</sup> PRAA-T NRG 8/3/63 Annual Reports (Sanitary) 1938-39 p 21.

<sup>10</sup> PRAA-T NRG 8/13/7 MOH(NT) to CCNT dd 25 October 1948 No. 9B/34.

<sup>11</sup> PRAA-T NRG 8/13/7 Extracts of Minutes of NT Territorial Council Meeting 17 December 1947.

sanitary overseer is something which can be done properly by someone with very little education." The Chief Commissioner made it known that public health was an important issue that required skill, consequently people without a reasonably high level of education were potentially not capable of carrying out the ideal functions of a sanitary staff.<sup>12</sup>

In 1948 the medical officer of health responsible for the North, Dr. B. B. Waddy also supported the re-opening of the school. Waddy argued that it was even well overdue for the existing sanitary officers to go for refresher courses to gain new knowledge. He pointed out that notwithstanding the educational level of the rural population it was necessary to have people to take charge of prosaic jobs, such as preventing mosquito breeding in houses. Although the M O H admitted that government was responsible for the systematic attack of epidemic diseases, he argued that after such campaigns were conducted there were many jobs connected with the prevention of recurrence which could be undertaken by the Native Authority overseers. In the opinion of Waddy the curriculum of the school should be rural biased and hence it was necessary for the trainer not only to be full-time but also to be familiar with the prevailing local problems to be tackled.<sup>13</sup> Waddy's opinion was based on his conviction that sanitary overseers needed encouragement to perform effectively. Accordingly, it was suggested that the school should be run on an English terminal basis with two or three terms a year. If this were done it would enable the trainees to return home during breaks while the sanitary superintendent could travel round and offer practical instructions to the trainees.

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<sup>12</sup> PRAA-T NRG 8/13/7 MOH(NT) to CCNT dd October 1948 No. 9B/34.

<sup>13</sup> Ibid.

While the Director of Medical Services was convinced of the rationale for re-opening the school, it was not done until 1952, principally due to the unavailability of a sanitary superintendent. In a letter to the ADMS in August 1949 the acting DMS could not foresee any possibility of sanitary superintendents being posted to the Protectorate because no recruits had presented themselves from Britain. While a policy had been laid down for the gradual promotion of locally trained inspectors to the rank of sanitary superintendents, the measure prohibited any great increase from this source.<sup>14</sup> It was in October 1951 that a Sanitary Superintendent was appointed and the school unofficially opened on the same date and was renamed Health Education Centre. The change in name was intended to reflect the educational and instructional role of its products. At a conference in Accra in 1952 it was decided that the school be known as School of Hygiene for the sake of uniformity with those in Accra and Kumasi.<sup>15</sup>

The reopened school differed from the previous experiment of 1938 in many respects. In the first place, its course was designed for three years; and the syllabus was approximate to that laid down by the Royal Sanitary Institute for the Sanitary Inspector's examination. Other themes like elementary surveying, elementary science and English were also taught. While the inclusion of English was intended to improve the pupils' level of expression, surveying was taught in anticipation of making products of the school responsible for town and village layout. Elementary science formed part of the course because of its bearing on hygiene and potential of it equipping pupils with basic explanation of disease causation. Instruction was not wholly theoretical; a practical method was integrated and included demonstrations, visits and district

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<sup>14</sup> PRAA-T NRG 8/13/7 Ag. DMS to ADMS (Tamale) dd 10 Aug. 1949 No. 295/54.

<sup>15</sup> PRAA-T NRG 8/13/7 Sanitary Superintendent i/c Health Education Centre to CCNT dd 17 October 1951 No. 25/010/51.

inspections. Obviously this arrangement ensured that the trainees had a foretaste of the work they were expected to perform on completion.<sup>16</sup>

Another area of difference between the two institutions was in qualification and selection procedures. Applicants were expected to possess the standard VII certificate and selection was based on written and oral examination conducted by a selection board. Rigidity was however not a rule. Qualification and selection procedures were waived for existing experienced Native Authority staff who had worked as sanitary overseers but lacked the standard VII certificate. The recruitment procedures were set high not only because the Medical Department targeted the standards of the Royal Sanitary Institute but it was based on the decision of the central government's drive to train men who would be teachers and instructors on all health issues to meet the changed approach to sanitary matters. As stated elsewhere, from 1935 government resorted to the use of persuasion through education rather than force as a means of sanitising the area. Indeed it was considered necessary to eradicate from the minds of the local people the bon mot "summa summa" as applied to sanitary overseers.<sup>17</sup> Standard VII certificate holders were the corps of people who were deemed capable of pursuing this objective.

