

**African Health Labour of the Gold Coast:  
Evolution of Attendant Care in Ghanaian Hospitals, 1860-1957**

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## **ABSTRACT**

This report examines African health labour in the Gold Coast (now Ghana) from 1860 to 1957 with a focus on the overlooked contribution of orderlies. In the process, it explores the intersection of race, gender and class in the recruitment of Africans into the colonial medical service. Though often referred to as ancillary and described as unskilled, orderlies deserve attention. British medical staff regularly relied on the labour of orderlies to fill in when formally trained staff like dispensers, nurses and midwives were in short supply. This research also suggests these “unskilled” orderlies were the first local African labour brought into the infrastructures of missionary and colonial medicine of the Gold Coast. This makes their essential, but under-appreciated, role important to understanding the advancement of “Western” scientific medicine into West Africa over the 19th and 20th centuries.

## **DEDICATION**

This work is dedicated to my sister and nephew, Elizabeth Tesinme and Emmanuel Amankwaah Nampal.

## **ACKNOWLEDGEMENT**

My heartfelt appreciation and gratitude goes to my supervisor, Dr. Sasha Mullally whose wise advice, guidance and unflinching support enabled me to write this report. I can't thank her enough for the continued care and concern she showed me when I began my studies in the Department of History at the University of New Brunswick as an international student. I owe a great debt of gratitude to the Faculty and Staff of the History Department whose assistance in various forms helped improve my writing and contributed to my growth as a historian. I would also like to give my sincerest gratitude to the History Department which supported me with Departmental scholarships and other research funds to pursue my MA degree. And lastly to my examiners, Dr. Lisa Todd and Dr. Cheryl Fury, for their insightful review and comments on this report.

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## **LIST OF ABBREVIATIONS**

AADMS – Acting Assistant Director of Medical Services

ACC – Ashanti Confederacy Council

ADMS – Assistant Director of Medical Services

AMS – African Medical Staff

AMTS – African Medical Training School

AMTS – African Medical Training School

ARPS – Aborigines Rights Protection Society

BMA – Basel Mission Archives

CMO – Chief Medical Officer

CMO – Colonial Medical Office

CNA – Colonial Nursing Association

CS – Colonial Surgeon

DMS – Director of Medical Services

GCMD – Gold Coast Medical Department

GCMU – Gold Coast Medical Union

GMC – General Missionary Conference

JMS – Junior Medical Staff

LMS – London Missionary Society

MAG – Manhyia Archives of Ghana

NMOs – Native Medical Officers

PRAAD – Public Records and Archives Administration Department

QRN – Qualified Registered Nurse

SACS – Senior Assistant Colonial Surgeon

SHO – Senior Health Officer

SMA – Catholic Societas Missionum ad Afros

SMS – Senior Medical Staff

SPG – Society for the Propagation of the Gospel

SRN – State Registered Nurse

SSC – Secretary of State of Colonies

UMCA – Universities' Mission to Central Africa

WAMS – West African Medical Service

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## Introduction

A 2005 report on the status of orderlies at the Korle-Bu Teaching Hospital in Ghana declared that all of these health workers felt “underpaid and undervalued.”<sup>1</sup> These frustrations with lack of recognition and reward within the hospital system are nothing new. Orderlies are not on the list of essential health service personnel in hospital systems, and their place in the hospital setting remains invisible to many, especially compared to the place of more prominent professionals such as doctors, nurses, and midwives. The contemporary undervalued role of orderlies in hospitals raises the question of their historical role. Close examination of archival data and secondary works helps provide some answers to the question of orderlies in the healthcare system. This report looks at the often-overlooked role of orderlies to the growth of attendant care in Gold Coast hospitals from 1860 to 1957. Orderlies were once a central category of African health personnel in the Gold Coast<sup>2</sup> region. Yet they are largely ignored in the history of health professions in Africa, particularly western states.

One reason for this invisibility is that Europeans and colonial officials in the Gold Coast inconsistently applied the term “orderly” when referring to the work of their African assistants or auxiliaries. From 1917 to 1918, District Commissioners and Medical Officers of the Gold Coast colonial service who documented their experience in diaries referred to their “African assistants” as orderlies.<sup>3</sup> These African health workers,

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<sup>1</sup> Christine Böhmig, *Ghanaian Nurses at the Crossroads: Managing Expectations on a Medical Ward*, (The Netherlands: African Studies Centre, 2010), 188.

<sup>2</sup> The country known today as Ghana is a former colony of Britain, which was known as the Gold Coast. Within the period under consideration in this report, that is 1860 to 1957 and for simplicity, I employ the name Gold Coast throughout this report.

<sup>3</sup> Lady Clifford C.B.E. ed., *Our Days on the Gold Coast: In Ashanti, In the Northern Territories, and the British Sphere of Occupation in Togoland* (London: John Murray, 1919), 56, 59, 70, 135-6, 147, 150, 166.

sometimes also called “aides,” worked throughout the colonial and Christian missionary medical services of the Gold Coast. By 1860, the work of these men (sometimes women) who offered care alongside European doctors and nurses had evolved into the recognisable occupation of “orderly.” A close look at the evolution suggests that it is from this general category that most other categories of African health workers evolved as Western medicine was introduced to and expanded in the Gold Coast. From 1860 to 1957, the following categories of Ghanaian health workers were involved in bedside care formed part of the colonial and missionary medical service: orderlies, dispensers, dressers [surgical assistants], doctors, nurses, and midwives. Apart from doctors, who held special professional status, all other groups of African health labour were variously labelled as “aides” to European doctors and nurses in attending to the sick in a Westernised medical system. In this report, the occupation of “orderly” from 1860 to 1957 is interpreted as a transitional one. Orderlies were able to become dispensers—a worker who we would describe as an apothecary or a sort of proto-pharmacist—as well as doctors, nurses and midwives based on recommendation of their European superiors for professional training and advancement.

African health labour of the Gold Coast, as with elsewhere on the continent, evolved and diversified quickly with the introduction of Western medicine (or biomedicine). The introduction of Western medicine transitioned healthcare delivery to Western-style clinical and hospital facilities, mostly staffed by Europeans. Prior to the practice of Western medicine in the Gold Coast, healthcare delivery took place in local communities, where people relied on the services of local medical practitioners rather

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This book, which is a collection of diaries of European colonial officials was originally produced in aid of the Red Cross Society in 1918.

than in health facilities.<sup>4</sup> Historians have shown how the introduction of Western medicine did not displace, but added on to traditional medicine, and the two systems combined to serve the healthcare needs of the people.<sup>5</sup> In part, this meant that from the mid-nineteenth century, the training of indigenous African people into the new medical system became important to the success of missionary and colonial health services. By 1860, missionaries and colonial officials had enlisted Africans to attend to the sick in the Gold Coast. But the enlistment of indigenous people as medical aides did not take place overnight, and not without social change. A Western form of education was needed to facilitate the training of African health labour.

Close reading of documented sources reveal that the Africans involved in Western medical activities in the Gold Coast often received some form of European education. Some of these were sponsored by government; others came through the missions. In fact, the educational efforts of the Christian missionaries produced most of the African labour who worked in both the government and missionary services prior to the 1880s when colonial policies paved way for the formal training of Africans into government service. For this reason, Western education of all kinds provided the foundation for the training and employment of African labour into the colonial and missionary medical space as auxiliaries, many of whom would contribute to the development of more formal categories, like nurses.

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<sup>4</sup> Kwame Gyekye, *African Cultural Values* (Accra: Sankofa Publishing Company, 1996), 2.

<sup>5</sup> Traditional and Western medicine constitute the two mainstream medical systems in Ghana. These medical systems have their own set of established patterns of behaviour that influences their practices. Western medical practices dominate the health system of Ghana. However, traditional medicine has a wider coverage in terms of access and affordability as it extends to the grassroots level. See Patrick A. Twumasi, *Medical Systems in Ghana: A Study in Medical Sociology* (Tema: Ghana Publishing Corporation, 1975), 1; Patrick A. Twumasi, "History of Pluralistic Medical Systems: A Sociological Analysis of the Ghanaian Case", *A Journal of Opinion* 9, no.3 (1979), 30.

Historians have documented how Western medicine eventually became the main system of healthcare for Ghanaians. Unfortunately, existing medical and health historiographies have neglected how Africans enlisted in the missionary and early colonial health services contributed to the development of care in hospitals. The history of the professionalisation of Ghana's Western medical system remains incomplete. The works of medical historians and medical sociologists like Stephen Addae, Patrick A Twumasi and David K Patterson have attempted to explore the African health labour and the development of health delivery in Ghanaian hospitals, but rarely paid attention to the earliest African personnel of the missionary and colonial healthcare services, personnel often referred to as auxiliaries, attendants or orderlies.<sup>6</sup> Although the works of Addae, Twumasi and others often mention orderlies in passing, they have also not made a serious attempt to assess the interplay between missionary and early colonial medical services in framing this fundamental form of work, and explore issues of class, race and gender in the recruitment of African medical service through this gateway profession.

Orderlies were the first generation of health personnel of African descent to have worked in the new Western medical system. They were already present before the system began training and including local labour as professional nurses and doctors. However, little is known about them. Because historiographies of African medical personnel of the Gold Coast largely exclude orderlies, we have only an incomplete picture of the history of attendant care in Ghanaian hospitals functioned, and how local labour was integrated into care. This research project fills this gap in the scholarship. This report examines this

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<sup>6</sup> Stephen Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," (PhD Dissertation, University of Ghana, 1995); Patrick A. Twumasi, *Medical Systems in Ghana: A Study in Medical Sociology* (Tema: Ghana Publishing Corporation, 1975); D. K. Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-economic Change 1900-1955*, (Massachusetts: 1981).

African health labour in the Gold Coast from 1860 to 1957 to show that orderlies became vital to Western medical services when such services were on high demand among the African population and Europeans of the Gold Coast.

The expansion of medical infrastructure with its attendant staffing and financial challenges necessitated the demand for African personnel who were enlisted as assistants to sustain the healthcare system. It is commonly recognised that missionaries and colonial governments of Africa also regarded local labour as an asset to healthcare and able to contribute immensely to caring for the sick.<sup>7</sup> In addition to the need for enlisting Africans into missionary and colonial health system, local labour offset the challenge presented by those among the indigenous population who resisted Western medicine.

This report is largely based on qualitative research and critical reading and re-reading of textual records. Both primary and secondary sources are used to inform this analysis. The secondary sources are critically re-examined for fragmented details about these auxiliary workers. The primary sources of data include: archival documents from the Public Records and Archives Administration Department (PRAAD) in Kumase of Ghana; colonial records on the training of midwives and nurses in the Manhyia Archives of Ghana (MAG) in Kumase; annual medical and sanitary reports of the Gold Coast Medical Department from the digital archives of the Wellcome Library in London, United Kingdom; and digital collection of photographs from the Basel Mission Archives; and published primary sources such as correspondence of colonial officers published in the *British Medical Journal* and in the book, *The Government and Administration of*

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<sup>7</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 269; Linda Beer Kumwenda, “African Medical Personnel of the Universities’ Mission to Central Africa in Northern Rhodesia.” In Hardiman, David (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam and New York: Rodopi Press, 2006), 217.

*Africa, 1880-1939*.<sup>8</sup> The archival data from PRAAD and MAG contains a collection of colonial healthcare administration files on hospitals, diseases and general healthcare delivery. When considered together, these sources provide information on the intersection of missionary and colonial medical service, racial segregation of healthcare, and considerations of gender in training of health workers.

The digital archive of the Basel Mission Archives (BMA), for instance, has a rich visual record, and hosts photographs of some African health personnel who worked in the Basel medical service and in the Gold Coast Hospital (now the Korle Bu Teaching Hospital) from 1930 to 1945. Basel missionaries are recognised as the first group of Europeans to use photography in the Gold Coast, preserving a substantial visual record.<sup>9</sup> These photographs supplement the archival evidence on the gendered aspect of African medical personnel of the Gold Coast. Sources like these also help to re-examine the historiography on gender when it comes to the employment and training of African health labour. The digital archive of the Wellcome Library serves as a rich resource for archival documents of the British colonial government. These digitised archival collections cover a range of socio-economic, political and medical administrative matters of the British government in her former colonies in Africa including the Gold Coast. I also sourced relevant annual reports of the Gold Coast Medical Department from 1893 to 1930 from the Wellcome Library.

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<sup>8</sup> Andersen, Casper and Andrew Cohen (eds), *The Government and Administration of Africa, 1880-1939*, (London and New York: Routledge, Taylor & Francis, 2016).

<sup>9</sup> Linda Ratschiller, "The Basel Mission Doctors on the Gold Coast and the Making of Tropical Medicine 1885-1914," (MPhil Dissertation, University of Cambridge, 2013), 4.

With the advent of advanced digitisation technologies, and in an attempt to decolonise knowledge, there have been many efforts to digitise written and other primary sources related to European activities in Africa. These digitised primary sources can be accessed through subscription databases and open access repositories. They cover a wide range of data sources, including diplomatic dispatches, letters, investigative reports, first-hand accounts of events, texts of treatises, medical and sanitary reports, annual report of the colonial government, newspapers, missionary records, eyewitness reporting, editorials, legislative information, advertisements, photographs, among others.<sup>10</sup> In an attempt to bring together a fragmentary archive into one whole picture, I have also sampled from smaller repositories, such as the Colonial, Missionary and Post-colonial Past of Africa in the African Online Digital Library based at Michigan State University; Africa 1834-1966 [Confidential Prints] held as part of the Humphrey Winterton Collection of East African Photographs at Northwestern University Library; and The African Newspapers: Series 1 and 2, 1800-1925 held with the Centre for Research Libraries Online Repositories based in Chicago, the United States of America.

These useful digital archival primary sources are valuable, but they have their limitations.<sup>11</sup> Not all collections are accessible in scanned microfilm and there are gaps in

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<sup>10</sup> Araba Dawson-Andoh. "Collecting to the Core – Primary Sources in African History." *Against the Grain* (April 2019), 26-29.

<sup>11</sup> Extensive archival collections on colonial Africa are housed in the national archives and libraries of former colonisers. The records of Christian missionaries in Africa also serve as relevant primary sources for generating knowledge about Africa, but such records can extensively be accessed in their respective countries of origin with complete information. The national archive in the United Kingdom (UK) hosts a wealth of records of former British colonies in West Africa. Although some records were left in their former colonies for archival purposes, such records do not present a complete information for research. Africanist historians depending on the archive for research would have to travel to the UK to access such files. University Libraries in the UK also hold important colonial and missionary archival documents. Some of these universities include the School of Oriental and African Studies, Oxford University and Cambridge University.

the collections. However, the existence of finding aids provide a map to original sources where hard copies of complete files or collections can be accessed. Additionally, the archival data is supplemented with published and unpublished primary data including the correspondence of medical officers of the Gold Coast published in the *British Medical Journal* and diaries of missionaries and colonial officials compiled in the book, *Our Days on the Gold Coast: In Ashanti, in the Northern Territories, and the British Sphere of Occupation in Togoland*.<sup>12</sup>

When it comes to writing the histories of African health labour, one notes silences in the archival content on the activities performed within the colonial medical service. These workers, in the words of historian of nursing Peter L. Twohig, “ha[ve] been known by a number of names,” and can be difficult to trace in the health system over time.<sup>13</sup> It is common to see African health labour identified in the colonial and missionary records as orderlies, auxiliaries, aides, attendants, and even just as assistants. The imprecise categories and anonymity reflects what Saidiya Hartman and Michel-Rolph Trouillot describe as archival silences, a concept which denotes the absence of information on certain subjects in archival records.<sup>14</sup> In 2008, Saidiya Hartman published “Venus in Two Acts” to showcase the existence of violence and silence in the archive of Atlantic slavery.<sup>15</sup> She revealed how the archives dictated the conditions of silence and

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<sup>12</sup> Lady Clifford C.B.E. ed., *Our Days on the Gold Coast: in Ashanti, in the Northern Territories, and the British sphere of occupation in Togoland* (London: John Murray, 1919).

<sup>13</sup> Peter L. Twohig. “An immediate solution to our nurse shortage”: The reorganization of nursing work in Nova Scotia, 1940–1970.” *Journal of the Royal Nova Scotia Historical Society*, 14 (2011), 138.

<sup>14</sup> Saidiya Hartman, “Venus in Two Acts,” *Small Axe* 12, no. 2 (June 2008), 1-14; Michel-Rolph Trouillot, *Silencing the Past: Power and the Production of History*, (Boston, Massachusetts: Beacon Press, 2015). Saidiya Hartman is a scholar of African American studies and cultural history while Michel-Rolph Trouillot was a Haitian anthropologist, historian and writer. Both scholars discuss the silences and violence of the archives of slavery and the Atlantic world with focus on varied historical experiences.

<sup>15</sup> Hartman, “Venus in Two Acts.”

representation using Venus, an emblematic figure of enslaved woman in the Atlantic world as a focal case study. Although Hartman focused solely on this figure, the broader concept of silence and violence has been replicated in the world of medical archiving, where the histories of certain historical phenomenon and figures are also ignored.

Michel-Rolph Trouillot provides an explicit exposition on how silence finds its way into historical production.<sup>16</sup> According to Trouillot, the silence in historical production takes place at four crucial moments of: “fact creation (the making of sources); fact assembly (the making of archives); fact retrieval (the making of narratives); and retrospective significance (the making of history in the final instance).”<sup>17</sup> The silences in historical production is inevitable so long as the sources of information to construct, deconstruct and reconstruct are organised around power. Thus, the silence is a “product of uneven power in the production of sources, archives and narratives.”<sup>18</sup>

Correspondingly, the current historiography of African health labour and the evolution of Western medicine in Ghana reflects the silence of the contribution of African health auxiliaries, particularly orderlies to the evolution of attendant care. The historical accounts of orderlies do not treat pertinent issues concerning the broader meaning of the term “orderlies” and the varied representations of the individuals who formed this category of African health labour. Orderlies only merit passing comments in the historiography – a problem partly created by the uneven distribution of the fragmentary colonial archive and the disappearance of certain terminologies from archival entries in favour of the creation of other categories of health occupations. Indeed, as some scholars

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<sup>16</sup> Trouillot, *Silencing the Past*, 27.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

argue, all archives are “figured.”<sup>19</sup> They are arranged to display and narrate power relations. In this way, the archive is preferentially created, arranged and organised to house certain pasts. The archives of health missions and colonial administrations are a good example of this because the creators recorded incidents that were of interest to them as certain historical phenomenon are well represented in the records than others.

The foundational work of Linda Beer Kumwenda on “African Medical Personnel of the Universities’ Mission to Central Africa in Northern Rhodesia” drew attention to the place of missionary records in researching African medical personnel.<sup>20</sup> In this work, Kumwenda examined the activities of the largely forgotten figure of the African medical orderly. She made use of biographical data on African medical personnel from missionary records and reports to document the experiences of orderlies under the auspices of the Universities’ Mission to Central Africa (UMCA) in Northern Rhodesia (present Zambia). Her work highlighted the complex relationship between white doctors and nurses, priests and African orderlies within the mission’s medical service.

Kumwenda emphasised the ways that orderlies formed an integral part of the medical mission’s team in Northern Rhodesia such that the UMCA could not afford to lose them. Kumwenda raised an important methodological consideration into researching African medical personnel. From her perspective, mission records about African labour are more

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<sup>19</sup> Carolyn Hamilton, Verne Harris, Michèle Pickover, Graeme Reid, Jane Taylor, and Razia Saleh, (eds). *Refiguring the Archive*, (Cape Town and Dordrecht: David Philip and Kluwer Academic Publishers, 2002).

