Nurses as Middlers: Colonial Medicine, Intimacy, and Professionalization in Ghana, 1920s to 1960s

A Senior Honors Thesis Submitted to the Department of History,
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CONTENTS

PREFACE

"A person cutting a path [into the bush] does not know that the path behind him/her is crooked." This Akan proverb explains how an individual venturing into the unknown does not always proceed most easily; it is only after the path has been cleared that one notices that it is not straight. In many ways, this proverb describes my experiences with this project, in and out of Ghana. I often found myself in unfamiliar situations, both culturally and academically, with an open-mind as my sole armor. Looking back, I realize that my path was never straight and that I made many turns. Nonetheless, now I can also appreciate that it was this crooked path that led to many unexpected encounters, which made this project not only possible but also a truly meaningful learning experience.

My first trip to Ghana was in 2004, through the University of California Education Abroad Program (UCEAP). I was vaguely interested in the HIV/AIDS epidemic and started to volunteer at the HIV/AIDS unit at the Korle Bu Teaching Hospital in Accra, the largest hospital in the country. It did not take a month before I understood how naïve I was about the situation; the painful experience of seeing one patient after another suffer— in part caused by the acute shortage of resources and the profound stigma attached to the illness—soon became overwhelming. Still, I was genuinely interested in the HIV/AIDS epidemic and in the larger significance of the Western healthcare system in Ghana, but could not continue working at Korle Bu Teaching Hospital. Instead, by a referral of a counselor at the hospital, I started to volunteer at a smaller clinic run by a non-profit organization called the West Africa AIDS Foundation (WAAF) in the Roman Ridge section of Accra. The small clinic allowed me to interact with the staff, as well as the patients, on a more personal level. Their warm atmosphere comforted me. I spent much time chatting with staff members and patients. This experience left a profound mark,

I wanted to develop a better understanding. I compiled what I had learned through this internship as an independent study project but felt that it was not enough.

Upon returning to the United States I knew I had to go back to Ghana. In a dire search for means to study this subject and a return ticket, one day, I walked into Professor Stephan Miescher's office and rather abruptly requested to do an independent studies project with him. I am sincerely grateful for Professor Miescher who kindly accepted this sudden proposal, who even suggested to enroll in the History Departments' Senior Honors Thesis course, despite my limited knowledge in the study of history. With his help, I narrowed down my topic to the history of Ghanaian nurses. I had strong recollection of how the staff and patients at WAAF commented on the rude and heartless behavior of Ghanaian nurses. Such images of nurses seemed to contribute powerfully to the negative perception of Western healthcare system. I owe much gratitude to Professor Sears McGee who generously accepted me into the thesis program, and to Professor Armand Kuris, my biology advisor, who so enthusiastically encouraged me to take up this project that had little to do with my major in biological science. These mentors also helped me obtain funding for this research project.

My first trip was supported by scholarships from the UCEAP office as well as the Educational Opportunity Program of University of California, Santa Barbara (UCSB). The Undergraduate Research and Creative Activity Office and the College of Creative Studies generously assisted in paying for my second trip. Moreover, the UCSB Multicultural Center continuously supported me by providing a work-studies position to a student who was always busy and rarely available. It was such financial backings that made this project possible. It is unfortunate and quite disappointing to hear that, in the face of budget cuts, these offices and

departments recently had to cut down means for funding research projects of undergraduate students.

Ghanaian hospitality is not a mere phrase. In Ghana many introduced me to the country's rich culture and supported this project whole-heartedly, some of whom I will never know their name. I deeply appreciate the people of Korle Bu Teaching Hospital and WAAF who warmly welcomed me into their space. I thank Professor Anne Hugon, University of Grenoble, for connecting me to two great women, Professor Mary Opare of the Nursing Department at Legon, University of Ghana, and Mrs. Cynthia Blavo, a former nurse, who kindly shared their knowledge and recollections. Mrs. Harrietta Owusu, Mrs. Akosia Naomi Amaniwah, and Mr. Kwame Baah also took the time to share their valuable stories. I again thank Professor Miescher, who generously helped me become familiar with the National Archives of Ghana at Accra. I also benefited from the assistance of the archives' staff and a group of retired registered nurses. I owe a deep thank you to Ransford Kwakye who not only facilitated and translated some of the interviews, but also rescued me multiple times when I got lost in the streets of Accra.