The above stringent recruitment qualification hitherto set was relaxed when the school opened in 1952, principally because the paucity of standard VII certificate holders persisted. Initially the problem was not so great because recruits were drawn from the sanitary overseers who had been given the six months course in 1938 and had acquired valuable experience. When this caliber of entrants had been exhausted and

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<sup>16</sup> PRAA-T NRG 8/13/7\_Memo by training officer School of Hygiene dd 10 Feb. 1953.

<sup>17</sup> This term represented the existing populations view of the duties of Sanitary overseers/inspectors; summons.

the need arose to obtain standard VII certificate holders these could not readily be available as only few senior schools had been established. The object of education in the Protectorate as Bening pointed out was the provision of education up to standard III; training of pupils beyond this standard was effectively regulated so as to turn out a number that could immediately be absorbed into available employment vacancies. In line with this objective before 1947 government provided for only one senior school at Tamale. The products of this school regarded sanitary supervisory jobs with disdain. The majority preferred the teaching profession. For example out of twelve boys who attained standard VII level at the Tamale school in 1937, six opted to be teachers, three became clerks and only two entered training as dressers.<sup>18</sup> Preference for teaching was not only due to the dignity acquired as a teacher but principally because of the remuneration obtained. The salary of a sanitary overseer who had been in service between 12 and 14 years was £96 per annum, while beginners received remuneration as low as between 30 and 40 pounds per annum.<sup>19</sup>

While the school continued to function, one thing became clear: either the salary of its products would be reviewed upwards or the institution would collapse. In 1951, the acting ADMS (Tamale) took up the issue of salary seriously. In a letter to the Chief Commissioner he declared:

. . . men trained in the health training centre will be highly trained, and ought to receive a salary in the same way commensurate with that of their colleagues in the south. I believe that this principle has been accepted in respect of teachers, and since I cannot admit that the work of trained health men is less important than that of teachers the same principle would seem to apply.<sup>20</sup>

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<sup>18</sup> ARNT 1937-38 p.61.

<sup>19</sup> PRAA-T NRG 8/13/7 Officer-in-charge School of Hygiene to CCNT dd 8 Jan. 1952 No.1/ p.107. Comparatively a second division teacher earned up to £122 after about four or five years in the profession in the 1930s. See Gold Coast Blue Book 1931-32 p. 148.

<sup>20</sup> PRAA-T NRG 8/13/7 Acting. ADMS(Northern Territories) to CCNT dd 27 Oct. 1951 No. NT. 102/51.

The fear of the assistant director was that if there was no appreciation of sanitary inspectors' salaries it was highly unlikely they would return after training to work for the Native Authorities. Although the Chief Commissioner admitted that salaries were low and would have to be improved, he did not take any action because a committee, the Wallie and Erzuah Committee set up to conduct inquiries into the issue of teachers' salaries had not completed its work.

Ironically, while by 1953 the prospect of further recruitment was not encouraging and was certain to remain so, extensions were beginning to be made to the school building. The extension was intended to provide more classrooms to cater for an annual intake of twenty-five students and a laboratory. As long as the service conditions were poor and the rate of pay low the training school had to contend with second-rate entrants who even were not forthcoming. From 1953 the health training officer resorted to touring middle schools trying to interest boys in the profession of sanitary inspector.<sup>21</sup> It appears no progress was made with this measure because admission continued to be uncompetitive. A majority of the boys seemed to prefer nursing training because this profession held promise in terms of service conditions and salary.