<sup>20</sup> Linda Beer Kumwenda, “African Medical Personnel of the Universities’ Mission to Central Africa in Northern Rhodesia.” In David Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, (Amsterdam-New York, NY: Rodopi, 2006), 193-226. Another intervention by Kumwenda is her work on the training of African female medical auxiliaries in missionary hospitals. In this work she interchangeably used the terms “orderly” and “nurse” depending on how they are entered in the records of the missionary institutions involved. See Kumwenda, “The Training of Female Medical Auxiliaries in Missionary Hospitals in Northern Rhodesia, 1928-1952,” *Social Sciences & Missions*, 16 (2005), 103.

informative than colonial records even though the colonial government also employed them to work in hospitals. But her work stands in isolation. Since her book was released, there has only been one additional work on African medical personnel, but it focused on the missionary system.<sup>21</sup>

Kumwenda noted that mission records reveal rich social and cultural details, offering insight into the qualities that defined an orderly as “good” or “difficult” and hence, determine the character deficiencies of ‘the African’ according to Western standards of behaviour, standards that were often racialised. These records also highlight ways in which missionary training equipped Africans to express their grievances against their employers regarding unfavourable working conditions and describe how such situations were resolved.<sup>22</sup> Missionary records host a wealth of information on studies of African medical personnel and other African labour. However, scholars’ attempt to study the histories of Western medical care in West Africa and the Gold Coast have neglected such sources, and relied on colonial records, even though missionary medicine coexisted with colonial medical structures. Thus, in pulling together the fragmentary colonial archive, one should also include the archives of colonial partners like missions, that produced records that complete our understanding of the broader development of attendant care in Western-styled healthcare environments.<sup>23</sup>

Scholars are aware of these sources, but the few studies drawn from the missionary archives are more concentrated on the socio-economic and religious impact of

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<sup>21</sup> Benjamin Bronnert Walker, *Religion in Global Health and Development: The Case of Twentieth-Century Ghana*, (Montreal, Kingston, London, Chicago: McGill-Queen’s Press, 2022).

<sup>22</sup> Kumwenda, “African Medical Personnel of the Universities’ Mission to Central Africa in Northern Rhodesia,” 195.

<sup>23</sup> Walker, *Religion in Global Health and Development: The Case of Twentieth-Century Ghana*.

missionaries through their encounter with indigenous people than in their medical histories.<sup>24</sup> Explaining and interpreting these changes push historians to employ both conventional and unconventional approaches and to utilise fragmentary sources to produce fulsome and meaningful narratives about the past. Missionary archives, while promising, are difficult to access, so this report will rely on the fragmented colonial and few missionary records that are digitised and combine these with supplementary references from secondary sources that utilised them: books, journal articles and dissertations. These will be read critically to clearly highlight the overlooked contribution of orderlies to the evolution of attendant care in Ghanaian hospitals.

This report is organised into four sections. The first section takes a historiographical look at the development of a Westernised medical system in the Gold Coast. It reassesses various accounts of scholars on the development of Western medicine through European encounters with Africans in religious, imperial and economic activities. The institutionalisation of Western medicine created space for the employment of indigenous people to assist in healthcare delivery in the new medical system. In this section, the formalisation of Western medicine is traced to the moment it starts to serve the local population. The local population's increase in demand for Western medical service initiated the necessity for an expansion in health infrastructure and the

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<sup>24</sup> The most important scholarship on the Gold Coast that drawn on missionary archives identified and accessed for this report include: H. W. Debrunner, *History of Christianity in Ghana* (Accra: Waterville Publishing House, 1967); Adam Mohr, "Missionary Medicine and Akan Therapeutics: Illness, Health and Healing in Southern Ghana's Basel Mission, 1828-1918," *Journal of Religion in Africa* 39, no. 4 (2009), 429-461; Jon Miller, *Missionary Zeal and Institutional Control: Organizational Contradictions in the Basel Mission on the Gold Coast 1828-1917*, (Routledge, 2014); Ulrike Sill, *Encounters in Quest of Christian Womanhood: The Basel Mission in Pre- and Early Colonial Ghana*, (Leiden, Boston: Brill, 2010); Robert Addo-Fening, "Akyem Abuakwa, c.1874-1943: A Study of the Impact of Missionary Activities and Colonial Rule on a Traditional State," (PhD Dissertation, University of Ghana, 1980); Ratschiller, "The Basel Mission Doctors on the Gold Coast and the Making of Tropical Medicine 1885-1914."

recruitment of African personnel. Central to this section is the introduction of the contribution of Christian missionary groups into discussions of the development of Western medicine in Ghana, which has received no attention in the existing historiography.

The second section examines the categories of African health labour which emerged in the Gold Coast with the introduction of a Westernised medical system; orderlies, dressers, dispensers, doctors, nurses and midwives. The African labour involved in Western medical care from the mid-nineteenth century were predominantly males who had been educated in missionary and government schools. This section sheds light on the minimum qualifications for recruitment of indigenous people into the colonial and missionary medical service as well as the motivations for recruitment and training of African health labour. This section initiates a discussion into professionalising healthcare in Gold Coast hospitals beginning from African health labour who possessed no recognised qualification for their work.

The third section investigates the interconnectedness of gender, race and class in the employment of African health labour. The gendered aspect of this section interrogates how European and African gender codes defined the work regime of African health labour. Building on the second section, this section explains why men were employed and trained to work in hospitals in the early stages of the development of Western medicine and the shift from training of men to women as nurses in the late 1920s. In the discourse of African health labour within the context of colonial and missionary medical service is the subject of racial discrimination in the organisation of health service. The second aspect of this section discusses the instances that reflected racial discrimination

against Africans in the colonial medical service and how women were at the receiving end of racial and gender bias.

Among all the categories of African health labour, orderlies are not well-represented in the Ghanaian historiography and the colonial archive. The fourth section examines the place and role of orderlies in professionalising African health labour and the provision of attendant care. The subject of orderlies raises several questions. Given the seemingly overlapping responsibilities of African health labour and their categorisation into skilled and unskilled, which group of workers constituted orderlies? Why have orderlies merited only passing comments in the historiography? Is it about the absence of a clear vocabulary to represent the term “orderly” in colonial and missionary archival records? This section responds to these questions and explores past responsibilities of orderlies with contemporary ones to understand the transformation in the orderly profession in hospitals.

## **Historiography of the Development of Western Medicine in Ghana**

The introduction of Western medicine on the West Coast of Africa from the 15th century marked a major historical event on this part of the African continent. A significant legacy of Western medicine is its contributory role in the institutionalisation of a medical system which created new avenues for healthcare delivery in Ghana. Western medicine was applied alongside traditional medicine, which had served the healthcare needs of the people before missionary and colonial activity. The development of Western medicine in the Gold Coast has seen contentious debate among medical historians and sociologists. While some scholars traced the beginning of Western medicine to the colonial era, specifically, to the bond of 1844,<sup>25</sup> others traced it to the period of early European settlements in the Gold Coast. A central point of debate is whether the development of Western medicine should be traced to the first instance of Western medical practice or from the period when it became formally instituted with the building of health infrastructures like dispensaries and hospitals. This section looks at two distinct, yet complementary subjects in the evolution of Western medicine in the Gold Coast: it traces the development of Western medicine in the region and the evolution of the historiography on the subject.

Prior to the practice of Western medicine in the Gold Coast, healthcare delivery took place in local communities, where people relied on the services of local healers and

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<sup>25</sup> The bond of 1844 was an agreement between some local chiefs of the Fante ethnic group of the Gold Coast and the British government. The bond of 1844 is a significant event in the history of Ghana since it marked the period when the British imperial power assumed formal control of the coastal territory of the Gold Coast and later the entire Gold Coast territory in 1874 with the annexation of Asante. See J. B. Danquah, "The Historical Significance of the Bond of 1844," *Transactions of the Historical Society of Ghana* 3.1 (1957), 4; F. K. Buah, *A History of Ghana* (Macmillan, 1998); Gocking, *The History of Ghana*.

health practitioners rather than seeking care in health facilities.<sup>26</sup> In the social construction of health and healing among the indigenous people of western African regions, there was no separation between the natural and physical world.<sup>27</sup> Because of this, people assigned both spiritual and physical explanations to ailments and considered this when choosing the right therapy to administer. Under the traditional medical system, the family and traditional medical practitioners were the agents of healthcare delivery.<sup>28</sup> With the influx of European Christian missionaries and colonial officials on the Gold Coast, the landscape of healthcare began to change because of the introduction of Western medicine. European activities in religion, trade, education, agriculture and healthcare through their encounters with the indigenous people transitioned healthcare delivery from the community and the home to the hospital environment. The medical historian, Stephen Addae rightly noted how “European and other cultures invented hospitals, clinics and dispensaries or their equivalents where the sick could be attended in an organised way. No such equivalents appear to form a part of the Ghanaian African healing methods.”<sup>29</sup> Documented sources are replete with different categories of Western-styled health infrastructure in the nineteenth centuries. These include hospitals, dispensaries, sanatoriums and dressing stations. While impressive on paper, according to Addae these were “were poorly, badly designed and often consisting of converted old bungalows adapted for the purpose. They were often referred to as bush hospitals and sometimes built with bamboo or swish with thatched roof. Equipment and drug stocks

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<sup>26</sup> Kwame Gyekye, *African Cultural Values*, (Accra: Sankofa Publishing Company, 1996), 2.

<sup>27</sup> Twumasi, *Medical Systems in Ghana*, 8.

<sup>28</sup> For details on the indigenous medical system and practitioners, see Twumasi, *Medical Systems in Ghana*.

<sup>29</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 8.

were poor and inadequate.”<sup>30</sup> The hospitals, however, were better equipped with staff and medical supplies and offered both in-patient and out-patient services while the other facilities, albeit temporary, offered only out-patient services.

The first recorded European presence in the Gold Coast dates back to 1471 when the Portuguese arrived on the coast.<sup>31</sup> The construction of the Castle of São Jorge da Mina (Elmina Castle) in 1482 marked the beginning of European settlement in the Gold Coast. The Spanish, Dutch, English, Swedes, Danes, French and Germans from the Brandenburg also arrived and built forts and castles for the purpose of trade and fortification. The forts and castles mainly served these purposes: to fulfil a religious obligation<sup>32</sup>; for use as safe store-houses for imported European goods such as textiles, copper and brass ware, iron bars products to be exchanged for gold, spices, ivory and slaves; to serve as permanent living quarters for European merchants and as military garrisons against competing European powers.<sup>33</sup> Existing records do not reference the exact date of the arrival of these Europeans, but fragmentary data provide insight into the period when each of them first set foot on the coast of what is now Ghana. Literary evidence indicates that Spanish merchants were present on the Gold Coast by 1475 and traded with indigenous people from the coastal towns of Shama and Elmina.<sup>34</sup> The first

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<sup>30</sup> Ibid., 66-67.

<sup>31</sup> Roger S. Gocking, *The History of Ghana* (Westport, CT: Greenwood Press, 2005), 25.

<sup>32</sup> This is true in the case of the first castle, São Jorge da Mina built on the Gold Coast by the Portuguese. King John II of Portugal, with the consent of the Pope saw it as a religious obligation to build a castle to glorify God for the discovery and possession of a new territory. Records indicate that the castle was named after the patron saint of Portugal called St. George. The castle housed a church, which was dedicated to the saint. See Debrunner, *History of Christianity in Ghana*, 16-18.

<sup>33</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 4-6.

<sup>34</sup> Debrunner, *History of Christianity in Ghana*, 16.

English expedition to the West African coast dates to 1553 under the captainship of Thomas Windham, but their presence on the Gold Coast is not fully established.<sup>35</sup>

The arrival of the Dutch on the Gold Coast appears in two different, but closely related, accounts. The first account relates that the Dutch first arrived there in 1596 when their voyage from an unknown destination to Brazil accidentally landed on the Gold Coast.<sup>36</sup> In another account, the Dutch is noted to have arrived in the region in 1593.<sup>37</sup> The Danes established themselves on the Gold Coast in 1656 while Germans from Brandenburg are said to have participated in the coastal trade from 1680.<sup>38</sup> The Portuguese, who had maintained monopoly over the coastal trade until the early seventeenth century, faced fierce competition from other Europeans. The main item of trade that generated competition was gold, and later slaves. Sources indicate that the lucrative gold trade enabled the Portuguese to finance their subsequent discoveries. The Portuguese involvement in the slave trade from their first contact with coastal West Africans set precedence for the transatlantic slave trade. From the early sixteenth century, the Portuguese imported slaves from Benin and Congo to the Gold Coast and sold them to Africans at Elmina and transported some to Portugal and the Americas.<sup>39</sup>

Historical evidence on the history of Christianity in Ghana shows that the Portuguese who first arrived in the Gold Coast in the fifteenth century were Roman Catholic missionaries under the mission of Prince Henry of Portugal.<sup>40</sup> These

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<sup>35</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 4-6.

<sup>36</sup> Ibid.

<sup>37</sup> Debrunner, *History of Christianity in Ghana*, 28.

<sup>38</sup> Ibid., 44-45.

<sup>39</sup> Ibid.

<sup>40</sup> Ibid., 5.

missionaries arrived as crusaders and later as merchants after discovering the profitability in the gold and later slave trade. Other Christian missionaries that operated with great influence in the Gold Coast prior to the twentieth century include the Society for the Propagation of the Gospel (SPG) in the 1750s, the Basel Mission in 1828, the Methodist Mission in 1835, the Bremen Mission in 1847, and the Catholic Societas Missionum ad Afros (SMA) fathers in 1880.<sup>41</sup> Effective and organised missionary work did not begin in the Gold Coast in the fifteenth century until the 1820s after the abolishment of the slave trade.<sup>42</sup> Christian missionaries from Europe are touted as the pioneers who introduced sub-Saharan Africa to Western education, trade and medicine. Emory Ross, a missionary and mid-century scholar of African history, observed that missionaries played a lead role in the provision of Western medical services and organised training for and with Africans.<sup>43</sup> From about the sixteenth century to the nineteenth century, there was a thin line between missionary movements, merchants and the colonial administration in West Africa as far as education, trade and health are concerned. In the Gold Coast, governors were from a strong Christian background. Several governors in the forts and castles were sent to the Gold Coast as missionaries and chaplains before assuming the governor status.<sup>44</sup> In 1805, Governor Torrane requested for the posting of a chaplain from England to Cape Coast Castle because he regarded the castle to be too “respectable a garrison to be without a chaplain.”<sup>45</sup> In 1832, Captain George Maclean, an English Governor of the Gold Coast added to his vision to attract missionaries to Cape Coast. The church-state

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<sup>41</sup> Debrunner, *History of Christianity in Ghana*, 5; Sandra E. Greene, *Sacred Sites and the Colonial Encounter: A History of Meaning and Memory in Ghana*, (Indiana University Press, 2002), 19.

<sup>42</sup> Gocking, *The History of Ghana*, 29.

<sup>43</sup> Emory Ross, “Christianity and Ghana,” *Africa Today* 4, no.2 (1957), 28.

<sup>44</sup> Debrunner, *History of Christianity in Ghana*, 21, 60-70, 85-93.

<sup>45</sup> *Ibid.*, 93.

relation became strong to the extent that wherever missionaries were present, the economically and geographically driven European colonialists were also present.<sup>46</sup>

An important point which deserves mention is the occupational background of early Christian missionaries. The personnel recruited for the Basel Mission to the Gold Coast in the early 1820s were drawn from the working class. They claimed occupations of traders, shoemakers, weavers, carpenters, sail makers, glaziers, pot makers, bakers, farmers, servants, lathe operators, students, teachers, and scribes (stenographers).<sup>47</sup> Not ignorant of the disease environment in the Gold Coast, which claimed the lives of many Europeans, the early missionaries of the Basel Mission in 1828 were given medical training on how to treat tropical diseases with cold baths, bloodletting and arsenic before their departure.<sup>48</sup> Unfortunately, these techniques were ineffective and harmful in confronting tropical diseases like malaria and yellow fever. The mortality rate was high among the first group of Basel missionaries who came to Ghana in the nineteenth century. The same is true of other Europeans, partly because of inadequate medical knowledge about tropical diseases.

The Ghanaian historiography of Christianity is important because it offers a clues about beginning of education and healthcare and how these are tied to the activities of European missionaries, then merchants, and later, the colonial administration. This is because Christian missionaries influenced trade, education and healthcare on the Gold Coast long before the colonial administration intervened in the 1840s. The first reference to a school on the Gold Coast dates to 1529 when the Captain and Governor of Elmina,

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<sup>46</sup> Miller, *Missionary Zeal and Institutional Control*, 18-19.

<sup>47</sup> *Ibid.*, 53.

<sup>48</sup> Mohr, "Missionary Medicine and Akan Therapeutics," 444.

Estevão da Gama was ordered to convert the indigenous people to Christianity. The children of Elmina were to be instructed in Portuguese on how to read, write, sing, pray and perform other obligations related to divine service.<sup>49</sup> A Dutch school opened at Elmina in 1641. These schools, mainly located in the castles, were necessary to lay the foundations of Christianity. By the eighteenth century, these schools produced the first African elites of the Gold Coast. Apart from taking appointments in the church as catechists, missionaries, and ministers of the gospel, educated Africans entered the labour force as soldiers, middlemen in trade, government clerks, teachers, interpreters on or off board ships in the eighteenth century and beyond. A detailed account of the development of schools and how that offered the people of the Gold Coast, particularly those in the coastal towns, the opportunity to enter into European general and health care labour force is explained in section two of this report.

But when did this health care labour become important? This takes us back to the introduction and evolution of Western-style health care. Patrick A. Twumasi, a medical sociologist, positions the development of Western medicine in the Gold Coast back to 1844.<sup>50</sup> After that, medical officers were posted to the Gold Coast to provide medical care to colonial administrative officers resident in the European forts and castles discussed earlier in this section. During the same period, Christian missionaries also brought in medical officers to take care of their personnel and established dispensaries across their territories of influence.

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<sup>49</sup> Debrunner, *History of Christianity in Ghana*, 21.

<sup>50</sup> Twumasi, *Medical Systems in Ghana*, 62.

Kodwo Ewusi, in his book *Equity and Efficiency in the Supply of Health Manpower in Ghana* takes a different approach and offers a different timeline. Ewusi argues that the history of Western medicine in Ghana began in 1868 when the first European hospital was built at Cape Coast.<sup>51</sup> According to Ewusi, the local chiefs who signed the bond of 1844 only understood it to be a treaty that established the region as a British protectorate. Thus, the chiefs saw the agreement as a provision of defence. Also, he denies the importance of 1844 in the establishment of Western health services and sees no provision of any type of medical officers to the Gold Coast. He notes that there were some medical officers in the European forts and castles earlier in the nineteenth century, but deployed largely for the Europeans themselves:

the scourge of malaria disease made it necessary for all European expedition[s] from Europe to West Africa to be accompanied by medical officers called surgeons at that time. There were medical officers in all the forts and castles built along the coast. Thus, the first medical officer would have come to the country early in the seventeenth century. However, these medical officers were brought to take care of the European personnel in the castle.<sup>52</sup>

Ewusi stressed that the building of the hospital at Cape Coast in 1868 marked the first provision of medical services to the local people, specifically the senior administrative officers of African descent who worked in the colonial civil service.<sup>53</sup> Within this framework, the development of Western medicine in the Gold Coast only began after medical services were provided for the indigenous people in the civil service and later to the general African population.

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<sup>51</sup> Kodwo Ewusi, *Equity and Efficiency in the Supply of Health Manpower in Ghana* (Tema: Ghana Publishing Corporation, 1989), 28-29.

<sup>52</sup> Ibid.

<sup>53</sup> Ibid.

A decade later, Stephen Addae, a professor of medicine and historian, clarifies some inconsistencies in the accounts of Ewusi and Twumasi. In a survey of the very beginnings of Western medicine in the Gold Coast between 1480 and 1880, Addae concluded that the trading activities of Europeans inevitably introduced Western medicine into Ghana.<sup>54</sup> He speculated that a surgeon might have been on board the first Portuguese expedition to the Gold Coast in the fifteenth century. However, Addae asserted that the facts from this event only suggest but do not prove that a surgeon was a member of the expedition and less likely that they built permanent medical facilities.<sup>55</sup> He further notes there were possibly medical officers at post in the late eighteenth and early nineteenth centuries when he cited medical officers like Dr Paul Erdmann Isert, a German-born doctor and Dr Peter Thonning, a Danish doctor who served at the Christiansborg Castle between 1783 to 1787 and 1799 to 1803 respectively.<sup>56</sup> Addae was uncertain about the presence of European medical officers in the Gold Coast in the late eighteenth century and early nineteenth century. Debrunner, however, locates Samuel Brun, a surgeon of Basel descent who arrived on the Gold Coast from Holland in 1616 to attend to Dutch soldiers at Fort Nassau at Moree.<sup>57</sup> Samuel Brun remained at the fort and provided medical assistance to sick and wounded Europeans. Brun was the only surgeon at the Fort following the death of the Fort's surgeon and his assistant.

These histories tell us that European surgeons and physicians were resident in the forts and castles in the seventeenth and eighteenth centuries and were involved in the

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<sup>54</sup> Addae, "Evolution of Modern Medicine in Ghana," 22.