It is odd, and even embarrassing, that I knew very little about the work of my mentor Professor Miescher for nearly a year that I had worked with him. Often, I took his wise comments and insights for granted, when trying to answer my research question. It was not until recently that I had the opportunity to flip through the pages of his newly published book. Although the subjects we focus on are quite different, I was surprised and filled with awe to learn that there was a form of historical studies I had been searching for, only even more enriched, so elegantly put together. It was truly a privilege to work with a mentor like him. I only regret my shortcomings and time constraints that, at times, constrained the full potential of the resources that were available to me.

Introduction

In its 1954 annual report, the Gold Coast ministry of health described an alarming shortage of nurses which threatened a shut-down of major hospitals and wards.[1] Scarce medical resources were no news in the Gold Coast; earlier reports frequently commented on the lack of doctors, nurses, and other medical supplies. Yet, the mid-1950s shortages of nurses exceeded the habitual paucity, both in its severity and specificity. This was rather an odd phenomenon. About a decade earlier, the first nurses training college in British West Africa had opened in the Gold Coast. By the early 1950s, this college annually produced approximately thirty graduates, who became the Gold Coast's first African State Registered Nurses (SRNs). The health ministry also welcomed the informal training of nurses at large urban hospitals. Additionally, after the Second World War, the ministry recruited former military nurses into the civilian healthcare system. Thus, strangely, the 1950s shortage of nurses occurred against a backdrop of increasing efforts to strengthen the human resources of the nursing profession.

Likewise, the history of nurses from the 1920s to the 1960s in Ghana is filled with tangled meanings and peculiar outcomes at first glance. For instance, men dominated the occupation until the end of the Second World War. The new nursing training college, however, only accepted female candidates. This abrupt change reflected the colonial context of Ghana, then called the Gold Coast, where the harsh economy of political power shaped the medical institutions and policies. In Ghana, as in most other parts of Africa, the nursing profession and an institutionalized Western medicine started as products of the colonial imagination.[2] How these

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[1] The Ministry of Health of the Gold Coast, *Report of the Ministry of Health for the year 1954* (Accra: Government Printing Office, 1955), 89, National Archives of Ghana, Accra (hereafter NAG-A), ADM 5/1/131.

[2] The term "Western medicine" is problematic because it neglects the vast contribution of non-Westerners to the medical system. In Ghana, African doctors have been practicing "Western

imported and imposed ideas of health, disease, and healing came to be in Africa, where supposedly very different healing systems were in practice, has long fascinated historians. Although a sizeable literature exists on the subject, only few scholars have paid attention to nurses. Even fewer works investigate what these biomedical inventions and interventions came to signify in an African society that had its own ideas and structures of healing. Nonetheless, the rich and broad topics covered by the historical and anthropological literature provides us with an important background to colonial and African medicine.

Steven Feierman's innovative 1985 essay first connected the African healing process to the communal organization and economy. Feierman asserted that it was often a group of lay people, comprised of the patient's relatives and neighbors, rather than the healer, who negotiated and exercised authority over the course of healing. In such a context, Feierman argued, both "doctors" and "traditional healers" played a mediating role at the most.[3] Subsequent works in social history and medical anthropology in Africa tended to agree with Feierman's assessment that colonialism and biomedicine had essentially marginal impacts on the African healing process.[4] According to such studies, local healing systems proved to be quite flexible and adaptive; they were constantly modified according to people's need.[5] This rather celebratory

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medicine" for over a century. Scholars have used the term "biomedicine," which is also inadequate, because it implies empiricism. In an African colonial context, however, "biomedicine" and "sciences" often implied cultural assumptions explained in terms of biology. By convention, here, I use Western medicine and biomedicine interchangeably.