## 5.2 TRAINING OF NURSES AND MIDWIVES

Up to 1938, no training facilities existed in the North for the training of nurses and midwives; neither was any arrangement made for their training elsewhere in the Gold Coast. The prevailing practice was for nurses and midwives to be trained in the Colony then posted to serve in the Protectorate. There appeared to have been no need to open any training centre in the North because the hospitals that required their services were

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<sup>21</sup> PRAA-T NRG 8/13/7\_CRNT to Health Training Officer dd 27 Feb. 1953. No. NT. 04/9/78.

few: particularly around the early 1920s. For instance, in 1921, only the Tamale African hospital had an attendance level that merited the assistance of a nurse and by this date the hospital had three nurses. The other hospitals made do with untrained attendants.<sup>22</sup>

The idea of the training of nurses and midwives in the North was probably mooted first in 1926, by Dr. Oakely the Assistant Director of Medical Services. In his tour of inspection Dr. Oakely, noted with disappointment that untrained boys acted as attendants in the majority of the hospitals. He preferred to see trained African nurses at all stations in the protectorate, and yet was aware that the supply from the larger hospitals could not cope with this demand. He recommended a scheme where a training establishment would be initiated at Tamale as in the larger hospitals on the Coast to train boys from the Protectorate as nurses. It however appears that the political authorities did not favour Oakely's recommendations. This was probably due to the anticipation of initiating the Medical Assistants and Nurse-Dispenser scheme. In 1938, and for the second time Dr. Duff, the Director of Medical Services, raised the issue of training in the Protectorate again. This idea formed part of the general measures that Duff thought would aid in the improvement of health delivery. According to him, ". . . a big step forward would be possible if educated north country girls could be trained at Tamale as midwives for their own people."<sup>23</sup> Discussions were held with the Chief Commissioner of the Protectorate on a plan to construct a midwives' hostel at Tamale. Duff's idea was necessitated by two principal factors: although unrecorded it was obvious that maternal and infant mortality was high. It appears also that midwives and nurses were reluctant to accept posting to the North.

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<sup>22</sup> Gold Coast Blue Book 1921 p. 85.

<sup>23</sup> PRAA-A CSO 11/1/427 Notes on medical and sanitary facilities in the Northern Territories p. 7.

They regarded their services in the Protectorate as an exile of sort, because they were deprived of the "good things of life".

In 1927, the Secretary of State appointed a committee to formulate a scheme for the establishment in British West Africa, of a college for the training of medical practitioners and the creation and training of an auxiliary service of Medical Assistant. Following the committee's recommendations, Dr Inness, DMSS designed a scheme for the training of Medical Assistants in 1928. Inness' scheme which intended to produce a total of 250 Medical Assistants at Korle- Bu involved an expenditure of £73,000 on school buildings and a recurrent cost of £95,250 by the time the Medical Assistants had completed the programme. Unfortunately, Dr. Inness' designs failed to materialise because the World Depression had so affected the country that the scheme for a medical college had to be suspended. Meanwhile, governor Slater insisted on the extension of the village dispensary system, which of course meant that an alternative mode of obtaining staff to match the extension was urgently required. Thus in November, 1929 a new simplified scheme whose purpose was to train up to 80 fully qualified dispensers by the mid-1940s to act as assistants to the medical officers and to administer first aid was evolved. This scheme received the Secretary of State's approval and became known as the Nurse-Dispenser Scheme. This scheme, as it turned out also failed to meet the full aspirations of both the colonial government and medical authorities. Five years after the inauguration of the scheme only 14 nurse-dispensers had graduated, a number far less than the 40 nurse-dispensers expected. Given this critical scenario, it became imperative that nurses from the Protectorate should be trained to man the growing number of health facilities the Medical Assistants and nurse-dispensers were expected to have fulfilled. Dr. Duff's idea remained dormant until the 1950's when the training of midwives in the North began in earnest; training

of nurses had started a little earlier. The dormancy was due to the insufficient supply of local candidates with a sound degree of education, particularly females; a problem that had earlier caused the closure of the Sanitary Overseers' Training School in the 1940's.