<sup>55</sup> *Ibid.*, 9-15.

<sup>56</sup> *Ibid.*

<sup>57</sup> Debrunner, *History of Christianity in Ghana*, 30-31.

examination of slaves before they were bought and sold.<sup>58</sup> Dr Paul Erdmann Isert arrived at Christiansborg in 1783 as a surgeon for the Danes. He was later appointed as commander for a newly built fort of the Danes at Ada and also presided over the Danish trade at Whidah of the Kingdom of Dahomey. Debrunner documents that Dr Isert's surgical prowess reached the interior of the Gold Coast, specifically Asante where the King of Asante "sent his sick sister to Dr Isert for treatment."<sup>59</sup> Thomas Birch Freeman, a Methodist missionary and doctor is also noted to have treated a female Paramount Chief of Juaben of Asante between 1838 and 1890.<sup>60</sup> In 1817, Dr. Tedlie, a colonial medical officer also treated the ailments of the brother, uncle and treasurer of the then King of Asante. From the accounts of Drs Isert, Tedlie and Freeman, it is likely that some medical assistance was extended to the indigenous people who were either servants in the castles or resided close to the castles in the eighteenth century. There is also little doubt that the children of Elmina who schooled and worked in the castles received some medical care from European doctors. Other accounts suggest European health care occasionally reached the interior of the Gold Coast.

Ultimately, Addae's contribution to the literature is that he takes an organisational and systems approach to this history and categorises the development of Western medicine in the Gold Coast into four phases: 1880 to 1919, 1920 to 1930, 1931 to 1950 and 1951 to 1960. This periodisation traces institutional and political developments, beginning with the period when the first civil hospital was built in Accra in 1878 to the

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<sup>58</sup> Sowande M. Mustakeem, *Slavery at Sea: Terror, Sex, and Sickness in the Middle Passage*, (University of Illinois Press, 2016), 45; Debrunner, *History of Christianity in Ghana*, 50.

<sup>59</sup> Debrunner, *History of Christianity in Ghana*, 86.

<sup>60</sup> Addae, "Evolution of Modern Medicine in Ghana," 18.

period around when Ghana attained Republic status after independence in 1957.<sup>61</sup>

Addae's categorisation is also based on the development of colonial public health policies and the African government's health policies after independence. With this focus on public health, particularly disease control, we see that colonial surgeons of the West African Army, especially those based in the larger towns such as Cape Coast, gave some form of medical assistance to the indigenous population by the middle of the 1840s.<sup>62</sup> Addae places emphasis on the formal organisation of public health services from the 1880s as the beginning of the practice of Western medicine.

To pin the origins of Western medicine to the moment it starts to serve the local population is understandable. This meant an increase in demand for such services, prompting an expansion in health infrastructure and the recruitment of personnel to respond to the growing demand for health service. Nonetheless, the timeline for the period, and determining when the local population first received treatments from Western medicine, needs some clarification. An examination of existing documentary sources reveals that a section of the coastal people of the Gold Coast, specifically those resident at Cape Coast and Elmina, had used the Western medical services provided by early missionaries and Europeans in the late eighteenth centuries.<sup>63</sup> Although indigenous resistance to Western medicine was documented during its introductory years, Western medicine gained popularity among the local population the late nineteenth and early twentieth centuries. In the 1850s, it was reported that "local populations," referring likely to Cape Coast, were hesitant to "use the services of a colonial surgeon provided for

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<sup>61</sup> Addae, "Evolution of Modern Medicine in Ghana," 9-15.

<sup>62</sup> Ibid.

<sup>63</sup> Debrunner, *History of Christianity in Ghana*, 30-31.

them.” The common reason cited for this hostility towards Western medicine is that Africans saw the European doctor as a strange figure “who had to use an interpreter. He often asked impolite questions, demanded, [for reasons unknown to patients] samples of blood, urine and faeces; and sometimes cut open the bodies of the dead.”<sup>64</sup> Interestingly, and by contrast, missionary records depict missionary stations were safe havens for the sick in the 1850s.<sup>65</sup>

Historiographies of the twenty-first century also highlight the events leading to the evolution of Western medicine. Some of these studies respond to the accounts of previous twentieth-century publications while others add to the contribution of missionaries to the development of Western medicine. Jonathan Roberts’ article “Medical Exchange on the Gold Coast in the Seventeenth and Eighteenth Centuries” largely agrees with Addae and Twumasi but focusses on medical practice exchange. Roberts documents the surgeons who were on board slave ships from Europe to West Africa.<sup>66</sup> However, he notes that the hostile climatic condition of West Africa deterred most surgeons from accompanying slave ships to the region; a majority of them perished during their voyages. The surgeons who did embark on voyages to West Africa did so for financial gain and not for acquiring new medical knowledge.<sup>67</sup> They possessed limited knowledge about the health and

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<sup>64</sup> Patterson, *Health in Colonial Ghana: Disease, Medicine and Socio-Economic Change, 1900-1955*, in Addae, *Evolution of Modern Medicine in Ghana*, 19.

<sup>65</sup> Debrunner, *History of Christianity in Ghana*, 167.

<sup>66</sup> Jonathan Roberts, “Medical Exchange on the Gold Coast during the Seventeenth and Eighteenth Centuries,” *Canadian Journal of African Studies* 45, no.3 (2011), 490.

<sup>67</sup> For details on European surgeons and physicians on board ships to West Africa during the Trans-Atlantic Slave Trade era in the seventeenth century, see Mustakeem, *Slavery at Sea: Terror, Sex, and Sickness in the Middle Passage*.

diseases of the indigenous people, hence, were ill-equipped to handle the medical conditions of the African population. Roberts describes these surgeons as

amateurs who were given cursory training after the completion of a perfunctory examination. Their chief duty was to patch up wounded sailors and evaluate the physical health of slaves, and their professional merit was evaluated according to how much of the crew and how many of the slaves survived the journey to West Africa.<sup>68</sup>

Health care became more important as the colonial activities and infrastructure became more permanent and fixed. In the 15th century, European settlement on the Gold Coast suffered from unfavourable health conditions, particularly endemic diseases such as malaria and yellow fever.<sup>69</sup> West Africa was known as the ‘White Man’s Grave’ because of the high mortality among Europeans in the region.<sup>70</sup> Following the high rate of European mortality, it became essential for doctors, including both surgeons and physicians, to be sent to the Gold Coast to look after the health of the European population.

Early 21st-century writers, like Kodjo A. Senah, Joseph K. Adusei and Samuel A. Akor align with this earlier and longer timeline for European medicine. From missionary accounts they analyse, the beginning of Western medicine in the Gold Coast dates from the colonial era when European physicians were brought to the Gold Coast to take care of

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<sup>68</sup> Roberts, “Medical Exchange on the Gold Coast,” 491.

<sup>69</sup> Samuel Ofose-Amaah, *Health and Disease in Ghana: The Origins of Disease and the Future of Our Health*, (Accra: Ghana Academy of Arts and Sciences), 183.

<sup>70</sup> Philip D. Curtin, “The White Man's Grave: Image and Reality, 1780-1850,” *Journal of British Studies* 1, no.1 (Nov., 1961), 94-110. See also Philip D. Curtin, “The End of the ‘White Man's Grave’? Nineteenth-Century Mortality in West Africa,” *The Journal of Interdisciplinary History* 21, no.1 (Summer, 1990), 63-88; Ernest Eiloart, “The Land of Death: A Pamphlet Addressed to the Members of Both Houses of Parliament; With Some Observations on the Present Mode of Making Selections for Colonial Appointment, 1887” In Andersen, Casper and Andrew Cohen (eds), *The Government and Administration of Africa, 1880-1939*, (London and New York: Routledge, Taylor & Francis, 2016), 53-54.

the colonial officials and other Europeans.<sup>71</sup> But, Senah, Adusei and Akor offer a more critical account of the history of Western medicine, representing a new generation of scholars willing to engage with colonial critiques of Western medicine and its activities in the region, a perspective they share with many African scholars in the early twenty-first century. They call attention to how the indigenous African people were initially denied medical care under a system of medical apartheid where Western medical care was provided only for Europeans. Only from the 1850s were Western medical services extended to the local population. This was when the British colonial administration realised that the health of the Europeans could not be guaranteed unless the healthcare needs of the indigenous people were addressed.<sup>72</sup> Specifically, Europeans became conscious of the risk of being infected with diseases endemic in local African populations. Similarly, colonial governments in Africa began to provide medical attention to the indigenous population at the time when the health of Europeans were secured.<sup>73</sup>

What is evident in the Ghanaian historiography is that only occasionally do Christian missionaries feature as principal contributors in the introduction of Western medicine. A newer literature on the history of medicine in Africa, centring on East and Central Africa, has established that Christian missions extensively provided medical services to both Europeans and Africans prior to the organisation of the colonial medical service. As reported in the works of these scholars, while colonial medical services were for a long period of time withheld from Africans, the missions remained an important

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<sup>71</sup> Kodjo A. Senah, Joseph K. Adusei and Samuel A. Akor, *A Baseline Study into Traditional Medicine Practice in Ghana* (MOH/DANIDA PROJECT, 2001), 6.

<sup>72</sup> Senah, Adusei and Akor, *A Baseline Study into Traditional Medicine Practice in Ghana*, 6.

<sup>73</sup> Clement C. Chesterman, "The Training and Employment of African Natives as Medical Assistants." *Proceedings of the Royal Society of Medicine* 25, no.7 (1932), 1067.

source of Western medical services to them. Insights from this literature suggest that, in fact, missionaries played a lead role in the extension of medical services across British Africa. Michael Jennings, a Reader in International Development, has argued that missionary medicine cannot be disassociated from the early colonial health services.<sup>74</sup> This is because missionaries provided medical services for people in remote areas where colonial medical service was absent. Their services extended especially to the rural communities and established dispensaries or mission hospitals in those locations. Jennings further reports that in the early years of the colonial period in West Africa, Western medical services were predominantly provided by the missionaries, especially to the African population than the colonial medical services which were concentrated in the urban and administrative centres.<sup>75</sup> Jennings contends that

the services offered by the state and by missions and indeed by the commercial companies were part of one system, albeit with different emphasis, different structures of authority and funding, but nevertheless too vital parts that only together could justify a claim to provide medical care for Africans.<sup>76</sup>

Barbra Mann Wall, a historian of nursing, likewise placed the genesis of Western medicine in sub-Saharan Africa within the context of a coexistence between missionaries and colonial administration both of which provided medical assistance to Europeans and Africans.<sup>77</sup> Wall explored the Catholic medical mission movement in sub-Saharan Africa with focus on the work of Catholic sisters from 1945 to 1985. From a methodological approach that foregrounds gender, she stated that examining the lived reality of mission

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<sup>74</sup> Michael Jennings, "Healing of Bodies, Salvation of Souls: Missionary Medicine in Colonial Tanganyika, 1870s-1939," *Journal of Religion in Africa* 38, no.1 (2008), 27-39.

<sup>75</sup> Ibid.

<sup>76</sup> Ibid.

<sup>77</sup> Barbra Mann Wall, *Into Africa: A Transnational History of Catholic Medical Missions and Social Change*, (Rutgers University Press, 2015), 1-5.

work on where health care was really provided reveals how political movements, religious shifts, and views about medicine and nursing intersected with American and European women's contacts with the people from Africa. Her work gives insights into the missionary role in the training and employment of African health labour. The motivation of missionaries to train African nurses and midwives was to ensure acceptance of their religious and medical ideals.<sup>78</sup>

Hans W. Debrunner, a Swiss German historian and theologian, brings these observations to the forefront in Ghana. His account of the early missionaries assert that the main contribution of missionaries to healthcare was in the training of personnel. Missions increased the supply of Christian doctors and nurses, and engaged in the training of African staff.<sup>79</sup> However, here and elsewhere in the literature on the development of Western medicine in Ghana, discussions are skewed toward colonial medical services with little reference to early missionary efforts in the development of Western medicine.<sup>80</sup> The reason for the colonial favoured narratives is fraught in uncertainty, but it may be accurate to speculate that unlike the colonial archive in Ghana, the challenge of archival access and the availability of extant medical missionary records could contribute to such a setback. That stated, there is little doubt concerning the availability of medical missionary records amid the question of accessibility. The main challenge with the missionary archive in Ghana revolves around the depth of available records to extrapolate data for research. The literature on Christianity in Ghana that consulted missionary records largely accessed missionary archives outside the country.

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<sup>78</sup> Wall, *Into Africa: A Transnational History of Catholic Medical Missions and Social Change*, 1-5.

<sup>79</sup> Debrunner, *History of Christianity in Ghana*, 344.

<sup>80</sup> Walker, *Religion in Global Health and Development: The Case of Twentieth-Century Ghana*.

The challenge perhaps relates to enough funding for visiting those distant archives in the United Kingdom, Germany, Switzerland and other countries that hold these archives. For this reason, the introduction and formalisation of Western medicine in the Gold Coast, including the transition from attending to the sick from the home environment to formal European-style health care facilities need to be re-examined with the inclusion of missionary accounts to understand the historical development of Ghana's pluralistic health system and other pertinent issues concerning the practice of medicine and healthcare. Re-examining missionary and colonial texts can help reposition timelines on the evolution of Western medicine in Ghana and reframe our understanding of the contribution of African health labour to the evolution of attendant care in Ghanaian hospitals.

Some early historical writers can be reread as primary texts, helping to advance this investigation. H. J. O'D Burke-Gaffney, an European physician in his address at a symposium on the history of medicine in the African countries, including the Gold Coast stated that the introduction of Western medicine into West Africa began with the development of European settlements.<sup>81</sup> According to him, naval and military surgeons as well as missionary doctors and nurses had made headway in the practice of Western medicine in the eighteenth century but their contribution was limited. Burke-Gaffney believed the pioneers in the provision of and extension of Western medical services to Africans were the Christian missionaries. The Christian medical missions took a lead in

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<sup>81</sup> H. J. O'D. Burke-Gaffney, "The History of Medicine in the African Countries," *Medical History* 12, no.1 (1968), 31-32. This paper was read at the Symposium on the History of Medicine in the Commonwealth, Faculty of the History of Medicine and Pharmacy, London on September 23, 1966.

the establishment of dispensaries and hospitals in East, Central, West and South Africa.<sup>82</sup> A part of the core mission of the early missionaries was to secure the health and well-being of individuals as a means to proclaim the message of salvation to them.

Burke-Gaffney is not alone. An 1860 report of Robert Clarke, a British Colonial Medical Officer and a former Acting Judicial Assessor of the Gold Coast reveals that medical facilities, mostly dispensaries but also a hospital for local populations, existed prior to 1860.<sup>83</sup> The report captures his experience and observation of the topography and diseases of the Gold Coast through a service of nearly twenty-three years in Sierra Leone and the Gold Coast. Clarke's account suggest that dispensaries existed in the Gold Coast at Accra prior to 1860. The people of the Gold Coast in the mid-nineteenth century reported to the dispensaries with various diseases like measles, yaws, scabies, goitre, impotency, elephantiasis, leprosy, psoriasis palmaris, cataract, and other chronic and infectious diseases for treatment.<sup>84</sup> Clarke gave details of his involvement in providing medical assistance to African populations of the Gold Coast, including performing several surgeries to remove tumours, dry gangrene of the little toe, fractured limbs, and wounds.

According to Clarke, in 1857, diseases were treated at a hospital in Accra and that patients who were given medical attention in the hospital had visited the dispensaries in the town.<sup>85</sup> This account challenges the positions of Addae, Twumasi and Ewusi that Western medical services were opened to the African population after the 1850s.<sup>86</sup> The

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<sup>82</sup> Burke-Gaffney, "The History of Medicine in the African Countries," 31-32.

<sup>83</sup> Robert Clarke, "Remarks on the Topography and Diseases of the Gold Coast," (London: J. Richards, 1860).

<sup>84</sup> *Ibid.*, 28-34.

<sup>85</sup> *Ibid.*, 29.

<sup>86</sup> Addae, "Evolution of Modern Medicine in Ghana," 46.

existence of dispensaries, although Clarke did not specify either their purpose or who built those structures (the missionaries or colonial government), indicates that institutional initiatives to provide health care to both the African and European population occurred earlier than accounts presented in the historical literature. With Clarke and Burke-Gaffney as an example, this suggests that the re-examination of missionary and colonial records could provide a more nuanced understanding of the beginning and development of Western medicine in the Gold Coast.

Historians of health and medicine in Ghana have for many years focused on the colonial state. This report joins other writers to reconsider the role of and incorporate missionary activities in the development of Western medicine. This results in a more balanced account and highlights the interplay between colonial and missionary medicine in the development of a Western health system in Africa. For example, extending the timeline and widening the scope helps advance the discourse on African health labour, particularly their contribution towards the development of many kinds of attendant care in hospitals. The closest a historian comes to a thorough history of African health labour is Stephen Addae.<sup>87</sup> The group of African health labour that received attention in Addae's account were dispensers, dressers and nurses, described under the common name as "supporting staff" or "assistants." But even his work reveals only an incomplete picture of the history of attendant care in Ghanaian hospitals. This calls for purposeful and focussed research on the African health labour. Against this historiography this report examines African health labour in the Gold Coast from 1860 to 1950 with a focus on the overlooked

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<sup>87</sup> Addae, "Evolution of Modern Medicine in Ghana," 268-295.

contribution of orderlies who constitute the first generation of health care providers in Ghana's Western system of health care.

## The Evolution of African Health Labour in the Gold Coast

From the mid-nineteenth century, Western medicine was an essential component of missionary and colonial health services in the Gold Coast. The enlistment of indigenous people as medical aides in this system was critical to its performance, but it did not take place in a vacuum. As documented in the previous section, the educational efforts of the Christian missionaries prior to the 1880s produced most of the African labour in the Gold Coast. Evidence suggests that Western education provided the foundation for the training and employment of African labour into the colonial and missionary medical space. The earlier activities of the Christian missions prior to the inception of, and during the colonial period transcended education to include healthcare.<sup>88</sup> We have seen now twentieth-century publications on missionary and colonial histories of Africa show that medical personnel of African descent had received their first training and experience in healthcare through their work of Christian medical missions.<sup>89</sup> A former missionary to the Belgian Congo and secretary of the African Committee of the Division of Missions of the National Council of Churches in America, Emory Ross, commented on the Gold Coast that “Christian missionaries introduced the first sustained Western-type education.”<sup>90</sup> Education remains a central component of this story.

Emergent historiography also shows that the training of Africans into Western medical services were initiated almost everywhere on the continent by missionaries.<sup>91</sup>

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<sup>88</sup> Walker, *Religion in Global Health and Development*.

<sup>89</sup> Adell Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, (University Press of Florida, 1996), 2; Debrunner, *History of Christianity in Ghana*, 344.

<sup>90</sup> Ross, “Christianity and Ghana,” 28.

<sup>91</sup> *Ibid.* On 19th October, 1978, the president of the Royal Society of Tropical Medicine and Hygiene, Dr. S. G. Browne adjudged medical missionaries as pioneers in the introduction of Western medicine into

Through a study of the history of missionaries on the continent, we know that missionaries in West Africa were training and engaging locals as health care providers. Also, the fragmentary archive strongly suggests that the same is true when considering the missionary health services of the Gold Coast. Notwithstanding the recognition of missionary role in the employment of African health staff, the Ghanaian historiography of medicine has favoured the more limited colonial narrative of the subject. The limitations of existing accounts derive from their over dependence on colonial archives and a disinterest in biographical approaches to constructing such histories, an approach whose value is demonstrated by Kumwenda. The current narrative collates accounts produced from both colonial and missionary archives to trace the evolution of African health labour in the Gold Coast.

Nonetheless, we can see that, by 1860, missionaries and colonial officials had enlisted Africans to attend to the sick in the Gold Coast. Evidence from scattered accounts in primary sources and references in secondary works show that from 1860 to 1957, these categories of African health labour existed in the Gold Coast: orderlies, dispensers, dressers, doctors, nurses, and midwives. Work regimes and qualifications separated each group. Apart from doctors, all other categories were grouped as medical auxiliaries under the supervision of European medical officers and nurses. The accounts of the enlistment and training of the African medical auxiliaries in the colonial medical service have been documented within wider studies, except orderlies who have merited passing comment.