Against the background of insufficient educated candidates the Chief Commissioner, W.J.A. Jones proposed the training of a few illiterates or semi-illiterate women in asepsis. Jones hoped to obtain these from households of chiefs and the White Fathers. He believed that though their knowledge of English was limited they could be taught domestic and personal hygiene and also taught to give simple advice and treatment.<sup>24</sup> Due to the impracticability of the suggestion no attention was given to it by the Medical Department. Dr. Duff favoured the option of waiting until such a time that a small supply of females was available. Nonetheless, by the beginning of 1938, the Mother Superior of the White Fathers Mission (a trained nurse) began giving instructions in personal and domestic hygiene to the pupils of the mission school. However this move was not designed to train them as nurses or midwives; but for their own personal good.<sup>25</sup>

An important measure towards the training of Northerners in nursing was made in 1945 when a training college was opened at Kumasi. This college was designed to cater for pupils with varied levels of educational background. The progression was from a post primary period of one year, through a preliminary of four months, to a general nursing course of three years. By this structure it was hoped to produce nurses with a standard of training equal to that given in Britain.<sup>26</sup> This arrangement was significant because it offered the opportunity for North country pupils particularly girls who

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<sup>24</sup> Ibid.

<sup>25</sup> ARNT 1937-38p. 61.

<sup>26</sup> GCMSDR 1946 p. 6.

hardly went beyond primary school level. However, the decentralised nature of the college and its courses made it difficult for pupils from the North to gain easy access. Indeed, the post-primary training period of one year, an essential aspect of the whole programme was held at Achimota College at Accra while the other aspects were pursued in Kumasi. It was a costly venture to undertake and competition was also high. In the mid 1940's, the Kumasi Nursing College was the only nursing training centre ran effectively. Difficulties in obtaining building materials had delayed the expansion programme of the Nursing Training School at Korle-Bu in mid-1940s. Indeed, of the twenty vacancies for January 1946, there were between 300 and 400 applicants.<sup>27</sup> On the basis of this competition and limited places, a high academic performance was used as criterion of selection; a qualifications which eliminated most candidates from the North.

Pupils from the North began gaining access to the Kumasi Nurses' Training School only from the 1950s principally because by 1949 the rehabilitation of the Nurses' Training School at Accra had been completed and training had commenced. In 1949 this college had an enrolment of 130 students, 42 students less than its capacity which created more vacancies at Kumasi.<sup>28</sup> From 1950 vacancies were open for the training of female pupil nurses at the Kumasi general hospital. Applicants were to be either Asantes by birth or from the Northern Territories and holders of at least, the primary school leaving certificate who were above fifteen years. Under this training arrangement, pupils were first required to work as 'candidates under trust' for three months after which their suitability as pupil nurses would be determined.<sup>29</sup> As to

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<sup>27</sup> PRAA-T NRG 8/13/7 Acting. DMS to CCNT dd 28 Dec. 1945 No. 1266B/334.

<sup>28</sup> GCMSDR 1949 pp 7-8.

<sup>29</sup> PRAA-T NRG 8/13/7 ADMS (Northern Territories) to Regional Public Relations Officer (Tamale) dd 27 nov.1950 No. NT 14/166.

whether this opportunity was exploited, we are not told; but it is most likely that the chance did not elude the officers in the North. The ADMS declared in a letter to the DMS that: " There were so few girls of Northern Territory extraction with sufficient educational qualification for training that every opportunity should . . . be taken to train as fully as possible, these suitable ones." <sup>30</sup>

In 1951, and for the first time, the acting ADMS sought and received authority to start the training of nurses at the Tamale Central Hospital. The ADMS deemed it necessary to establish nursing training schools because, he observed in that year that hospitals in the Protectorate were under-staffed if the normal standards were seriously adhered to.<sup>31</sup> It appears the ADMS was also motivated by the growing potential of available girls holding the standard VII certificate. In 1942 a girls' senior school was opened by the White Fathers at Navrongo but was transferred to Jirapa a year later. This school gained recognition in 1947 from the Education Department. In 1947 another senior school for girls was started at Tamale. On account of this, and perhaps the desire to turn out quality nurses, standard entrance requirements were set for the training schools. Applicants were required to be holders of standard VII certificate, of Northern lineage and be between the ages of 17 and 20 years. The training was designed to last three years. Girls who completed this course were entered for further training as midwives. These finally qualified as " Nurse-Midwives."<sup>32</sup>

In 1952, a midwives' training school was begun at Jirapa. The establishment of this school was not the realisation of any long-term plan as was typical in the South. The idea of a Nurses' Training School at Jirapa emanated from Dr. Cheverton, Principal

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<sup>30</sup> PRAA-T NRG 8/13/7 ADMS (Northern Territories) to DMS dd. 1 Mar. 1951 No. 5/ Vol.3/ 1150.

<sup>31</sup> This requirement was one nurse per every three beds. Yendi hospital for instance had five nurses manning thirty-six beds.

<sup>32</sup> PRAA-T NRG8/9/13 Ag. ADMS (Northern Territories) dd. Oct. 5 1951 No. NT. 34/41.

Medical Officer in 1951. While on a visit to acquaint himself with the health activities of the White Fathers Mission, Cheverton observed the presence of three Catholic Sisters (working as attendants in the Hospital) who were registered nurses; but of different nationalities. The idea to open a Nurses' Training School came up when the Principal Medical Officer visited the Jirapa Middle School run by the White Fathers where he was immediately impressed by the population of girls in attendance. With the potential of good material from the school and the availability of qualified nurses, Dr. Cheverton suggested the commencement of a training school for either nurses or midwives to absorb some of the middle school's products.<sup>33</sup>

The transformation of this idea into practice became the responsibility of Sister Cyprian (Mary Catherine Swales), a Scot registered nurse and midwife. After feasibility studies were made by a Miss Caulfield permission was given and a midwifery training school was officially started on 2nd February 1952. From the beginning the school was not enclosed; it was conducted under a big and shady tree, with just a black board and a few books. By 1953 when the midwifery school was running smoothly, Sister Cyprian relentlessly pursued Dr. Cheverton's twin idea of establishing a nursing training school. In January 1954 permission was granted and the training of Qualified Registered Nurses (QRN) began at Jirapa. Indeed even before this date, the training of nurses and midwives was offered at the Bolgatanga Hospital through government sponsorship.<sup>34</sup>

The gradual growth of nursing and midwifery training facilities in the North had two effects:- one positive and the other, negative. In the first instance the development

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<sup>33</sup> A personal memoir of the first Christian missionary among the Dagaaba and Sissala of North West Ghana; Remigius F. Mc Coy.

<sup>34</sup> Ibid.

fostered an increase of the number of nursing staff in the Protectorate. On the other hand, because graduates of these training schools were employed by government their salaries were higher than those who worked for the Native Authorities. This seems to have diverted the attention of most of the school leavers to nursing training, and therefore denied other areas, like the School of Hygiene (Tamale) of applicants. From 1953/54 for instance there were no candidates to fill vacancies in the Tamale School of Hygiene necessitating the invitation of candidates from the south to attend.<sup>35</sup>

Thus in the early stages of the Medical Department of the Protectorate, the need for regional health and medical training facilities was not felt as the focus of medical attention was the Europeans. Because they were few in the Protectorate, health and medical personnel were often imported from the coast. The need for training facilities in the Protectorate emerged in the 1930s when the area of administration was gradually out-pacing the number of para-medical staff. Health facilities were becoming widespread and the local people's quest for European therapy was growing. But because the success of regional health and medical training depended largely on the availability of averagely educated pupils who were difficult to come by, the serious take-off of the training of sanitary staff and nurses had to wait until a fairly adequate number of pupils were turned out from the Protectorate's educational institutions in the 1950s.

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<sup>35</sup> GCMSDR 1954 p. 17.