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many tropical countries at a meeting held at Manson House, UK. See Royal Society of Tropical Medicine and Hygiene, "The Contribution of Medical Missionaries to Tropical Medicine," *Transactions of the Royal Society of Tropical Medicine and Hygiene* 73, no.4 (1979), 357.

All forms of African labour were central to the success of the emerging health system. From the late eighteenth century to the early nineteenth century, colonial and missionary medical officers constantly succumbed to tropical diseases, notably malaria, yellow fever and dysentery.<sup>92</sup> As part of a solution to this problem, colonial officials and missionaries decided to train Africans to assist European medical officers to look after the health of Europeans and, later, the African population. To missionaries and colonial officials, Africans had built immunity against some of the diseases of the tropics, therefore their training into the medical system would help to sustain both the health of Europeans and imperial system.<sup>93</sup>

As a result, from the 1790s to 1900, African doctors from the West Indies were trained for this purpose. With Sierra Leone as the centre of recruitment, the new European-trained doctors were posted to other British colonies in West Africa. These early trained doctors include individuals well known to western African historians of medicine: Dr. William Fergusson, Dr. John Farell Easmon, Dr. Spilbury Smith, Dr. J.O Coker, and Dr. William Awooner-Renner.<sup>94</sup> The services of these doctors and other medical auxiliaries in the British West African colonies won over indigenous people, encouraging them to seek treatment at Western medical facilities. In the early development of Western medicine and related infrastructure in the Gold Coast, records from the 1840s show that indigenous people were generally reluctant to avail themselves

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<sup>92</sup> Curtin, "The White Man's Grave: Image and Reality, 1780-1850," 94-110.

<sup>93</sup> Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 56-57.

<sup>94</sup> *Ibid.*; See also Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 240; Florence Ejogha Nkwam, "British Medical and Health Policies in West Africa c.1920-1960," (PhD Dissertation, University of London School of Oriental and African Studies, 1998), 152-153.

for Western medical treatment. This resistance can be framed around the implications of traditional notions of healthcare, race and colonial healthcare policies.

Indigenous people initially became suspicious of Western medicine partly because the concept of sickness, and therefore also modes of treatment, did not match traditional concepts of sickness. By the 1900s, a majority of indigenous people were not willing to accept Western medical treatments because they regarded European medical officers as strange figures who used strange methods of treatments such as collecting blood and faecal samples, cut open dead bodies, and, as mentioned before, asking impolite questions through their interpreters.<sup>95</sup> The indigenous people also disliked prolonged treatments in Western medical facilities, especially treatments related to the care and management of chronic and other diseases such as smallpox.<sup>96</sup> To retain the confidence of Africans to patronise Western medical service required the inclusion of Africans into the medical service.

Ordinarily, Africans were needed in the missionary and colonial medical service to prove to their fellows that Western medicine was not only the preserve of the “white man.” In the 1840s, Debrunner reports that the people of Akropong, an inland territory of the Gold Coast did not accept the message of the Basel missionary, Andreas Riis until he showed them “black men who could read the whiteman’s book [bible].”<sup>97</sup> The Basel Mission acted upon the suggestion of the then Governor of the Gold Coast, Sir T. F. Buxton to recruit Africans from the West Indies and Sierra Leone. In 1885, the Accra General Hospital recorded an increase in attendance rates among the African population

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<sup>95</sup> Addae, “Evolution of Modern Medicine in Ghana,” 19.

<sup>96</sup> Gold Coast Medical Department (GCMD), “Medical and Sanitary Report 1897,” (Gold Coast: Government Printer, 1897), 175.

<sup>97</sup> Debrunner, *History of Christianity in Ghana*, 107.

at a time when the African, Dr. Easmon was the resident medical officer.<sup>98</sup> During his stay, a daily record shows that fifty-three inpatients and one hundred and six outpatients were treated at the hospital. In May 1897, Governor William Maxwell introduced a Hospital and Dispensary Fee Ordinance which required the people of the Gold Coast to access health care at a fee. This policy also deterred the indigenous people, who could not afford hospital fees.<sup>99</sup> Other sources cite distance as a factor for poor patronage of hospital services.<sup>100</sup> But, in the context of resistance, distance does not completely explain rationales behind indigenous people's unwillingness to patronise the services of Western medicine. The employment of African health labour was deemed essential to solve the problem.

In 1874, the Gold Coast formally became a British colony and the changes from this period are insightful. This period marked the beginning of expansion of colonial government infrastructure. We must not forget that the contribution of Christian missionaries to education and health continued throughout the colonial period. Therefore, any reference to an increase in medical infrastructure included those by missions. From 1880, the British colonial government began to expand health facilities in the Gold Coast and engaged missions in this expansion. Prior to 1914, the Gold Coast like other British West African colonies had suffered from a shortage in health staff, and this continued because of first World War.<sup>101</sup> Over these decades, the Colonial Office in London could not recruit more British doctors for the colonies. The Colonial Nursing Service

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<sup>98</sup> Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 103.

<sup>99</sup> Sylvester Gundona, "A Study of Health Conditions and Disease Control in the Northern Territories of the Gold Coast, 1897-1956," (MPhil, University of Ghana, 1999), 35.

<sup>100</sup> *Ibid.*, 36-37.

<sup>101</sup> Nkwam, "British Medical and Health Policies in West Africa c.1920-1960," 156-182.

experienced similar challenges and the colonies could no longer depend on the supply of medical officers and nurses from Britain. The employment and training of more African staff appeared the only plausible solution to the staffing problem at a time of increasing in health demand and expansion in infrastructure. In 1917, Governor Hugh Clifford of the Gold Coast instituted a dispensary scheme aimed at expanding medical infrastructure in the colony to benefit the African population.<sup>102</sup> Yet, the European medical staff were insufficient to meet Governor Clifford's plan for the establishment of dispensaries to supplement hospitals in the colony. The only solution was to employ and train more African medical auxiliaries, and eventually train them for more advanced occupations.

Of all the African medical auxiliaries, which excludes the special professional category of doctor, dispensers were at the top of the hierarchy within the colonial medical service organisation in terms of training, work and qualifications. As early as 1901, Gold Coast dispensers commanded the respect of colonial officials while other African supporting staff like dressers and nurses (exclusively males) struggled to please colonial officials.<sup>103</sup> When the proposal to train African doctors locally advanced in the early twentieth century, dispensers were found to possess the minimum qualifications, which was a four-year dispenser training certificate and experience to enter medical schools.<sup>104</sup> This pipeline into the medical profession goes back, from documented sources, to the late nineteenth century. Addae indicates that the earliest dispensers were recruited from Cape Coast and Accra.<sup>105</sup> As previously stated, the coastal towns of the Gold Coast colony

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<sup>102</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 232.

<sup>103</sup> GCMD, "Medical and Sanitary Report 1901," (Gold Coast: Government Printer, 1901), 14.

<sup>104</sup> Addae shows that the third and fourth Ghanaian doctors, Nanka-Bruce and C E Reindorf who graduated in 1907 and 1910 respectively, practiced as dispensers for several years before proceeding to study medicine. See Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 269.

<sup>105</sup> Ibid.

including Cape Coast and Accra were the first to experience Western forms of education and healthcare because of their encounter with Europeans from the fifteenth century.

From these communities, many clinicians would be recruited and trained.

Addae mentions names like Sutton, Hagan, Smith, Fynn, Plange, John Cato, Bartels, Thompson, Wellington and Lartey who all worked as dispensers between 1880 and 1910. There are no details given about these individuals in Addae's work, with the exception of John Cato who we learn had a long tenure as a dispenser from 1887 to 1922.<sup>106</sup> Dispensers functioned as the immediate assistants to medical officers and were tasked with the responsibility to treat common diseases such as malaria, diarrhoea, yaws and upper respiratory problems. They also dispensed drugs and compiled annual medical reports for their health posts. From the 1890s to the 1910s, the duties of sanitary inspectors became part of the work of dispensers until the establishment of the Sanitary branch of the Medical Department.<sup>107</sup>

Up to 1895, dispensers in the Gold Coast colony were mainly trained at the Accra General Hospital established in 1878.<sup>108</sup> They later received training from the Cape Coast and Elmina Hospitals. In terms of recruiting candidates for training, Addae revealed that qualified candidates had obtained some secondary education, but the records do not show to what level. However, he speculated that the minimum qualification would have been the Standard VII school certificate, roughly equivalent to Junior High school completion.

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<sup>106</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 269.

<sup>107</sup> Ibid. From 1923, dispensers, nurses, and midwives received their training at the Gold Coast Government Hospital, now the Korle-Bu Teaching Hospital after its inauguration in the same year.

<sup>108</sup> Ibid., 270.

In the Gold Coast pupils spent nine to ten years in primary school education.<sup>109</sup> After completion of primary school, they took the Standard VII certificate examination. Those who passed this examination were awarded the Standard VII certificate and could attend secondary schools. Dispensers received a three-year training at the hospitals and afterwards obtained a license to practice under Ordinance No.14 of 1892 after passing a final examination.

The role of dispensers is tied to the history of orderlies through this loose categorisation of “medical auxiliary” that captured both orderlies and dispensers in the historical records. There were persistent challenges with attracting candidates for training as dispensers. The historiography has emphasised poor educational standards and working conditions as deterrents. From the late nineteenth century to the mid-twentieth century, only few individuals had obtained the minimum educational requirement: Standard VII certificate for training as a dispenser.<sup>110</sup> In the Northern territories of the Gold Coast, the government faced difficulty in securing local candidates for training since formal education started late in those territories.<sup>111</sup> The government also did not have enough instructors to train candidates. Dispensers were thus typically supplied to the North from the Southern territories of the Gold Coast, and these relocated staff complained about the poor working conditions of the remote areas. Concerns over conditions remained a deterrent, and when combined with poorer pay, curtailed the recruitment of health personnel.

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<sup>109</sup> Ebenezer Ayesu, Francis Gbormittah and Kwame Adum-Kyeremeh, “British Colonialism and Women's Welfare in the Gold Coast Colony,” *Africa Today* 63, no.2 (2016), 15.

<sup>110</sup> *Ibid.*, 271.

<sup>111</sup> Gundona, “A Study of Health Conditions and Disease Control,” 48.

Remuneration was a persistent problem. Although dispensers were at the top of the medical hierarchy among African medical auxiliaries, they earned poor salaries as compared to other professionally related occupations like clerks in commercial industry. In 1900, the annual salaries of the medical staff were: Newly recruit medical officer - £400; European nurse - £200; Senior dispensers - £50; Dressers £36; Nurses - £24.<sup>112</sup> Here, although Addae did not specify the category of ‘Nurses’ as entered in colonial reports, this group might refer to African nursing assistants. Again, the category, ‘Senior dispensers’ in the colonial medical reports leaves the impression that there was more than one class of dispenser. The class structure within the health system will be addressed in later sections, but we know that between 1880 and 1920, the poor remuneration culminated in the mass resignations of dispensers and other African auxiliary staff. These individuals left to take up jobs in the booming cocoa industry in the 1910s, which was more materially rewarding. In 1912, the medical department devised schemes to improve the conditions of service of the African auxiliary staff.<sup>113</sup> In 1935, for instance, the medical department introduced field allowance to pay dispensers in order to retain them in the service, accept postings to the North, and to attract more candidates for training.<sup>114</sup>

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<sup>112</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 271.

<sup>113</sup> *Ibid.*, 272.

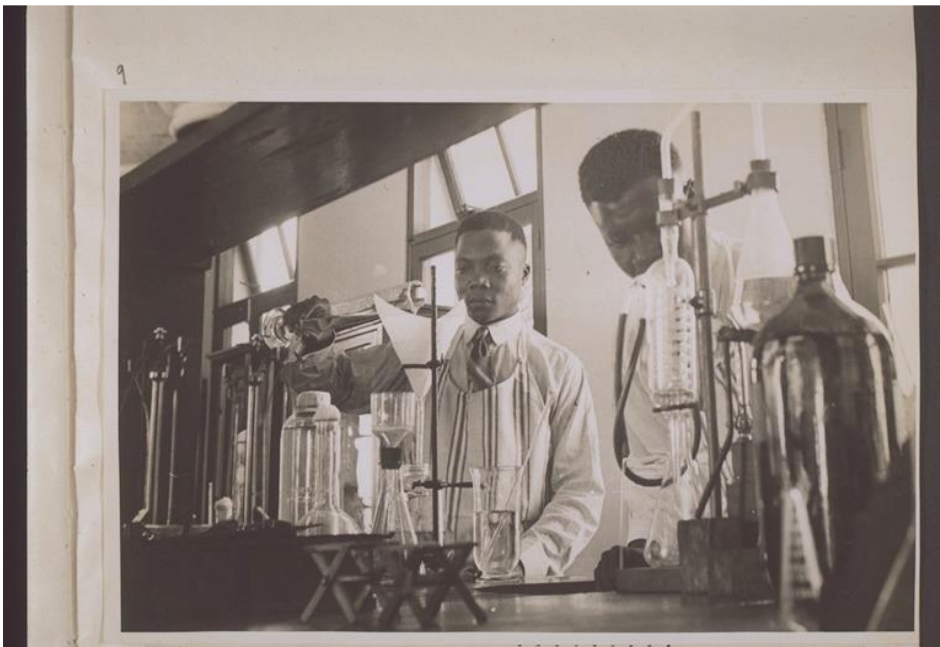
<sup>114</sup> Gundona, “A Study of Health Conditions and Disease Control,” 49-50.

**Figure 1: A Class of Students at the School for Dispensers, Gold Coast Hospital, 1941-1945**



Source: Basel Mission Archives (BMA), Ref. no. QD-30.102.0008, "Work of the Gold Coast Hospital, Accra-School for Dispensers," August 01, 1941-Dec 31, 1945.

**Figure 2: Dispensers at the Gold Coast Hospital, 1941-1945**



Source: BMA, Ref. no. QD-30.102.0009, "Work of the Gold Coast Hospital, Accra-School for Dispensers," August 01, 1941-Dec 31, 1945.

For reasons that remain unclear, dispensers were grouped into three classes: first, second and third. This occupational stratification strongly suggests the category of auxiliary was becoming more complex. While the class distinctions might depend on period of training or qualification, between 1880 and 1960, Addae showed four transformations in the vocabulary of dispensers: Dispensers (1880-1930); Dispenser-nurse (1930-1950); Clinical Superintendent (1950-1960); Health Superintendent (1960).<sup>115</sup> In 1930, for instance, the stratification saw the Medical Department of the Gold Coast proposed a new scheme for the training of candidates from the grade of dispensers to dispenser-nurse.<sup>116</sup> The Department implemented the new scheme in 1931. The responsibilities of the new grade of dispensers were seemingly not different from their previous roles. Dispenser-nurses were tasked to nurse wounds of all kinds, attend to common diseases like malaria and others, provide first aid, give injections, and dispense drugs. Dispenser-nurses were instructed in a four-year course; nursing was taught in the first two years and dispensing, elementary medicine and surgery in the last two years.<sup>117</sup> The Gold Coast Hospital that opened on October 09, 1923 became the central facility for training dispenser-nurses. By 1932, about fifty dispenser-nurses were posted to man dispensary across the Gold Coast. In the 1950s, the medical department introduced a new grade, clinical superintendents to replace dispenser-nurses. Dispenser-nurses were required to undergo another year of training to qualify as a clinical superintendent. Clinical superintendents manned various dispensaries under the supervision of district

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<sup>115</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 278.

<sup>116</sup> *Ibid.*, 275-276.

<sup>117</sup> *Ibid.*

medical officers. In 1960, health superintendents replaced clinical superintendents and were put in charge of health education and provide curative medical services.<sup>118</sup>

Before the complexities of work stratification, credentialing and specialisation were implemented in the 20th century, the government set various gateway for local labour to enter the system more readily. A good early example of this practice is the training of medical officers, and medical doctors. In 1919, the Governor of the Gold Coast, Sir Frederick Gordon Guggisberg put forward an initiative to train African medical officers locally.<sup>119</sup> Guggisberg believed that the training of African medical officers locally would equip them with enough clinical experience so they could be integrated into the health systems of West Africa. Previously, African doctors from British West Africa received their training from Britain. However, the absence of a medical college in the Gold Coast prohibited the successful implementation of Guggisberg's plan. In 1921 and in the absence of a medical college, Guggisberg consulted Winston Churchill, the then Secretary of State for the Colonies of the possibility of training medical assistants in place of fully qualified medical doctors.<sup>120</sup> In 1927, the Secretary of State instructed colonies to train "medical assistants," including those who could work as dispensers.<sup>121</sup> Initially, the state attempted to recruit dispensers into this category, but, once again, the initiative failed due to lack of educational resources.<sup>122</sup> This is an example of how the gateway model sometimes proved

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<sup>118</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 276.

<sup>119</sup> Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 156.

<sup>120</sup> *Ibid.*

<sup>121</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 273.

<sup>122</sup> Nkwam, "British Medical and Health Policies in West Africa c.1920-1960," 34.

insufficient to move African health personnel up through the system hierarchy, but shows how reliant the system was on the gateway model itself.

This was a significant change, because by the 1930s, the Medical Department considered the construction of health centres below the grade of dispensaries called treatment centres or dressing stations.<sup>123</sup> These centres existed to supplement the work of dispensaries and most importantly, extend healthcare to rural communities where dispensaries were non-existent. Another group of African medical auxiliaries known as dressers constituted the main staff of the treatment centres while dispensers paid periodic visits. “Dressing stations” differed from dispensaries by their smaller size and dressers seemingly had a smaller, surgical scope of practice.<sup>124</sup> There is not much literature on dressers although Sylvester Gundona’s work<sup>125</sup> on the study of health conditions and disease control in the Northern Territories of the Gold Coast suggest the duties of dressers included: to give injections for yaws, dress wounds, treat scabies and round worms, administer smallpox vaccinations, and assist in education on the use of quinine.<sup>126</sup> In the Northern territory of the Gold Coast, suitable candidates were trained at the Tamale African Hospital. Dressers received training for one year before being deployed to the field, training that was expanded to eighteen months by 1950. The literature is silent on the minimum educational qualification. However, anecdotal account shows that suitable trainees might possess qualifications up to Standard VII certificate. A training school for dressers was established at Kintampo, a town of the middle belt of the

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<sup>123</sup> Gundona, “A Study of Health Conditions and Disease Control,” 50-51.

<sup>124</sup> Ibid.

<sup>125</sup> Ibid.

<sup>126</sup> Ibid.

Gold Coast which served individuals from Asante and the Northern territory. Successful for a decade or so, in 1950, the school closed down because there was no instructor to train candidates. The medical department then resolved to train dressers in hospitals, through an on-site curriculum.

The further the historical record gets from the traditional categories of doctor and dispenser, and the further the health service gets from the main cities of what is now Ghana, the scarcer the documentary record of who the attendants, auxiliaries, and aides were. We also know less and less about these workers' actual training and the scope of their work. On the other hand, we do know a great deal from reports, and colonial official complaints, that they were filling a health service need, and that this category fed into the other categories of health service in the region. By the late nineteenth century, for instance, European medical officers trained local boys noticeably orderlies to perform basic nursing tasks such as washing and feeding patients, cleaning hospital wards, and administering drugs.<sup>127</sup> The historiography of nursing in Ghana does not provide any details of these "supporting staff," but only that passing comment about their work.<sup>128</sup>

Many studies place emphasis on professionalising nursing in Ghana which began after 1899. While it is acknowledged that the local training of professional nurses in Ghana generally began after 1899 under the instruction of colonial European nurses, the

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<sup>127</sup> Docia A.N. Kisseih, "A Brief Survey of Nursing in Ghana," *Ghana Medical Journal* (1962), 22; Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 279; Böhmig, *Ghanaian Nurses at the Crossroads*, 42.

<sup>128</sup> Key scholarly works in the area of the development of nursing in Ghana include the works of Chief Nursing Officer, Kisseih on "A Brief Survey of Nursing in Ghana," 22-24; Addae, "Evolution of Modern Medicine in Ghana, 1880-1960"; Mary Opere and Judy E. Mill, "The Evolution of Nursing Education in a Postindependence Context—Ghana from 1957 to 1970," *Western Journal of Nursing Research* 22, no.8 (2000), 936-944. and Böhmig, *Ghanaian Nurses at the Crossroads: Managing Expectations on a Medical Ward*.

timeline for locating when these nurses first took appointments in the Gold Coast is contested in the literature. For example, Addae has documented that the first two European nurses arrived in the Gold Coast in 1878 after the completion of a hospital at Accra.<sup>129</sup> He states further that, until 1897, the appointment of European nurses to the Gold Coast was not regularly done. In the same year, 1897, three nurses arrived in the Gold Coast to conduct a three-year feasibility study into the suitability of starting nursing work in the colony. After this survey, nurses were regularly posted to the Gold Coast from 1899 to offer health services and lay the foundation for training indigenous people as professional nurses.<sup>130</sup> In the account of the Ghanaian Chief Nursing Officer, Docia A. N. Kisseih on the training of nurses, she identifies 1899 as the year when the first two European nurses came to the Gold Coast from Britain.<sup>131</sup> Notwithstanding this lack of consensus, we know that European nurses began to take appointments in the Gold Coast in the second half of the nineteenth century to lay the foundation of training African professional nurses.

The training of the professional nurse up to 1940 was apprentice-based. Candidates studied under European nurses for three years in relatively larger hospitals in Accra, Cape Coast, Sekondi, Kumase and Koforidua. By 1920, European nurses were stationed in these hospitals to offer health services and to train African nurses for bedside care.<sup>132</sup> The ultimate plan was to train women for this role. In the British West African colonies, colonial officials aimed at developing nursing as a profession for women.<sup>133</sup>

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<sup>129</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 278.

<sup>130</sup> *Ibid.*, 279.

<sup>131</sup> Kisseih, "A Brief Survey of Nursing in Ghana," 22.

<sup>132</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 280.

<sup>133</sup> Nkwam, "British Medical and Health Policies in West Africa c.1920-1960," 233.

However, the difficulty in attracting adequate number of women for employment and training made nursing a male-dominated profession in this region. The inadequacy of finding suitable and prospective women for training has been attributed to the lack of formal education among a majority of women, meaning they could not meet recruitment criteria.<sup>134</sup> But local women considered nursing a lower status position in society, and were traditionally discouraged or even prohibited from work outside family home.<sup>135</sup>

According to Addae, the teaching curriculum for training nurses tried to offset “universally-low educational standards of the time.”<sup>136</sup> Candidates for training were instructed in anatomy and physiology, medical and surgical nursing, hygiene and first aid. Successful candidates at the end of their training were issued with the Director of Medical Service Certificate and graded as Second Division Nurses under the supervision of European nurses.<sup>137</sup> Hierarchically, the colonial nursing service was divided into two; the Junior Civil Service and Senior Civil Service. Until the 1940s, when advanced nursing trained began to be offered, all locally trained nurses made up the Junior Civil Service. The Senior Civil Service was made up of only European nurses and local girls

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<sup>134</sup> Kisseih shows some variation in the qualifications of prospective trainees in both government and missionary facilities. Some prospective trainees possessed the Middle School Leaving Certificate (Standard VII). Others had some few years of schooling but entered the service because they had good knowledge of English. See Kisseih, “A Brief Survey of Nursing in Ghana,” 22. The educational standard of trainee-nurses coupled with their attitude towards work created problems for medical officers. In the 1900s, medical officers constantly complained about the difficulty in training local boys with little education. Locally trained male nurses were regarded as lazy individuals who did not understand their responsibilities. Out of frustration, a Principal Medical Officer, Dr W R Henderson is noted to have made these statements in 1901: “I would strongly recommend that some steps be taken to encourage a better class of men join the nursing service for really the type of boys we have had applying recently is too bad for anything. They are all ‘bush boys’ who have little education, so called, in the way of book work, otherwise they are absolute savages and quite unteachable.” See Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 280-281.

<sup>135</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 280-281; Kisseih, “A Brief Survey of Nursing in Ghana,” 22; Böhmig, *Ghanaian Nurses at the Crossroads: Managing Expectations on a Medical Ward*, 43.

<sup>136</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 280.

<sup>137</sup> Kisseih, “A Brief Survey of Nursing in Ghana,” 22.

who were trained in Britain. From 1928, governments of the Gold Coast developed a scheme to recruit, train and deploy more African nurses from the Gold Coast Hospital in Accra, Kumase and Sekondi hospitals.<sup>138</sup>

In the 1940s, successive colonial governments abandoned the apprentice system of training because a more formal training process failed to turn out the desired number of qualified nurses. They formulated a policy and a plan to train qualified nurses equivalent to British-trained nurses through on the job training.<sup>139</sup> To achieve this, two main classes of nurses were created by legislation: a higher-ranking State Registered Nurse (SRN) and subordinate Qualified Registered Nurse (QRN). In 1945, the decision to train a higher grade of nurses with qualifications equal to that in Britain led to the establishment of the first State Registered Nursing Training College in Kumase.<sup>140</sup> The school commenced with seventeen (17) students. The Kumase General Hospital offered the practical aspects of the training. Prospective applicants with a post-primary certificate (Standard VII certificate) took a competitive examination for selection to enrol in a one-year pre-nursing school at Achimota Secondary School in Accra. Successful students who completed the pre-nursing course proceeded to the Nursing Training College in Kumase through a four-month preliminary then to a three-year general nursing programme.<sup>141</sup> The Kumase Nursing Training School opened opportunities for girls in the Northern territories for nursing education. Entrance into the training school was opened to only women. And the record shows that the implementation of nurses' professional

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<sup>138</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 283.

<sup>139</sup> Kisseih, "A Brief Survey of Nursing in Ghana," 22; Nkwam, "British Medical and Health Policies in West Africa c.1920-1960," 233.

<sup>140</sup> Ibid.

<sup>141</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 285; Gundona, "A Study of Health Conditions and Disease Control," 159.

autonomy. The government also enacted a Nurses Ordinance in 1946. Implemented in 1947, the Ordinance institutes a Nurses Board to administer the credentialing.

**Figure 3: A Class of Nursing Students, Gold Coast Hospital, Accra, 1941-1945**



Source: BMA, Ref. no. QD-30.102.0007, “Work of the Gold Coast Hospital, Accra-Class of Students,” August 01, 1941- December 31, 1945.

From the above discussions, it is certain that the training of SRNs began in Kumase. The training was transferred to Accra in a period which is poorly understood in the historiography. During the 1940’s, a Nurses Training School for training SRNs and QRNs was also under construction at the Gold Coast Hospital. According to Addae, the training of SRNs was transferred to Accra in 1948.<sup>142</sup> In her account on the training of SRNs and QRNs, Florence Ejogha Nkwam indicated that in January 1945, the first six girls were admitted for training at the Nurses Training College at Accra. In July 1948,

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<sup>142</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 286.

four of the six students qualified as SRNs.<sup>143</sup> In July 1950, the training offered at the Accra Nurses College and examinations of the Nurses Board of the Gold Coast were “recognised as satisfying the requirements of the General Nursing Council of England and Wales for full reciprocity.”<sup>144</sup> By 1950, major hospitals in Accra, Kumase, Tamale, Sekondi and Cape Coast were providing training for nurses.

The last category of African subordinate health staff recruited and trained in the Gold Coast is the midwife. Little is known about the training of midwives in the Gold Coast. It appears that the only scholarly works that have considered the evolution of the local training of women in midwifery in Ghana are the works of Stephen Addae on the evolution of modern medicine in the country and Nana Akua Amponsah’s “Colonizing the Womb: Women, Midwifery, and the State in Colonial Ghana.”<sup>145</sup> Of these works, Amponsah’s detailed account describes missionary and colonial officials’ interest in improving maternal and child welfare services prompted the need to train indigenous people, preferably females to become, first, responsible mothers who would be able to raise a healthy generation, and second to train them as midwives. The earliest reference to infant welfare services dates to 1921. In this year, 1921, the Scottish Missionary, Dr. Jessie Beveridge is noted to have operated a welfare centre and a dispensary at Christiansborg (Osu), Accra, where she attended to minor ailments of schoolchildren and infants. She is noted to have extended her work to Aburi and Amedzofe. The colonial

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<sup>143</sup> Nkwam, “British Medical and Health Policies in West Africa c.1920-1960,” 233.

<sup>144</sup> Ibid.

<sup>145</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 287-295; Nana Akua Amponsah, “Colonizing the Womb: Women, Midwifery, and the State in Colonial Ghana,” (PhD Dissertation, University of Texas at Austin, 2011), 180-211.

government supported the work of Dr. Beveridge and supplied drugs, paid the salary of an interpreter and a grant-in-aid.<sup>146</sup>

In the 1930s, the Wesleyan Methodist Missionary Society also carried out some maternal and infant welfare services in the rural areas of the coastal territories and in Asante. They distributed items such as sponges, soaps, powder, basins, bandages, creams, clothes, and medicines to women and educated them on personal hygiene. By 1920, colonial officers and their missionary counterparts had conceived Gold Coast women as lacking the capacity to raise healthy children.<sup>147</sup> In 1911, Dr. O'Brien, a medical officer of the Gold Coast conducted a survey of the health of children in the colony and reported a high incidence of maternal and child mortality, calling for the education of indigenous women. In 1915, a Ghanaian medical officer, Dr. F. V. Nanka-Bruce raised concern about the rate of maternal and infant mortality and advocated for the proper training of indigenous midwives and the establishment well-equipped maternity hospitals.

In 1924, Governor Guggisberg approved a mother and child health plan including the training of African auxiliaries designed by Dr G J Pirie.<sup>148</sup> Governor Guggisberg began the construction of the Accra Maternity Hospital until he left office in 1927. In 1928, Mr. T. S. W. Thomas, the Acting Governor of the Gold Coast opened the Accra Maternity Hospital to provide maternity services and to train midwives. The Maternity hospital initially began a year of Western midwifery training programme for African nurses who had completed two years of general training at the Gold Coast Hospital. Dr. G. M. L. Summerhayes, a Woman Medical Officer was appointment to supervise the

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<sup>146</sup> Amponsah, "Colonizing the Womb," 99-100.

<sup>147</sup> *Ibid.*, 84.

<sup>148</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 252.

programme.<sup>149</sup> The individuals who complete the one-year midwifery and two years nursing programmes became nurse-midwives. They carried out their responsibility as nurses and midwives, and as health visitors. The midwives were responsible for the instruction of mothers in personal hygiene during and after pregnancy, vaccinations, reproductive health, nutrition, and sanitation.<sup>150</sup> During this period, ante-natal clinics were also in operation at Christiansborg, the Princess Marie Louise Hospital Welfare Clinic, and other government and mission welfare centres in the Gold Coast.

Amponsah has argued that, in the early stage of the recruitment and training of midwives in the 1920s, the colonial government prioritised men.<sup>151</sup> According to her, the colonial records do not offer explanation into the rationale behind the government's regulation regarding the practice of midwifery in domestic contexts. However, she surmised that colonial authorities imported into Africa, "the male physician's usurpation of obstetric care from laywomen that had occurred in Europe in the nineteenth century."<sup>152</sup> Other explanations offered include the colonial gender ideology that viewed women as only good for activities of domesticity and not for educational pursuits. The colonial officials eventually reversed this programme after realising that Ghanaian women were reluctant to patronise the services of male midwives and obstetricians. The long-term effect of training indigenous people in Western midwifery was to reduce maternal and infant mortalities on one hand. On the other hand, colonial officials regarded the training of midwives as an avenue to eliminate traditional midwives,

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<sup>149</sup> Amponsah, "Colonizing the Womb," 157-158.

<sup>150</sup> *Ibid.*, 195.

<sup>151</sup> *Ibid.*, 144-146.

<sup>152</sup> *Ibid.*, 199.

commonly known as Traditional Birth Attendants (TBAs). In the eyes of colonial officials and medical officers, TBAs lacked scientific knowledge in childbirth, and were the cause of maternal and infant mortalities.<sup>153</sup>

In 1931, the Governor of the Gold Coast, A. R. Slater passed into law a Midwives Ordinance to regulate the training and practice of midwifery.<sup>154</sup> As with the Nurses Ordinance that came later, the Midwives Ordinance of 1931 instituted the Midwives Board responsible for, among other things, the training, examination, regulation, licensing, and sanctioning of the behaviour of midwives in the country. The Ordinance defined two groups of midwives allowed to practice in the country: Unqualified Midwives and Registered Midwives.<sup>155</sup> The unqualified midwives consisted of traditional midwives who were trained in Western obstetric practice. Registered midwives were recognised qualified midwives gazetted in a Roll of Registered Midwives. By 1952, the number of registered midwives stood at three hundred and sixty-two. Some of them were employed into government service while others entered private practice but received government subsidies to expand the services of Western midwifery practice to remote areas.

The historiography of African health labour in Ghana leaves the impression that the subject is understudied. What is poorly understood is a clear distinction and transformations in the work of auxiliaries whose work overlapped with the other occupational categories. Apart from the regulated category of medical doctor, all other

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<sup>153</sup> Amponsah, "Colonizing the Womb," 182. In the traditional African society, women, particularly the TBAs oversaw maternal and child issues, including the management of the birthing process.

<sup>154</sup> *Ibid.*, 185.

<sup>155</sup> For details of the scope of training and course requirements for the training of Unqualified and Registered Midwives, see *Ibid.*, 187-194.

health occupations had an auxiliary component at the foundation of its local development. Then, stratification and specialization among the categories eventually bring the health worker identities and roles into line. However, power relations between African medical auxiliaries and their European medical superiors are poorly understood within these complex and shifting hierarchies. The daily routine, function, organisation and schemes of training for orderlies, dressers, need more detailed attention, and these are unfortunately not extant in the colonial archive. Yet, from the fragmentary archive captured and critically re-examined across a broad range of writers and secondary source literature, we see how the seemingly overlapping occupational responsibilities among the categories of African auxiliaries, the gendered nature and racial discrimination against African health labour also merits investigation. To understand the important of auxiliaries, the next two sections aim to address these elements.

## **Gender, Race and Class at Work:**

### **Enlisting African Health Labour in the Gold Coast**

The gendered nature of recruiting Africans into the colonial medical service was heavily influenced by European and African gender codes. European gender ideologies in the Gold Coast were introduced and maintained by colonial officials and Christian missionaries. The history of African health labour in the Gold Coast benefits from a gender and racial analysis. An examination of the experience of African health auxiliaries shows a gender bias, racial discrimination and class difference among doctors, dispensers, orderlies, dressers, nurses and midwives.

The first group of African health labour (orderlies) from the second half of the nineteenth century were men. Men dominated many categories of African health labour until the 1940s when more women began to enter the health service. Access to formal education, the persistence of traditional local gender norms, and the gendered ideologies of colonial governments and missionaries played significant roles in delaying women's inclusion in the health care system and finding a place within the Western medical service. These factors are key to understanding the gender disparity and the late employment of women into colonial health services and helps explain the sudden shift from training of male African labour to females in the 1920s.

Historically, the circumstances which surrounded female education in the Gold Coast reflect interesting developments in relation to gender and labour within the colonial healthcare services. The education of girls to a standard level that would make them meet the requirements for training as health personnel began late in the Gold Coast. The

educational system from this period to the 1840s was designed to provide a form of literacy that enabled children to read and write in European languages, predominantly English.<sup>156</sup> Additionally, by the eighteenth century, Christian missionaries frequently sent African boys from the Gold Coast to Europe for education and training to prepare them for both missionary work and to assist in European-African trade.<sup>157</sup> Thus, priority was given to men to pursue higher educational standards, as a reflection of the fact that missionary activities were a male-dominated venture. Although the wives of missionaries were involved in educating girls in the Gold Coast, girls were educated in domestic science to become good housewives and not as future missionaries. Also, the wives of missionaries were not considered as part of mainstream missionary work until the late eighteenth century when British middle-class women became active in evangelical work and as the main actors to effect social change among African women and children.<sup>158</sup> In the 1820s, the labour of the wives of missionaries was considered as important as their husbands' roles to ensuring the success of the various missions.

By 1850, missionary schools in the Gold Coast admitted both girls and boys at the elementary level. For instance, in 1848, thirty-seven girls and twenty-five boys attended a missionary school at Akropong.<sup>159</sup> Secondary sources are replete with accounts of schools for girls opened by missionaries. Their training was largely restricted to training in the domestic arts like weaving, knitting, and patching clothes, and the girls were thus taught to be good wives and servants in the Lord. It is not until the 1920s, that European

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<sup>156</sup> Debrunner, *History of Christianity in Ghana*, 27.

<sup>157</sup> *Ibid.*, 61-65.

<sup>158</sup> Sill, *Encounters in Quest of Christian Womanhood: The Basel Mission in pre-and early colonial Ghana*, 42.

<sup>159</sup> *Ibid.*

nurses in the Gold Coast proposed training local women in the field of nursing.<sup>160</sup>

However, they faced difficulties because a majority of local women lacked the basic literacy to follow an advanced or professional course of training.<sup>161</sup>

The educational level of African women mitigated against their early involvement in the colonial medical service, but the gendered ideology of colonial governments also played a role. For instance, Amponsah has argued that, in the early stage of the training of midwives in the 1920s, the colonial government prioritised men for this work.<sup>162</sup> The reason is not explicit, but she speculates that colonial authorities imported into Africa “the male physician’s usurpation of obstetric care from laywomen that had occurred in Europe in the nineteenth century.”<sup>163</sup> Other explanations for the preference to train men for midwifery reflect colonial and missionary gender ideologies that viewed women as only good for domestic work. On the other hand, missionaries and the colonial government of the Gold Coast regarded domestic science education as very important.

Domestic science education was seen as an opportunity for African women to gain elementary knowledge in skills such as cookery, needlework, housewifery and hygiene. At the heart of domestic science education was the attempt to promote public interest in the education of African girls.<sup>164</sup> Over the early twentieth century, the colonial governments, in conjunction with Christian missions, established twenty-two schools

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<sup>160</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 280.

<sup>161</sup> Kisseih shows some variation in the qualifications of prospective trainees in both government and missionary facilities. Some prospective trainees possessed the Middle School Leaving Certificate (Standard VII). Others had some few years of schooling but entered the service because they had good knowledge of English. See Kisseih, “A Brief Survey of Nursing in Ghana,” 22. Because of this, nursing and other categories of African health labour remained the preserve of men.

<sup>162</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 144-146.

<sup>163</sup> Amponsah, “Colonizing the Womb,” 199.

<sup>164</sup> Ayesu, Gbormittah and Adum-Kyeremeh, “British Colonialism and Women’s Welfare in the Gold Coast Colony,” 14-15.

purposely for educating girls. Out of these, sixteen were structured to deliver between nine-to-ten-year primary education.<sup>165</sup> With the remaining six, one ran an infant system of schooling (kindergarten) and the other a junior or middle school system. Women missionaries supervised these schools and the colonial government subsidised the joint effort to promote primary education among girls.<sup>166</sup> The colonial government later showed interest in training more women for work outside the home, particularly in the healthcare services, but they were hampered because no post-primary education existed for girls.<sup>167</sup>

Traditional women's roles in African society also placed constraints.

Traditionally, women's responsibilities were centred around their role as wives and mothers. Women were expected to submit to men and to keep the house, an ideology which excluded them from most paid work, and placed them under the dominion of men as fathers and husbands.<sup>168</sup> By the late 19th century, observers report that women were also largely responsible for reproduction and childcare, as well as domestic works such as cleaning, collecting firewood, drawing water, preparing food. Among the Akan women, for instance, this work included most tedious domestic tasks such as pounding *fufu*, a Ghanaian staple prepared from the mixture of starches mostly yam, cassava, cocoyam and plantain.<sup>169</sup> Women were important to other aspects of the economy, especially

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<sup>165</sup> The records do not clearly state the grade or age an individual might have reached or attained after going through the nine-to-ten-year primary education. It can however be deduced from the discussions on education in the Gold Coast that the nine-to-ten-year primary education consisted of kindergarten up to grade nine after which students sat for the Standard Seven (VII) primary school certificate examination.

<sup>166</sup> Ibid.

<sup>167</sup> Amponsah, "Colonizing the Womb," 84.

<sup>168</sup> Ayesu, Gbormittah, and Adum-Kyeremeh, "British colonialism and women's welfare in the Gold Coast colony", 6-7.

<sup>169</sup> Ibid.

textile production by spinning and trading in local markets. The manufacturing of plain pottery was also considered women's work. Women also traditionally participated heavily in farming. By 1884, Ayesu, Gbormittah and Adum-Kyeremeh shows that women did most of the farming in the Gold Coast Colony.<sup>170</sup> Thus, women did participate in both social and economic activities through food production.