## CONCLUSION

The study of the development of health and health services in Northern Ghana clearly show that prior to the dawn of British administration the people had been living with a variety of diseases such as malaria, smallpox, guinea worm, tropical ulcers and trypanosomiasis. Others like tuberculosis, syphilis and gonorrhoea were introduced into the Protectorate during the colonial period mainly through labourers who were recruited from the region. The local people had also developed their concepts and mode of handling some of the numerous diseases prevalent in the area. Disease was largely conceived to be caused by supernatural forces although natural causation was not totally ruled out. As a consequence treatment was based mainly on appeasing these supernatural forces who had caused the disease. The people also relied on the use of plants and animal material. Knowledge of the aetiology of disease was virtually unknown. Hence treatment was mainly directed towards expunging the physical characteristics of the ailment.

In 1901, British colonial administration supervened and the first western style health service facility was started at Gambaga. From then on hospitals became a common feature of Northern Ghana's health delivery system. While the health of the inhabitants remained a problem, efforts by the colonial authorities at resolving these, was characterised by a bias towards the southern parts of the country, particularly the coast. Even Ashanti which effectively came under colonial occupation at the same time as the Northern Territories was many years ahead of it in terms of health service developments. This disparity, a clear feature of the period up to 1930, is evidenced by the evolution of hospitals, dispensaries, maternal and child welfare services. Regardless of who was governor, hospitals and dispensaries in the Northern Territories

in general remained in dilapidated conditions throughout a substantial part of the period of study. Although there were a few decent hospitals and dispensaries they could not match those of the south. An equally glaring illustration of bias is found in the number of medical officers and other health workers. There had been no occasion when Northern Ghana received adequate medical staff. The few who volunteered to serve in the Protectorate lived under deplorable conditions; conditions which were in sharp contrast with the situation of their counterparts in Ashanti and the coast. Nonetheless, mainly because of ignorance and their conception of disease being a condition which hindered their capacity to conduct daily affairs, Africans were generally reluctant to avail themselves of European medical care up to the mid 1910s. When they did, it was normally after traditional therapy had failed, by which time the disease had reached its most advanced stage.

Developments in preventive health explicitly show a similar picture of bias. Although sanitary problems existed throughout the country, colonial authorities in the Protectorate concentrated on European areas where strict sanitary measures were pursued, leaving Africans to grapple with inferior sanitary structures. Excreta and refuse disposal methods in areas where Africans resided were so rudimentary and the local people so reluctant to follow them that force in the form of prosecution had to be resorted to. While a larger chunk of the population of the Protectorate for instance depended on rain water and water from rivers and a few wells, often shallow and dry for long spells, pipe borne water was provided for some coastal towns. It was only after these towns were adequately catered for that Northern Ghana obtained its first pipe borne water network at Tamale in 1932 under governor Ransford Slater. After this maiden attempt, the provision of pipe borne supply was deferred until the 1940s.

Similarly, until the 1950s when a town planner was appointed for the first time, housing and town planning were not seriously pursued although it was apparent that the structural designs of houses played a significant role in the outbreak and spread of epidemics in Northern Ghana.

The contrasting development in curative and preventive health services between the Protectorate of the Northern Territories and the rest of the Gold Coast occurred because of a controversial concept held by the policy administrators that each division of the Gold Coast should develop according to its means. This concept worked against the North because at that time the area possessed hardly any resource of economic value. And because government was reluctant to spend money beyond what was generated in the Protectorate, the medical authorities resident there, who merely played the role of policy implementers, were compelled to limit medical attention to the Europeans, African members of the colonial administration and the constabulary. Until Clifford's administration, catering for the health of the local population was not a priority of the colonial set-up.

While this concept gradually disappeared because of the role labourers from the Northern Territories played in the generation of wealth in the mines and cocoa plantations, the disparity still persisted because, periods of economic boom in the Gold Coast economy coincided with policy priorities directed at the south. While there was a steady growth of revenue in the Gold Coast between 1919 and 1927 Guggisberg relegated the North to the background. Ironically policy initiators who understood the plight of the North often faced the problem of lack of funds. Slater was one such governor who sympathised with the Protectorate but whose effort to uplift the status of health facilities was frustrated by the economic depression of the 1930s.