Men constantly benefited from the labour of women. And the cultural position of women in the Gold Coast dictated a labour structure that worked against women and deprived them of pursuing education to any higher level and to engage in other male-dominated professions. Because of the confines of these traditional roles, they were often bought and sold as forms of labour in the pre-colonial period. For instance, among pre-colonial Asante, many slaves were women who were either offered free or sold to the Asante men who secured wives and children for labour.<sup>171</sup> The enslavement of women and the commented gender roles informed European characterisation of the African woman as a "beast of burden": ignorant, diseased, and trapped within these traditional boundaries.<sup>172</sup> An early 20th century quest to improve the welfare of women and children called for better education. But not for social or economic empowerment as much as for the perceived need to train indigenous girls to reach a European standard of ideal

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<sup>170</sup> Ayesu, Gbormittah, and Adum-Kyeremeh, "British colonialism and women's welfare in the Gold Coast colony," 6-7.

<sup>171</sup> Ibid.

<sup>172</sup> Nakanyike Musisi, "The Politics of Perception or Perception as Politics? Colonial and Missionary Representations of Baganda Women, 1900-1945," In Allman, J., Susan Geiger, and Nakanyike Musisi (eds), *Women in African Colonial Histories*, (USA: Indiana University Press, 2002), 95-115.

motherhood and educate other women on issues of health and hygiene, a common eugenic outlook of the interwar period.<sup>173</sup>

While women bear the responsibility of reproduction and also traditionally took care of the sick, they were not traditionally permitted to work outside the family home in caregiving jobs.<sup>174</sup> This became a barrier to women's participation in attending to the sick in the Western medical service from the nineteenth century to about the 1940s. As alluded to above, traditional society regarded nursing as menial work, which involved a direct contact with the sick. Many families discouraged their daughters from joining the profession.<sup>175</sup>

These gendered conceptions informed labour policy and structure of healthcare. Rennick has observed that the organisation of nursing and medical work in the nineteenth century reflected European scientific beliefs in the biological inferiority of women compared to men.<sup>176</sup> This, in turn, helps explain how colonisers regarded and shaped the role of women in the administrative affairs of the Gold Coast and especially colonial healthcare services. The colonial administration was largely male-centred and as a result, education, health, and housing were largely organised to serve the needs of men.<sup>177</sup>

Missionary work, which became intensive in the Gold Coast in the 1820s was also highly

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<sup>173</sup> From the 1930s, the attention of the colonial government was drawn to improving the welfare of women and children in the Gold Coast colony. Prior to this date, 1930, the Wesleyan Methodist Mission and other Christian Missions had begun operating women and child welfare centres with the support of the government. The training of indigenous women to assist in manning these centres marked the beginning of training the Ghanaian midwives locally. At this point, there was a sudden shift in the training of males in nursing and midwifery as only girls were preferred. See Section two of this report for details.

<sup>174</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 280-281; Kisseih, "A Brief Survey of Nursing in Ghana," 22; Böhmig, *Ghanaian Nurses at the Crossroads: Managing Expectations on a Medical Ward*, 43.

<sup>175</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 279.

<sup>176</sup> Rennick, "Church and Medicine: The Role of Medical Missionaries in Malawi 1875-1914," 166.

<sup>177</sup> Amponsah, "Colonizing the Womb," 84.

gendered.<sup>178</sup> Correspondingly, the development of colonial and missionary healthcare services in nineteenth-century Gold Coast can be read and understood as highly patriarchal. But, by the first decades of the twentieth century, one begins to see the recruitment of women into the service, mainly to the field of nursing.

The organisation of nursing in the nineteenth-century British West African colonies borrowed the scientific belief system that characterised women as subordinate, but also linked femininity to caregiving. A good nurse was conceived as a good mother, possessing virtues such as cleanliness, sobriety, humility, obedience, gentleness and a calm demeanour.<sup>179</sup> In the early twentieth-century development of professional nursing in the Gold Coast, the colonial government initially preferred male nurses, who worked in this role as part of the “auxiliary” category. The situation was similar in Northern Rhodesia, where Kumwenda observed how, in the 1920s, the General Missionary Conference (GMC) sought local African men to train as medical assistants to European medical officers, taking on the role as “nurse equivalent.”<sup>180</sup> Then, in 1936, the colonial government of Northern Rhodesia established the African Medical Training School (AMTS) to train male nurses for hospital work. By the 1940s, Kumwenda shows how colonial officials shifted their thinking, and began to stress the importance of developing and expanding the African Medical Staff (AMS) to include more women. The government believed that employing women would ultimately lead to an “improved standard of nursing and greater quietness” in various hospitals.<sup>181</sup>

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<sup>178</sup> Miller, *Missionary Zeal and Institutional Control*, 65.

<sup>179</sup> Rennick, “Church and Medicine,” 166.

<sup>180</sup> Linda Beer Kumwenda, “The Training of Female Medical Auxiliaries in Missionary Hospitals in Northern Rhodesia, 1928-1952,” *Social Sciences & Missions* 16 (2005), 103.

<sup>181</sup> *Ibid.*

This transition is mirrored elsewhere. In colonial Malawi, the skills associated with nursing responsibilities were regarded as innately feminine. Women who nursed their sick relatives often accompanied family members to hospital to continue providing care.<sup>182</sup> Witnessing this, Christian Missions in Malawi recruited African unmarried women over the age of thirty to perform such roles and trained them to undertake medical procedures. They saw this class of women as possessing a stronger vocational calling than younger women. This made them suitable candidates to “labour for Christ” and wouldn’t be distracted by their own family life.

In the Gold Coast, colonial governments resolved to train more women in midwifery and nursing to solve the deficit in the supply of health labour in the 1930s. From archival evidence, women who initially worked as orderlies (using a range of terms to describe general bedside and ward work) were easily trained because of their experience with hospital work than new applicants to training schools. From the 1930s, colonial governments paid attention to the further training of such women. Their biographies and backgrounds are lost to history, but anecdotes from primary sources indicate that these institutions preferred young girls between the age of seventeen and twenty. On 30th November 1949, the Acting Assistant Director of Medical Services (AADMS) for Asante in a correspondence to the Ashanti Confederacy Council (ACC) on the recruitment of individuals for training as nurses endeavoured to receive applications from girls in this select age group.<sup>183</sup> He signalled a shift in the gender status of nursing

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<sup>182</sup> Rennick, “Church and Medicine,” 196-197.

<sup>183</sup> “Training of Nurses and Midwives Ash, 1949-1950,” MAG 9/1/12, Manhyia Archives of Ghana (MAG), Kumase.

care, stating that “no men will be considered for training as we [now] intend [to] train only female nurses.”<sup>184</sup>

In the specific category of midwifery, twentieth-century colonial administrators and health authorities limited admission to only women. On March 16, 1948, notices to invite applications for admission into the Kumase Maternity School were to include the end statement “only girls who were born in Ashanti or of Ashanti extraction or who were born in the Northern Territories should apply.”<sup>185</sup> The statement served two purposes: (1) Only girls were to apply (2) Admission was opened to few applicants as a class of twelve pupils was proposed to start the school. Yet the number of women in healthcare delivery remained low until mid-century.<sup>186</sup> In British West Africa no woman medical officer of African descent was recorded before the 1920s.<sup>187</sup> In the Gold Coast, the first woman to become a medical doctor was Dr Susan Gyankorama De-Graft Johnson. She obtained her medical degree in 1947 from the University of Edinburgh. She is followed by Dr. Matilda Clerk, who obtained her medical degree in 1949, also from Edinburgh.

Women were nonetheless marginalised within the active labour force of hospital work – an indication that women experienced inequality more than men, particularly if they were recruited out of the “auxiliary” category. Close examination of the justification for training and educating indigenous women in Western midwifery depicts an element of pseudo-scientific racism, which is discussed in the pages that follow.

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<sup>184</sup> Ibid.

<sup>185</sup> “Correspondence between the Assistant Director of Medical Services and the Director of Medical Services of the Gold Coast, March 16, 1948,” ARG 1/14/1/28, Public Records and Archives Administration Department (PRAAD), Kumase.

<sup>186</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 275.

<sup>187</sup> Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 28-29.

In the late nineteenth century, racial discrimination in the Gold Coast, as in other British West African colonies, evolved from residential segregation on health grounds and then became institutionalised in the colonial medical service. Within the same period, from residential segregation in European and African settlements, racial discrimination penetrated the hospital environment.<sup>188</sup> Yet, the historiography of the Gold Coast does not overtly address racism in connection with the work of African medical auxiliaries such as orderlies, dispensers, nurses, and midwives. To understand racial discrimination against other categories of African health labour, this section re-examines the racial discrimination against African medical officers with some consideration for the particular experience of medical auxiliaries. To be “auxiliary” meant one was more vulnerable than those with a firmer credential. This helps highlight some underlying factors that defined racial boundaries between African medical personnel and their European counterparts, boundaries that had a disproportionate impact on auxiliary workers.

Race animated a vocabulary of superiority and inferiority in the archives of world history. Contextualising the term “race,” Seth Suman drew on the concept of “race-science,” in the eighteenth century which offered a more restrictive explanation for determining racial differences based on environmental differences.<sup>189</sup> In the eighteenth century, race was understood in terms of environmental factors relative to climate and diet, and also expressed in systems of government, culture, and forms of behaviour.

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<sup>188</sup> Right from the establishment of the Colonial Medical Department of the Gold Coast and expansion in health infrastructure from the 1880s, two settlements based on sanitary conditions and fear of disease infestation separated the African population from the European population. There were also separate hospitals for Africans and Europeans. In instances where hospitals built were to accommodate both races, separate wards were created. See Thomas S. Gale, “The Struggle Against Disease in the Gold Coast: Early Attempts at Urban Sanitary Reform,” *Transactions of the Historical Society of Ghana* 16, no. 2 (1995), 185-203; Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 39.

<sup>189</sup> Suman Seth, *Difference and Disease Medicine, Race, and the Eighteenth-Century British Empire*, (UK: Cambridge University Press, 2018), 169-170.

Scientists believed that environmental factors caused physical differences but not differences in intellect and morality. Thus, environmental differences produced physical differences. In the nineteenth century, however, Seth shows that physical difference racially became the determinant factor for intellectual difference, hence Africans were thought to possess lower intellect than Europeans.<sup>190</sup> Racism in the British West African colonies manifested through the European notions of their superiority over other races, particularly Black Africans when it comes to intellectual capacities and strength of civilisation. Racism found its most complete expression in the late nineteenth century when Europeans created and embraced pseudoscientific eugenic explanations.<sup>191</sup>

Pseudoscientific racism permeated the colonial society – European businessmen, officials and missionaries believed that they were inherently superior to Africans.<sup>192</sup> It was present in the West African Medical Service by the 1890s, a period when racial comments were common.<sup>193</sup> By 1900, reports generated by Governors of the Gold Coast often referred to mission-trained African elites as “bush clerks,” rascals, evil, semi-educated and unprincipled in their dealings with the colonial government.<sup>194</sup>

From the 1890s, European officials and medical officers regarded the African settlements as insanitary and such populations were the cause of several infectious diseases in the Gold Coast. One ostensible “burden” undertaken by European officials in the Gold Coast and other parts of West African was to “save” the African from diseased environments through the implementation of superior colonial government structures and

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<sup>190</sup> Seth, *Difference and Disease Medicine, Race, and the Eighteenth-Century British Empire*, 170.

<sup>191</sup> Gocking, *The History of Ghana*, 48.

<sup>192</sup> *Ibid.*, 47.

<sup>193</sup> Colonial Nursing Association, “Tenth Annual Report of the Executive Committee of the Colonial Nursing Association (1906)”, In Andersen and Andrew Cohen (eds), *The Government and Administration of Africa, 1880-1939*, (London and New York: Routledge, Taylor & Francis, 2016), 103.

<sup>194</sup> Debrunner, *History of Christianity in Ghana*, 121, 213.

social services. In 1906, the tenth annual report of the Executive Committee of the Colonial Nursing Association (CNA) recorded how “men of our [British] race are toiling hard, often in lonely and depressing surroundings, to drain the swamps and clear the bush, to raise the native races and to prepare the way for the civilisation and justice which always follow the British Flag.”<sup>195</sup> This statement is only one of many racist ideas held by colonial officials, including medical officers, about the purported uncivilised state of Africans. Residential segregation was one of several welcome policies deemed necessary to protect the health of Europeans from the “unsanitary” African environment. This segregation policy formed part of the racialised colonial structure that developed in the Gold Coast from the 1880s to the 1930s.

Unsurprisingly, racial discrimination in the employment of African health labour in the Gold Coast became entrenched following the establishment of the Gold Coast Medical Department in the 1880s. The establishment of the medical department also classified the different categories of European and African medical staff. In British colonial territories, it was the Colonial Medical Office (CMO) in London who oversaw the recruitment of medical officers for the colonies.<sup>196</sup> The recruitment of nurses to the British colonial office was also the responsibility of the Colonial Nursing Service (CNS). These structures were in place for decades and lasted until the end of the 1930s Depression. In the lead up to and during the Second World War, the CMS and CNS saw recruitment for the colonies taper off as prospective recruits were drawn into the European war effort. As a result, the number of British doctors and nurses in the British

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<sup>195</sup> Colonial Nursing Association, “Tenth Annual Report of the Executive Committee of the Colonial Nursing Association (1906),” 103.

<sup>196</sup> Nkwam, “British Medical and Health Policies in West Africa c.1920-1960,” 120.

colonies began to decline.<sup>197</sup> The only solution was to encourage the recruitment and training of Africans into the colonial medical service, with some posts reserved only for Europeans.

Burke-Gaffney has described the structure of the colonial medical service in West Africa as having a central administration, which supervised the establishment of health facilities, the medical staff and the supporting staff. From the 1940s, the staff were increasingly pulled from local African communities, though, as mentioned, finding prospects with the requisite education remained a problem.<sup>198</sup> This combined with racist ideologies to encourage the maintenance of a very hierarchical structure within administration of the Gold Coast Medical Department. The Secretary of State of Colonies (SSC) occupied the top-most position and approved the appointment of medical officers to the medical posts of the colonies. Within the health system, the Chief Medical Officer (CMO) ranked next to the SSC and oversaw all medical and sanitary matters.<sup>199</sup> The next in the chain of command was the Colonial Surgeon (CS) who acted as the deputy of the CMO. They were assisted by the next senior staff member, the Senior Assistant Colonial Surgeon (SACS), who in turn was supported by the Junior Medical Staff (JMS). The JMS were predominantly made up of African doctors.

Europeans thus monopolised positions of authority in the colonial medical administration<sup>200</sup> and reserved Senior Medical Staff (SMS) positions of only European medical officers. By contrast, the JMS position was reserved for Africans, even if they possessed qualifications equivalent to their European counterparts. Doctors of African

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<sup>197</sup> Ibid., 156 & 182.

<sup>198</sup> Burke-Gaffney, "The History of Medicine in the African Countries," 31-41.

<sup>199</sup> The Chief Medical Officer was the Senior Medical Officer in the medical department.

<sup>200</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 242.

descent found their careers curtailed or even derailed when they attempted to apply for senior positions in the medical department, even into the 20th century. In 1902, Mr. Joseph Chamberlain, the Secretary of State for the Colonies informed colonial government officials that the various colonial medical departments of British West Africa would amalgamate into a single service known as the West African Medical Service (WAMS).<sup>201</sup> The WAMS was a consolidation of the medical service departments of Gold Coast, Nigeria, Sierra Leone, and the Gambia. Racial discrimination was entrenched by the time WAMS was established. Individuals of European backgrounds were eligible to apply to the WAMS, while African doctors were paid on a lower salary scale and relegated to a separate service as Native Medical Officers (NMOs). The highest rank an African could reach was SACS, a position inferior to even the lowest ranking European official. The establishment of WAMS further institutionalised racism and encouraged stratification within the colonial medical service.<sup>202</sup>

The improvement of health conditions of Europeans in the Gold Coast towards the end of the nineteenth century also contributed to a dramatic change in racial composition of staff, to the detriment and disadvantage of the African medical workers. In 1883, Africans held 43 positions in the government service. However, by 1908, only five positions in the government were still available for Africans.<sup>203</sup> Pseudoscientific ideas fed a negative bias against Africans, seen as intellectually and physically inferior. The psychological and sociological conditioning of Europeans was deeply influenced by

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<sup>201</sup> British Medical Journal, "The Medical Services of West African Colonies and Protectorates (1902)", In Andersen and Andrew Cohen (eds), *The Government and Administration of Africa, 1880-1939*, (London and New York: Routledge, Taylor & Francis, 2016), 61.

<sup>202</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 242.

<sup>203</sup> Andersen and Andrew Cohen, "Introduction," In Andersen, Casper and Andrew Cohen (eds), *The Government and Administration of Africa, 1880-1939*, (London and New York: Routledge, Taylor & Francis, 2016), 19-20.

these ideologies. To European physicians, their scientific knowledge and expertise went beyond their national boundaries, and thus they disregarded the interests and abilities of Africans in such endeavours. Facing frustrations, Africans left the medical service. By 1900, racial discrimination encouraged Africans to pursue careers other than medicine. Many others resigned from the medical service altogether, preferring to study law instead of medicine because at least African lawyers had autonomy, and occasionally political leverage, in the colonial courts.<sup>204</sup>

This labour shortage, and the devaluation of African medical workers created space for auxiliary advancement. In 1921, the Governor of the Gold Coast, Sir Frederick Guggisberg made plans to train African auxiliaries as medical doctors.<sup>205</sup> Guggisberg's idea gained traction, and by 1927, the Secretary of State for Colonies, Winston Churchill instructed governments in the British colonies to train medical assistants to become doctors pending professional training and advancement in the medical system. The idea had its detractors. To some, African auxiliaries were not equal, and never could be equal, to their European counterparts, especially those trained in the medical schools in Europe. Some missionaries saw the training of Africans in medicine as a mistake because they had no confidence in the intellectual capacities of Africans generally.<sup>206</sup> Missionary doctors were particularly sceptical of Africans' ability to uphold the practical and ethical standards of Western medicine practice. For example, in his address on the training and employment of Africans as medical assistants in 1932, Dr. Clement Chesterman, a medical practitioner of the Gold Coast reports that some colonial authorities and medical

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<sup>204</sup> Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 122.

<sup>205</sup> *Ibid.*, 156.

<sup>206</sup> Rennick, "Church and Medicine: The Role of Medical Missionaries in Malawi 1875–1914," 203-204.

officers objected to the training of Africans in medicine because of their low intelligence.<sup>207</sup>

Racial discrimination against medical officers of African descent in the Medical Department of the Gold Coast was extensive and touched all realms of work. In 1897, Governor Maxwell demoted Dr. John Farrell Easmon of his position as Chief Medical Officer (CMO) of the Gold Coast and later forced him to resign.<sup>208</sup> Dr. Easmon hailed from Sierra Leone and was among the fourth generation of African medical practitioners and a descendent of black Nova Scotian refugees. As the CMO, he was the highest ranking African in the colonial service from 1893 to 1896. According to some, he occasionally performed the role of Acting Governor for the Gold Coast colony in the absence of the governor.<sup>209</sup> No reason was ever given for this demotion. Governor William Maxwell (1895-1897), who succeeded Sir Brandford Griffith in 1895, was notoriously hostile to educated Africans and left a legacy of discrimination.<sup>210</sup>

Dr C. C. Reindorf, a Ghanaian doctor also suffered similar humiliation when he entered the colonial medical service in 1919. After graduating from the medical school in 1910, he took charge of the Venereal Disease Clinic of the Gold Coast Hospital as a temporary medical officer but was not able to join the medical service until 1919.<sup>211</sup> Though a trained medical doctor, he retired as a temporary medical officer, and position that came without a pension.<sup>212</sup> Another Ghanaian doctor, Dr Quartey-Papafio, had a career marked by meritorious service in the Gold Coast. He was likewise disregarded and

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<sup>207</sup> Chesterman, "The Training and Employment of African Natives as Medical Assistants," 1068.

<sup>208</sup> Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 95.

<sup>209</sup> Ibid.

<sup>210</sup> Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 115.

<sup>211</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 245.

<sup>212</sup> Gale, "Sir Gordon Guggisberg and His African Critics," 273.

denied promotion on several occasions to positions for which he was so much qualified.<sup>213</sup> European scientific expertise and scientific training was privileged and used to leverage institutional positions both at home and abroad. Europeans officials and medical officers failed to recognise and advance black doctors like Dr Easmon and his African colleagues, a practice observed throughout the entire colonial administration.

Such racial discrimination was resisted by some African leaders and elites. Observable in the late nineteenth century, it yielded some legislative reforms in the twentieth. In February 1913, the Aborigines Rights Protection Society (ARPS) petitioned the Secretary of State on the discrimination observed in the Gold Coast medical department. The ARPS demanded an amendment to the regulations that governed any appointment to WAMS, arguing for a change to enable African doctors to enjoy the same privileges as their European counterparts.<sup>214</sup> A well-organised resistance movement was also launched by the Gold Coast Medical Union (GCMU), an organization founded in 1938.<sup>215</sup> Well-organised and the first of its kind, this Union fought to protect the interest of African doctors.<sup>216</sup> African doctors, for instance, refused temporary appointments and positions in the infant and maternal welfare clinics of the Gold Coast, temporary appointments that only commanded low salaries. For instance, Dr W.A.C. Nanka-Bruce, declined a position in the baby weighing room of the Gold Coast Hospital, where he would only receive £10 per month be forced to vacate the position once the European doctor, Dr. Vane-Percy, returned from leave.<sup>217</sup> On March 26, 1952, Mr Charles D.M

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<sup>213</sup> Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 122.

<sup>214</sup> *Ibid.*, 112.

<sup>215</sup> Nkwam, "British Medical and Health Policies in West Africa c.1920-1960," 156.

<sup>216</sup> Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 246.

<sup>217</sup> Doris Susannah Essah, "Private Medical Practice: The Gold Coast Colony's Christiansborg Infant Welfare Clinic," *Cultural and Religious Studies* 6, no. 9 (2018), 536-537.

Owusu, the Headmaster of Wenchi Methodist Middle School in Asante of the Gold Coast wrote to the Health Commissioner of Asante expressing his discontent:

One thing I hate about the British rule is their disregard for African proficiency in both the faculty of Learning, and the World of Science and Medicine. Dr Amattoe could easily become the Director of Medical Services, but no! they will say he is a braggart. Doctor Azikiwe is world famed, as an internationally learned creature. A man of letters, as equally good as H.B. Wells or Bernard Shaw; yet a small British Oxford graduate will turn his nose away when it is so mentioned; so African qualified gold medalists should be made specialists in their own domain; for pigmentation is no individual crime. God know what He was about when He made certain people white and others Black.<sup>218</sup>

It was obvious to such writers that the colonial administration reserved higher ranking positions for Europeans while Africans remain auxiliaries. This larger story of racial discrimination in the colonial medical service of the Gold Coast, has overemphasised these experiences of African doctors, especially Easmon's experience. This has obscured other, and wider ranging practices, of racial discrimination against African auxiliary health workers. Recruiting Africans into colonial and missionary health was necessary to augment insufficient European staffing across many occupations. Colonial records and reference in secondary works show no African nurse or midwife rose to the higher rank of a Matron or Sister until the 1950s.<sup>219</sup> Europeans formed the higher grade of nurses while the locally trained staff were in junior under their supervision. The intersection between race and gender is clearly seen in European gendered ideology about African women. We have observed that one of the justifications for improving the welfare of women and children in the Gold Coast was to train

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<sup>218</sup> "A Letter from Mr Charles D.M Owusu to the Health Commission of Ashanti, March 26, 1952," MAG 21/1/198, Manhyia Archives of Ghana, Kumase.

<sup>219</sup> Kisseih, "A Brief Survey of Nursing in Ghana," 22. A survey of colonial medical reports and correspondence also reveal similar outcome. See "Training of Nurses and Midwives Ash, 1949-1950," MAG.9/1/12, Kumase; "Child Welfare Clinic and Lunatics, 1944-1951," ARG.1/14/1/24, PRAAD, Kumase; "Correspondence between Dr M.C Chappel and Dr H.S Townsend, September 30, 1946," ARG.1/14/1/24, PRAAD, Kumase.

indigenous girls to attain European standard of ideal motherhood and civilisation. This justification partly reflects a racial and gendered ideology. Training African women in Western midwifery allowed the system to replace indigenous birth attendants whose practices were seen as lacking scientific knowledge. The marginalisation of African women penetrated the colonial and missionary medical services; men formed the majority of African health labour until the 1940s when nursing and midwifery staff were restricted to only women.

## **Orderly Work and Auxiliary African Health Labour in the Gold Coast, 1860-1957**

The evolution of attendant care in Ghanaian hospitals is traced through the work of those we now call orderlies. They were the first African health workers used in the Westernised medical system of the region. Within the historiography of Western medicine in Ghana, there are several accounts of African health labour in the colonial medical service, but orderlies have merited only passing mention, and then often in reference to the evolution of nursing. Yet this category of auxiliary health work deserves attention, not only for the way such roles created space for Africans, but also for the way they reveal how gender and race equally shaped categories of African health labour over these decades.

Already by the late nineteenth century, European medical officers trained local boys to perform nursing tasks and called them orderlies. These included washing and feeding patients, cleaning hospital wards and hospital equipment, dressing wounds, and administering drugs.<sup>220</sup> Beyond these references, published work does not provide any details of their training, scope of practice and any limitations put on their work. We also know little about the relationship between orderlies and their European medical superiors.<sup>221</sup> For this reason, the work of orderlies in the Gold Coast is seen as unskilled. This assumption is based on the fact that they did not receive any formal training like those tied more closely to the science of medicine such as doctors, nurses and midwives.

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<sup>220</sup> Kisseih, "A Brief Survey of Nursing in Ghana," 22; Twumasi, *Medical Systems in Ghana*, 11; Addae, "Evolution of Modern Medicine in Ghana, 1880-1960," 279; Böhmig, *Ghanaian Nurses at the Crossroads*, 42.

<sup>221</sup> Key scholarly works on the development of nursing in Ghana include the works of Chief Nursing Officer, Kisseih on "A Brief Survey of Nursing in Ghana," 22-24; Addae, "Evolution of Modern Medicine in Ghana, 1880-1960"; Mary Opere and J. E. Mill, "The Evolution of Nursing Education in a Postindependence Context—Ghana from 1957 to 1970," *Western Journal of Nursing Research* 22, no.8 (2000), 936-944; and Böhmig, *Ghanaian Nurses at the Crossroads*.

Perhaps this is one reason, historians have focussed more attention on professional categories like doctors and nurses whose labour is skilled and often accredited, more than unskilled labour although they might be casually trained. From archival records and references in secondary works, we know that European medical personnel frequently used orderlies to supplement existing trained personnel who were in short supply. Though unskilled, orderlies played a significant role in professionalising healthcare in the country. They should not be overlooked because some roles assigned to orderlies, dressers, dispensers and nurses overlapped since they all worked in the same spaces.

As acknowledged above and in the introduction, use of the term “orderly” has been inconsistent in the literature. In her study of the work of nurses at the Gold Coast Hospital (now Korle Bu Teaching Hospital), the anthropologist, Christine Böhmig describes twenty-first century orderlies as those workers who clean wards and washrooms, wash hospital equipment, feed patients, re-fill oxygen cylinders, collect samples of blood and bodily fluid of patients to laboratories.<sup>222</sup> She observed that nurses instructed orderlies and assigned tasks, reflecting the hierarchical order between the two workers. Nurses were “trained” while orderlies were “hardly trained,” and nurses’ expertise gave them authoritative power. The work distribution of orderlies was also gendered in that the male orderlies carried out “rough work such as cleaning the floor and toilets” while women who worked as orderlies “cleaned smaller objects and distribute[d] food.”<sup>223</sup>

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<sup>222</sup> Böhmig, *Ghanaian Nurses at the Crossroads*, 185-187.

<sup>223</sup> *Ibid.*, 188.

The Ghanaian story about orderlies appears a bit complicated because Europeans and colonial officials in the Gold Coast inconsistently applied the term “orderly” to refer to the work of their African assistants or auxiliaries. For instance, from 1917 to 1918, District Commissioners and Medical Officers of the Gold Coast colonial service who documented their experience in diaries did refer to their African assistants as orderlies.<sup>224</sup> However, comparative accounts from Kumwenda on African medical auxiliaries in missionary hospitals in British Northern Rhodesia defines a medical auxiliary as “any type of medical worker without a recognised qualification.”<sup>225</sup> In her research, Kumwenda made use of the terms “orderly” or “nurse” depending on how they appear in the records of the missionary or government institutions. Orderlies often fall within this more general category.

Up to the 1940s, various Christian Missions in Northern Rhodesia employed male orderlies to assist in healthcare delivery.<sup>226</sup> The Christian Missions included the Universities’ Mission to Central Africa (UMCA), London Missionary Society (LMS), and Christian Missions in Many Lands. Therefore, unlike the Gold Coast, orderlies in Northern Rhodesia received some training, normally on-the-job training, supplemented by advanced education courses in nursing. Within these missionary hospitals, African orderlies were trained under the instruction of the Mission doctors and nurses. Orderlies

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<sup>224</sup> Lady Clifford C.B.E. ed., *Our Days on the Gold Coast*, 56, 59, 70, 135-6, 147, 150, 166.

<sup>225</sup> Kumwenda, “The Training of Female Medical Auxiliaries in Missionary Hospitals in Northern Rhodesia, 1928-1952,” 103.

<sup>226</sup> Kumwenda, “African Medical Personnel of the Universities’ Mission to Central Africa in Northern Rhodesia,” 209.

were also trained as evangelists who would contribute to the mission agenda of both healing bodies and saving of souls.<sup>227</sup>

If they received formal nursing training, orderlies took junior and senior exams set by European missionary nurses. Others were sent to an African Medical Training School (AMTS) established in 1936 at Lusaka, to undertake a three-month short course under the instruction of government medical officers.<sup>228</sup> Another training scheme took three years at the orderlies' stations of practice and three to four months at AMTS. One orderly, Eliam Zilinde, joined the medical service of the UMCA in 1941 at Msoro, a mission station of the UMCA. He took training for three years at Msoro and another three to four months at the AMTS in Lusaka. After completion of his education in 1946, Eliam took a Medical Assistant examination. Although he failed the exam, Kumwenda describes how the Medical Superintendent at Msoro assessed Eliam's skills and considered him to be an improved orderly and allowed to work after serving six month probationary period for failing the exam.<sup>229</sup> Demonstrating an ability to do the work often trumped a formal credential within this central African system.

The orderlies in Northern Rhodesia gave injections, administered drugs and performed some clinical examinations using the microscope – similar to tasks performed by dispensers in the Gold Coast. By the 1940s, orderlies in Northern Rhodesia also ran

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<sup>227</sup> Kumwenda, "The Training of Female Medical Auxiliaries in Missionary Hospitals in Northern Rhodesia, 1928-1952," 97.

<sup>228</sup> Kumwenda, "African Medical Personnel of the Universities' Mission to Central Africa in Northern Rhodesia," 200. Kumwenda does not give any details about the junior and senior exams as well as the composition of the three months course at the AMTS. The training offered to orderlies in the mission medical service did not qualify them to work in government service. See also, Kumwenda, "The Training of Female Medical Auxiliaries in Missionary Hospitals in Northern Rhodesia, 1928-1952," 122.

<sup>229</sup> Kumwenda, "The Training of Female Medical Auxiliaries in Missionary Hospitals in Northern Rhodesia, 1928-1952," 202-203.

missionary dispensaries.<sup>230</sup> One skilled orderly named Valentino caught the attention of the colonial government. In 1956, Valentino left missionary service to join government service as an orderly.<sup>231</sup> He did so well in this capacity that the government increased its grant for dispensaries from £50 to £150. The African orderlies, therefore, became the backbone of mission hospitals and dispensaries in Northern Rhodesia. While this contrasts to the tasks performed by orderlies in Northern Rhodesia and the Gold Coast, positioning orderlies within the context of and as a type of auxiliary health personnel helps to understand this fluid role and their evolution within the systems.

In what is now Ghana, one can confirm, from a close reading of secondary sources, and by assembling the fragmentary archive of primary sources, that orderlies were present in the Gold Coast health system by at least 1860. In 1860, Robert Clarke, a colonial medical officer of the Gold Coast, bemoaned the lack of nurses and advocated for the training of indigenous women to provide this care. They were to replace male orderlies who largely tended to the sick in European settlements.<sup>232</sup> To Clarke, male orderlies were unqualified to attend to the sick. Though he did not provide an assessment of orderlies' skills or training, Clarke remarked how:

In the time of sickness, the want of female trained nurses is seriously felt by Europeans in these settlements. There are no nurses, strictly speaking. It is true that an aged woman, who understands English imperfectly, is sometimes got to look after the sick, but her attendance is considered rather as a favour, and she seldom remains beside the patient all night, as she generally then returns to her home,

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<sup>230</sup> Kumwenda, "The Training of Female Medical Auxiliaries in Missionary Hospitals in Northern Rhodesia, 1928-1952," 123.

<sup>231</sup> Kumwenda, "African Medical Personnel of the Universities' Mission to Central Africa in Northern Rhodesia," 209.

<sup>232</sup> Clarke, "Remarks on the Topography and Diseases of the Gold Coast," 51. The call to train African females as nurses did not materialise until after 1900, when European nurses began to frequently arrive in the Gold Coast to execute the training of professional nurses and midwives, with preference for only females. See Section two of this report for further details.

leaving the sick to be tended by male servants totally unqualified to undertake that duty.<sup>233</sup>

Clarke, like many of his contemporaries in the early twentieth century, made derogatory comments about male orderlies, whom they often described as “servants.” The works of Addae and Gundona are replete with critical comments made by European medical officers. These officers expressed their bias against male orderlies in their annual medical reports. Medical officers, in fact, preferred to work short-handed than to work with orderlies who were often regarded as lazy individuals who did not understand their responsibilities. In 1901, Dr W R Henderson, a Principal Medical Officer of the Gold Coast bitterly complained about orderlies who were “too bad for anything.” He dismissed them as “‘bush boys’ who have little education, so called, in the way of book work, otherwise they are absolute savages and quite unteachable.”<sup>234</sup> In 1926, Dr Oakely, the Assistant Director of Medical Services toured the Northern territories of the Gold Coast and also expressed his disappointment over the employment of “untrained” orderlies as hospital attendants.<sup>235</sup> And yet these workers can be found throughout the health care system over these decades.

Anecdotal evidence from the secondary literature reveals that orderlies also helped in attending to psychiatric patients, though this is unclear. In his retrospective study of psychiatric practice in Ghana, the first Psychiatrist in Ghana, Dr Emmanuel F. B Forster mentions the presence of sixteen “untrained nurses” who took care of the patients at the only Mental Hospital of the Gold Coast, a facility which opened in Accra in

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<sup>233</sup> Clarke, “Remarks on the Topography and Diseases of the Gold Coast,” 51.

<sup>234</sup> Addae, “Evolution of Modern Medicine in Ghana, 1880-1960,” 280-281.

<sup>235</sup> Gundona, “A Study of Health Conditions and Disease Control in the Northern Territories of the Gold Coast, 1897-1956,” 156.

1907.<sup>236</sup> Forster does not provide any further details about these “untrained nurses,” but does on at least one occasion refer to them as “orderlies.” On 4th August 1951, medical officer Dr H. B. M. Murphy, published correspondence in the *British Medical Journal* describing the medical practice on the colony. In this piece, he makes specific reference to the shortage of medical practitioners, and commented that medical responsibility of the Gold Coast was “inevitably left to the nurses and orderlies, and if these were given the opportunity to raise their status in two or more stages they might become more ethical.”<sup>237</sup>

Dr Murphy’s comment reveals two things: the notion that European medical officers’ use of untrained orderlies as unethical and that the responsibilities of nurses and orderlies overlapped such that they could be characterized in one category. This reaffirms how orderlies are characterized as untrained and unskilled labour. Dr Murphy believed in the abilities of the African and that when orderlies and nurses are given the opportunity for further training, they could become ethically qualified to perform hospital tasks. Murphy’s comment reflects the view of some European medical officers and administrators who expressed discontentment for the work of African health labour, whose competence was tied to credentialling and formal education. From such quotations above, we read evidence of how the colonial records dismiss or are hostile toward the work of medical auxiliaries generally. Such bias obscures the contributions orderlies

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<sup>236</sup> Emmanuel F. B Forster, “A Historical Survey of Psychiatric Practice in Ghana,” *Ghana Medical Journal* 46, no. 3 (1962), 26.

<sup>237</sup> H. B. Murphy, “Correspondence: Medical Practice on the Gold Coast,” *British Medical Journal* (04 Aug 1951), 299.

made in attendant care in Ghanaian hospitals, as well as the development of nursing out of this role.

Missionary accounts offer a different perspective. In the Gold Coast, the Basel Mission Society is known as the first mission to have commenced any serious medical work. In 1832, the first Basel Mission doctor, C.F Heinze arrived to look after the health of missionaries on site. Unfortunately, he died in six weeks on his arrival.<sup>238</sup> Following Dr Heinze's death, and after deliberations about whether to deploy more doctors to the Gold Coast, the Basel Home Board agreed to send additional doctors and nurses to the Gold Coast. In 1882, the Board sent Dr. Ernst Mahly on a two-year special mission to ascertain the health conditions of the colony and make recommendations on the possible treatment of malaria and other tropical diseases. His report informed the Mission decisions to establish hospitals and encouraged the Board to send more missionary doctors and nurses to the Gold Coast.

They did not arrive in adequate numbers. In 1885, the Basel Missionary doctor, Dr Rudolf Fisch was appointed as a medical missionary to the Gold Coast. Dr Fisch provided medical services to both Europeans and indigenous populations at the Basel Missionary hospitals at Aburi and Abokobi.<sup>239</sup> The workload at the hospitals was increasing with uptake from the general population, convinced the Basel medical mission to recruit and train local boys as orderlies to assist in taking care of the sick. In her work on Swiss medical missions, Linda Ratschiller points out how "the beginning of the

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<sup>238</sup> Mohr, "Missionary Medicine and Akan Therapeutics," 450.

<sup>239</sup> Ibid.

medical mission went hand in hand with the employment of local medical assistants”<sup>240</sup> who performed work that we would ascribe to orderlies. They were trained to dispense medicine, dress and bandage wounds – tasks missionary doctors regarded as tedious and below their training.<sup>241</sup> Dr Fisch himself trained two of such orderlies at the Aburi hospital. Around the same time, one Dr Alfred Eckhardt, who began his practice at Christiansborg in 1887, trained three local men (See Figures 4 and 5) to undertake similar tasks. According to Dr Eckhardt, most of his assistants were former patients and mission converts. At the Aburi hospital, local pastors and schoolteachers were also trained as orderlies to perform basic treatments to Africans in remote areas.<sup>242</sup>

Use of African labour accelerated with mission expansion. On 21st March 1931, the Basel Mission opened a new, modern and well-equipped hospital at Agogo in Asante.<sup>243</sup> From 1948, the hospital doubled as a Nursing Training School for registered nurses. Photographic evidence of the personnel of this hospital, taken between 1930 and 1932, shows more African health assistants, both males and females, on site. These people worked in the hospital alongside European medical clinicians (See figure 6). Although the subject description of the photograph collection describes the African assistants as “nurses,” this could easily be a generic designation. What remains unclear is the categories of nurses represented in the photographs, and how they were recruited and educated. Were they trained in government hospitals and absorbed into missionary

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<sup>240</sup> Ratschiller, “The Basel Mission Doctors on the Gold Coast and the Making of Tropical Medicine 1885-1914,” 26-27.

<sup>241</sup> Ibid., 25-27.

<sup>242</sup> Ibid., 24.

<sup>243</sup> “Letter from the Tutor of Agogo Nurses Training to the Regional Commissioner of Kumase, September 29, 1965,” ARG 2/13/1/3, PRAAD, Kumase. The Agogo Basel Mission hospital was built in 1928 but officially opened on 21st March 1931.

service or were missionary-trained personnel? Of what grade and division were these nurses? Did any of them began their career as orderlies, as was often the case in mission work? Answering these questions would help historians understand the generation of African nurses in Ghana and how the nursing profession took shape over time. What is clear, nonetheless, is that mission work provided orderly work for local men and women of the Gold Coast.

**Figure 4: Dr. Rudolf Fisch's African Assistants at Aburi, 1885-1911**



Source: BMA, Ref. no. D-30.10.025, "Dr. Fisch's African Assistants," January 01, 1885 - December 31, 1911. This photograph was taken by Dr Rudolf Fisch at his dispensary and sanatorium at Aburi, the first inland station of the Basel Mission in Ghana between January 01, 1885 and December 31, 1911.