The health of the North became a matter of great concern to the colonial authorities only from the mid 1930s, under the governorship of Hudson. Although not much was done in terms of physical structures, for the first time it was conceded that health and health services development needed to be planned. This coincided with the period when the Native Authority administration system began to gain widespread acceptance and Native Treasuries became a common feature of these bodies. The emergence of these bodies brought tremendous development in health and health service in Northern Ghana. While they supported all facets of the health of the local people, it was in the area of provision of dispensaries, health centres, well water supply and indeed general sanitation that their contribution was most profound. The number of dispensaries in Northern Ghana reached an unprecedented 18 by 1942/43. These were supplemented by dressing stations sited all over the Protectorate. By this contribution, the Native Authorities achieved what the colonial government had tried to do in the periods immediately preceding the emergence of Native Authorities: making health and health service facilities accessible to as many people as possible.

Beside the emergence of planned development of health policies and health service facilities, the mid-1930s also saw the serious pursuit of designs of mass disease eradication in the Protectorate. Attention was devoted particularly to the epidemics of smallpox, cerebro-spinal meningitis, and trypanosomiasis as well as yaws which were endemic. Combining strategies of isolation and vaccination, delivered through an efficient organisational network, diseases like smallpox and yaws gradually became extinct although cerebro-spinal meningitis continued to cause episodic havoc in the Protectorate.

Adequate medical and health personnel was an important requisite for the effective maintenance of good health. Yet, as developments in Northern Ghana reveal, this condition was rarely met. Staff mainly trained in the southern sector of the country detested postings to the North, an area which lacked amenities and prospects offered by medical and health establishments on the coast and Ashanti. Staff of Northern extraction could also not be trained because the educational qualifications they held was too low that it not qualify them for nursing and related training in the south of the country. Training facilities in the North were deemed unnecessary because by policy medical attention was initially limited to the European population, the few clerical staff and members of the constabulary. This seemed to be adequately met by trained medical personnel from the coast.

By the mid 1930s, it became apparent that the provision of health and medical training institutions could no longer be held back. Even a little earlier than this date, the area of administration had steadily stretched which necessitated the opening of many more stations. This rendered the health task unbearable for the few staff. Moreover there was the need to obtain staff to match the rapid growth of dispensaries built under the regime of the Native Authorities. There was also a change in approach to sanitation. The use of coercion to induce the local people to be conscious of their surroundings was relegated to the background. This was replaced by persuading and educating the local people on the effects of stuffy surroundings. It was therefore necessary to recruit health staff of Northern extraction who could communicate effectively with the people. From humble beginnings pioneered by Dr. Vaughan, medical officer for Navrongo, a full-fledged Health Inspectors Training School developed in 1938. Although it turned out good sanitary overseers, the school was

closed down by 1947 largely due to the absence of an instructor. Through the effort of the Northern Territorial Council and the support of Dr. B.B. Waddy, the school was reopened in 1952 as the School of Hygiene. This school trained sanitary inspectors comparable in quality to their counterparts in Accra.

Just about the same time that the first Sanitary Inspectors School was opened, thought of establishing a school for nursing training was beginning to form part of the colonial government's arsenal to improve the quality of health delivery. This became necessary largely because while the population was increasing and confidence of the local people in western medicine was growing, nurses and midwives trained in the coast appeared reluctant to accept postings to the Protectorate. It was not until 1951 that training of nurses commenced in the Protectorate, in the government hospital at Tamale. In 1952 a Midwife Training School was opened at Jirapa, largely with the support of Catholic Sisters most of whom were registered nurses. These sisters were also responsible for the commencement in 1954 of a QRN training school at Jirapa.

While the environment of Northern Ghana was hostile as far as disease is concerned, colonial authorities initially resorted to the policy of limiting medical and sanitary surveillance to Europeans because the funds allocated to the Protectorate for this purpose was minuscule. However, orientation of colonial medical and sanitary policy changed in the 1920s to include the care of Africans in their crusade against diseases. This drive necessitated the initiation of a network of health delivery systems. But because government persisted in the allocation of inadequate funds to the Protectorate the new policy failed to pick-up. Indeed, it was the involvement of the local population, led by Native Authorities and missionary bodies that government's desire of providing medical and health care to the African population was facilitated.

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