**Figure 5: Dr. Rudolf Fisch with Wife and Assistants**



Source: BMA, Ref. no. D-30.10.019, “Dr. Fisch with Wife and Assistants,” January 01, 1910 – December 31, 1911. This photograph was taken at Dr Rudolf Fisch’s dispensary and sanatorium at Aburi in Ghana between January 01, 1910 and December 31, 1911.

**Figure 6: Personnel of the Agogo Hospital with Dr. William Stokes, 1931**



Source: BMA, Ref. no. D-30.65.033, “Personnel of the Hospital with Dr. Stokes, 1931.” This photograph was taken at the Basel Mission Hospital in Agogo of Asante in 1931.

Anecdotal accounts in primary sources and secondary works reveal that orderlies did not always receive formal training, unlike the professional nurses. Like other auxiliaries, their training was on-the-job in hospitals, while some took courses to upgrade their skills. As assistants to European medical officers and nurses in colonial and missionary medical service, orderlies were taught how to care for the sick as well as clean and maintain the hospital. They often also dispensed medication. In the annual medical and sanitary reports of the Gold Coast Medical Department from 1893 to 1901 do not mention orderlies per se on staff.<sup>244</sup> Yet, we can see from the above record that they existed in the health system. The following other categories of African health labour are listed, and they reflect some of the overlapping work of orderly medical auxiliaries and how they might be identified as ward helper, “native nurse,” dresser, dispenser, hospital steward and even the general and flexible term “warder.”

These varied occupational names suggest and describe the work of medical auxiliaries. And some fall within the formal hierarchies. Dressers, dispensers and nurses are, for instance, grouped into first, second, third and fourth “divisions” or “grades” in reports. The records do not show the work distribution among these divisions, but one could speculate that the graded “divisions” were based on duration and type of training. It might also reflect different responsibilities on the job. Therefore, when the categories of ward helper, native nurse, hospital steward, warder and dresser are considered as a sorting of African auxiliaries, one notes that the type of work is recognized but the casual terminology reflects a lack of recognised qualification. Yet, and importantly, these

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<sup>244</sup> GCMD, “Medical and Sanitary Report on the Gold Coast Colony 1893-1901,” (Gold Coast: Government Printer, 1893).

individuals were often singled out for advancement. For instance, in the 1930s, three categories of health assistance of lower grades had emerged out of maternity and “welfare” practices. They became known as untrained or trained health visitors, and ward helpers.<sup>245</sup> The untrained health visitors were the earliest Africans involved in the activities of maternal and child welfare. They became assistants to the “trained” health visitors, mostly Europeans engaged in various kinds of outreach social work. The “untrained” health visitors are an intriguing category, but except for these references, they have all but absent from the archival records. Ebenezer Ayesu, Francis Gbormittah and Kwame Adum-Kyeremeh notes that a category of “assistant health visitor” might be an expansion of the role assigned to “ward helpers.”<sup>246</sup> What is important is that the role was a gateway into other medical occupations. By 1944, the individuals in these categories, depending on their experience in hospital work, were often recommended for further training as professional nurses and midwives.<sup>247</sup>

On October 01, 1946, the Director of Medical Services (DMS) for the Gold Coast instructed Dr M C Chappel, the woman medical officer in charge of the Child Welfare Clinic in Kumase of Asante was asked to relieve her six ward helpers to Dr E.R Gauld, the Assistant Director of Medical Services (ADMS) of Asante for training as nurses.<sup>248</sup> Five of Dr Chappel’s six ward helpers namely Christiana Eyeson, Sarah Entsua, Georgina Fynn, Grace Renner and Grace Akoto were ultimately selected for this training. These girls were first taken as “candidates-under-test” for a period of three months. This meant

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<sup>245</sup> Ayesu, Gbormittah and Adum-Kyeremeh, “British Colonialism and Women's Welfare in the Gold Coast Colony,” 18-19.

<sup>246</sup> Ibid., 19.

<sup>247</sup> “Child Welfare Clinic and Lunatics, 1944-1951,” ARG.1/14/1/24, PRAAD, Kumase.

<sup>248</sup> “Correspondence between the Senior Health Officer of Ashanti and the Chief Commissioner of Ashanti, October 01, 1946,” ARG.1/14/1/24, PRAAD, Kumase.

that after passing the candidacy test, they were admitted as pupil nurses and were paid allowances from the government. The decision to train these girls and pull them from the rank of ward helpers into the more advanced category of nurse created administration tensions. Dr Chappel expressed her dissatisfaction with the decision and described it as a disservice to the Child Welfare Clinic, which also struggled to recruit personnel. It would take time to employ and train new girls as ward helpers, she complained. And there was no Registered Nurse at the clinic to supervise the training of new employees. She resolved to close the clinic until sufficient staff were available because in the absence of the five ward helpers, “it will not be possible to deal with the work either in the wards or in the Infant and Ante-natal Clinics.”<sup>249</sup>

In an earlier correspondence addressed to Dr H.S Townsend, the Senior Health Officer (SHO) of Asante on September 30, 1946, Dr Chappel proposed that the system of employing girls as ward helpers should be discontinued. The Child Welfare Clinic had adopted the system between 1930 to 1932, a period when the Gold Coast Medical Department could not supply the clinic with nurses.<sup>250</sup> She described the practice as a cheap method of obtaining labour to run hospital wards. Clearly, the state attempted to train medical assistants to become nurses and midwives, but this had only limited success and did not obviate the need for medical assistants within the system.

In 1957, dressers and ward helpers were still in active service, and involved in bedside care in hospital wards. Auxiliaries were still moving between worker categories even

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<sup>249</sup> “Correspondence between the Senior Health Officer of Ashanti and the Chief Commissioner of Ashanti, October 01, 1946,” ARG.1/14/1/24, PRAAD, Kumase.

<sup>250</sup> “Correspondence between Dr M.C Chappel and Dr H.S Townsend, September 30, 1946,” ARG.1/14/1/24, PRAAD, Kumase.

at mid-century. A series of reports on midwives show that midwives worked closely with their assistants to the extent that, in their absence, their assistants performed a number of their tasks. Health inspectors frequently chastised midwives' assistants, scolding them to put on their prescribed uniform to distinguish them from the trained midwives.<sup>251</sup>

Midwives worn a navy uniform or dress while their assistants worn a check dress. On December 17, 1956, a visit to a private midwife, Catherine Paha, drew attention to the fact that the midwife's assistant was performing deliveries on her behalf when she was sick.<sup>252</sup> On January 17, 1957, the visiting committee to a private midwife named Jemima Mensah reported as follows:

The midwife had been away from January 2nd to 16th to Elmina for her mother's funeral. The Ante-natal clinic cards were written up daily in her absence. New cases were given cards, with History etc...all complete. Measurements taken, stage of pre-pregnancy recorded, urine tested, some haemoglobin taken, and medicines given. This has all been done by the midwife's unqualified helper. Midwife was informed that this would have to be reported as a serious view was taken of such illegal practice.<sup>253</sup>

The unqualified status of African health auxiliaries did not allow them to perform tasks that were the preserve of qualified and skilled personnel. Yet, with their experience in hospital work and relationship with skilled workers, some trained up from the ranks of orderlies, African health auxiliaries were able to perform technical duties. These occasional complaints reveal the illegal scope of practice some adopted, but it also underscores how important auxiliaries were to the consistent delivery of care.

From this research, it is clear that the introduction of Western medicine into the Gold Coast relied on African health labour, which evolved in unequal and ad hoc ways,

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<sup>251</sup> "District Sisters Reports, 1956-1957," ARG 2/14/2/3, PRAAD, Kumase, 1346.

<sup>252</sup> "Report on Private Midwife at Mampong, December 17, 1956," ARG 2/14/2/3, PRAAD, Kumase.

<sup>253</sup> "Report on Private Midwife at Obuasi, January 25, 1957," ARG 2/14/2/3, PRAAD, Kumase.

dependent always on the informally trained auxiliary worker. From the mid-nineteenth century onwards, the spread of Western medical services in the Gold Coast paved way for the recruitment and training of Africans for health work. Early African health labour, often but not always referred to as orderlies, were recruited from the coastal cities of Elmina, Cape Coast, Winneba, Anomabo, Dixcove, and Accra. Many came into the health system due to the educational activities of Christian missionaries in the eighteenth century, and the education and training initiatives of subsequent the colonial authorities. But some came in through demonstrated capacities at work, and this report makes an argument in favour of their inclusion in the record. Additionally, the Gold Coast's history of professionalising African health labour extends beyond considerations of the growth of various kinds of health staff to include the ways gender and race defined both terminology and work regimes. This calls for an examination of African health labour across intersectional categories, and for work that interrogates the historical categories in light of professionalisation and utilisation of local labour. This reveals the development, evolution and contributions of the various African medical auxiliaries that help us to understand the organisation of health services in modern Ghana. Understanding of the type of work, the skills learned, and limitation of orderlies' services, would help to widen the range of local health workers visible in the system, all of whom contributed to the evolution of attendant care in Ghanaian hospitals.

## **Conclusion**

This report has documented the professionalisation of staff within Ghanaian hospitals, focusing on auxiliary African health labour employed in the colonial and Christian missionary medical service from 1860 to 1957, a category recognized in the health system today as “orderly.” It challenges the dominant colonial-focused narratives about the development of Western medicine by factoring the missionary services into the evolution of Western medicine in the Gold Coast and the role they played professionalising the categories of African health labour from orderlies or assistants. Through an analysis of fragmentary evidence in colonial and missionary archives, and examining references from secondary works, this report traces the methods and practices of enlisting Africans into Western medical care, discussing the nature of their work and training. The employment and training of African health labour began with the expansion of Western medical services in the Gold Coast from the mid-nineteenth century. By the late-nineteenth century, Christian missionaries like the Basel Mission, Society of the Propagation of the Gospel (SPG), Wesleyan Methodist Mission and the Bremen Mission, and the colonial administration had extended Western medical services to the local population and employed many Africans who assisted the European medical staff in the delivery of healthcare.

The eighteenth-century educational efforts of Christian missionaries and later the colonial administration facilitated the employment of these earliest African health workers, who were drawn from the coastal towns of Elmina, Cape Coast, Winneba, Anomabo, Dixcove, and Accra where European influence was great. By 1860, European doctors had enlisted the help of local men with good knowledge of European languages,

mainly Portuguese, Dutch and English, to assist in attending to the sick (both Europeans and Africans). However, by 1880, English became the only basic requirement for recruitment into the Gold Coast health services following it becoming a formal British colony in 1874.<sup>254</sup> By the beginning of the eighteenth century, several European schools had sprung up along the coastal stretch of the Gold Coast because of their high demand by the indigenous people for education that would expand their occupational options. These schools were mainly of Portuguese, Dutch, and British origin and the children who attended the schools were of African and Euro-African parentage.<sup>255</sup> However, English was the only medium of instruction in schools from the nineteenth century because of its practical use, reflecting the demand of the people for English schools and the English education.<sup>256</sup> The early European schools provided the first African health labour to augment the European medical staff in the Western hospital system.

From 1860 to the late 1950s, the following categories of Ghanaian health staff formed part of the colonial medical service: orderlies, dispensers, dressers, doctors, nurses, and midwives. As revealed in the report, although there appears to be some overlapping responsibilities among these African health categories, a study of their work regimes and qualifications reveals the distinctions of each group. Apart from doctors, all other categories were grouped as auxiliary, working under the supervision of Europeans. From the analysis of archival records, the auxiliary category can further be grouped into skilled and unskilled. Dispensers, dressers, nurses and midwives were considered as

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<sup>254</sup> Gocking, *The History of Ghana*, 12.

<sup>255</sup> Debrunner, *History of Christianity in Ghana*, 61-65.

<sup>256</sup> Sill, *Encounters in Quest of Christian Womanhood*, 115-116.

skilled, qualified or formal labour because of their training while orderlies were categorised among the informal, unskilled and untrained.

Yet this occupation provided a gateway into the trained, skilled work, at least for some. The history of professionalising African health labour in the Gold Coast reveal gendered and racial components of professionalisation. Gender and race intersected to marginalise indigenous women in taking care of the sick in a Westernised medical enterprise. Men formed the majority in the health labour force. European and African gender ideologies conspired to exclude women from the African health labour force up to the 1940s when women became more active in the service.

In the nineteenth century, both missionary and colonial administrators did not place importance on educating women because women were seen as only good for domestic activities such as cookery, needlework, housewifery and maintenance of hygiene, and were trained in that capacity.<sup>257</sup> Within western African gender norms, women were also not permitted to work outside of the home. Women were expectedly the custodians of household duties and reproduction.<sup>258</sup> The cultural position of women in the Gold Coast dictated a labour structure that worked against women and deprived them of pursuing education to any higher level and to engage in other male-dominated professions. These reasons among other barriers discussed in the report combined to cause the late involvement of women in healthcare to the extent that men dominated

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<sup>257</sup> Amponsah, "Colonizing the Womb," 199.

<sup>258</sup> Ayesu, Gbormittah and Adum-Kyeremeh, "British Colonialism and Women's Welfare in the Gold Coast Colony," 6-7.

many categories of African health labour until the 1940s when more women began to enter the health service.

Further, the justification for training and educating indigenous women in Western midwifery reveals pseudo-scientific racism at work. The establishment of the Gold Coast Medical Department in the 1880s created hierarchies among the different categories of European and African medical staff. In the late nineteenth century, racial discrimination in the Gold Coast as in other British West African colonies manifested itself in segregated housing, and then became institutionalised with the employment of African health labour into the colonial medical service. The African health labour were racially discriminated against based on the European misconception of colour difference as a determinant of intellectual capacity, an ideology that prevented Africans from rising above the medical hierarchy.

From employment to training, historical accounts of professionalising African health labour in Ghanaian hospitals revolve around understanding the role of the orderly. This report has examined their auxiliary work and traced the origin of the occupation from 1860, a period when such workers were the only category of African health labour in the Gold Coast. The report ends in 1957 when the occupation has morphed into several categories in the archival records: orderlies, auxiliaries, aides, attendants, and assistants. The argument advanced in this report is that the orderly work was the first African health labour to evolve from the Gold Coast and that almost all other categories of African health labour evolved from the orderly category until about the late nineteenth century when the colonial administration began to formalise the training of the African supporting staff.

Although the term “orderly” has not disappeared from the contemporary category of health labour in Ghana, the position of the work of orderlies within hospitals reflects past representations of this category as merely unskilled and untrained assistants. Yet, from 1860 to 1957 the orderly work could be interpreted as a fluid one, in that orderlies could become dispensers, doctors, nurses and midwives based on the recommendation of their European superiors for professional training and advancement. As an occupational category often described as informal, orderlies were not permitted to perform tasks which were tied to science and medicine. However, with their experience in hospital work and relationship with the qualified, trained and skilled workers like nurses and midwives, orderlies were able to perform scientific duties in the absence of trained personnel. Orderlies did not receive any formal training but learned on the job, hence the description as unskilled labour.

This research, however, reveals how unskilled work provided a pathway into the more formalised health professions. Understanding of the type of work, the skills learned, and limitation and capacities of orderlies’ education, widen the range of local health workers historically visible in the system. This small step can have a large impact. As the health historian, Anna Greenwood rightly states: “Gentle reassessments help us to re-orientate our former understandings of past historical events. They remind us once again that history is always on the move. We will never be able to capture the full story, but each baby step brings us a little closer to understanding it a little better.”<sup>259</sup> There are still questions to ask in connection with the work of orderlies and the professionalisation of

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<sup>259</sup> Anna Greenwood, “Introduction: Looking Beyond the State” In Greenwood, Anna, (ed.), *Beyond the State: The Colonial Medical Service in British Africa*, (Manchester: Manchester University Press, 2015), 15.

Ghanaian hospitals and this report has just provided some insights that help us understand the contemporary organisation of health professions. Orderlies played an essential, but under-appreciated, role in the growth of attendant and other clinical care in Ghanaian hospitals. They continually supplied hospital labour when formally trained staff like dispensers, nurses and midwives were non-existent or in short supply. And their presence and position provided an albeit controversial entry point for a wide range of African worker into the health systems of what is now Ghana.

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# CURRICULUM VITAE

## LUCKY TOMDI

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### EDUCATION

#### MA History

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### AWARDS

- **UNB History Department Scholarship:** Awarded at University of New Brunswick (UNB).
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- **Gale-Shaw Memorial Book Prize:** Awarded at UNB (2021/2022 Academic Year)
- **Henry Harvey Stuart Research Fund:** Awarded at UNB (2021/2022 Academic Year)
- **Dean's Academic Award, Faculty of Social Sciences:** Awarded at Kwame Nkrumah University of Science and Technology for persistent academic performance (June 2019)

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### CONFERENCE PRESENTATIONS

1. Adu-Gyamfi, Samuel and **Lucky Tomdi**. "Politics of Saving Lives: Race, Inequality, and Quarantine from Spanish Influenza to COVID-19 in Ghana." Paper presented at the African Studies Association of Africa (ASAA), 4th Biennial Conference co-hosted by HUMA – Institute for Humanities in Africa at the University of Cape Town, South Africa. Panel 42.A: De-Humanising Health? Responsibilisation and Racialised Space in Times of Corona, Virtual, April 15, 2022.
2. **Tomdi, Lucky**. "Worse Than Being Infected? Approaching A History of Non-Communicable Diseases and Epidemic Diseases Vulnerabilities in Ghana." Paper presented at the 21st Annual University of Maine-University of New Brunswick International History Graduate Student Conference: "Unheard Voices in History." Session 6: A Bodily/Corporeal Scale of History, Virtual, March 27, 2022.

3. **Tomdi, Lucky.** “A Historical Review of Immigrant Health Labour in Canada, 1950-1970.” Paper presented at the 19th Annual McGill-Queens History Graduate Conference. Panel IV: Citizens of the World: 20th Century Immigration, Virtual, March 11, 2022.
  4. **Tomdi, Lucky.** “The Medical Field Units as Embodiment of Epidemic Diseases Prevention and Control in Ghana, 1951 to 1970.” Paper presented at the 18th Annual McGill-Queens History Graduate Conference. Panel II: Public Health from Head to Toe, Virtual, March 12, 2021.
  5. **Tomdi, Lucky** and Benjamin D. Darkwa. “Food and Culinary History of Ghana: An Evaded Subject.” Paper presented at the 27th Annual UNB Graduate Research Conference. Session 3: History / Interdisciplinary Sciences, Virtual, May 06, 2021.
  6. Adu-Gyamfi, Samuel and **Tomdi Lucky.** “Historicising Dilemmas and Hope in a Hospital Setting during a Pandemic.” Paper presented at African Studies Association (ASA) conference, Session VII-AN-8: Africa Now! Virtual, November 19, 2020.
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#### **PUBLICATIONS (SELECT)**

1. **Tomdi, Lucky.** “The Science of Food in the Gold Coast.” *Past Tense Graduate History Journal* (Spring 2022 - Forthcoming).
2. Marfo, Charles Ofori, Samuel Adu-Gyamfi, Confidence Gbolo Sanka, Benjamin Dompheh Darkwa, and **Lucky Tomdi.** “By June, Everyone Would Have Died’: Historicising Humour during the Covid-19 Pandemic in Ghana.” *Modern Africa: Politics, History and Society* 9, no. 2 (2022): 57-81.
3. Adu-Gyamfi, Samuel, **Lucky Tomdi,** and Kwasi Amakye-Boateng. “Discourse on Non-Communicable Diseases Interventions in Ghana (1990-2018).” *Journal of Basic and Applied Research International* 26, no. 2 (2020): 17-26.
4. Adu-Gyamfi, Samuel, Edward Brenya, Razak M. Gyasi, Kabila Abass, Benjamin Dompheh Darkwa, Michael Nimoh, and **Lucky Tomdi.** “A Covid in the Wheels of the World: A Contemporary History of a Pandemic in Africa.” *Research in Globalization*, 3 (2020): 1-35.
5. Adu-Gyamfi, Samuel, Mariama M. Kuusaana, Benjamin D. D and **Lucky Tomdi.** “The Changing Landscape of Mission Medicine and Hospitals in Africa.” *Christian Journal for Global Health* 7, no.5 (2020): 65-81.