[3] Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review* 28, no. 2/3 (1985): 73-147.

[4] This should not be confused with Feierman's argument that colonial structures had serious consequences on pattern of distribution of health costs and benefits.

[5] For study of medical pluralism in Africa, see Gwyn Prins, "But what was the Disease? The Present State of Health and Healing in African Studies," *Past and Present* 124, no.1 (1989): 159-79. For an example of how local belief strategies evolved, see Natasha Gray, "Witches, Oracles, and Colonial Law: Evolving Anti-Witchcraft Practices in Ghana, 1927-1932," *International Journal of African Historical Studies* 34, no. 2 (2001): 339-363.

literature was produced by non-African authors who, occasionally with a mild hint of envy, presented Africans as autonomous figures in control of their health and healing. Nonetheless, many conclusions of this voluminous literature are sound. At times, however, Western medicine was imposed on colonial subjects with physical and political force. To treat the introduction and practice of Western medicine as merely an addition to the preexisting "medical pluralism" seems inadequate. Historian Megan Vaughan argues that biomedicine and associated "sciences" played an important role in "constructing the 'African' as an object of knowledge" in British colonial Africa.[6] According to Vaughan, this process was inseparable from the operation of colonial power. Detailed analysis of colonial objectification occupies the bulk of Vaughan's work. Yet, Vaughan notes that colonial subjectification and how these colonial interventions and ideas might have been "read" by Africans are beyond the scope of her work and its methodology.[7]

Along with this literature on African medical pluralism, skeptics of "modern science" have argued that biomedicine was problematic because it tended to objectify and isolate understandings of health, illness, and the patient from the social context in which they were created and to which they belonged.[8] Ghanaian scholar Kofi Appiah-Kubi stressed how "traditional" Akan healing systems operated in exactly opposite ways by catering to more holistic views of health.[9] Readers of Appiah-Kubi's comprehensive work should notice that the Akan people, the dominant ethnic group of Ghana, accepted both natural and supernatural causes

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[6] Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991), 8.
[7] Vaughan, *Curing their Ills*, 23-26. Also, Vaughan, "Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland," in *Contesting Colonial Hegemony: State and Society in Africa and India*, ed. Dagmar Engels and Shula Marks (London: British Academic Press, 1994), 173.
[8] Meredith Turshen, *The Political Ecology of Disease in Tanzania* (New Brunswick: Rutgers University Press, 1984), 16-19. Also see Prins, "What was the Disease?"
[9] Kofi Appiah-Kubi, *Men Cures, God Heals: Religion and Medical Practice among the Akans of Ghana* (Totowa, N.J.: Allanheld, Osmun, 1981).

of illnesses. Hence, both natural remedies, such as herbs and oils, as well as supernatural processes such as divination, were often used sided by side, fitting to a specific illness and its context. Another Ghanaian scholar, P. A. Twumasi, studied the relationship between Western medicine and local healing systems in Ghana. His work, although now dated, is probably the most comprehensive on the practice of "medical pluralism" in Ghana. Twumasi advocated modifying the Western medical system to suit the "Ghanaian situation." Although components of "traditional medicine" may never completely disappear, he argued, such "traditional" practices would eventually give way to scientific methods.[10] Twumasi's work, often dismissed as an overly simple and linear analysis, is still valuable as an account of how an individual working for the Ghana Ministry of Health understood his contemporary health context.

So far, few scholars have focused on African nurses, despite their central role in maintaining Western medical institutions, as well as in shaping patients' experience. It is surprising that the analysis of nurses has been so sparse, considering the importance studies of colonialism have placed on middle figures.[11] A perception of nurses being mere passive subordinates may have contributed to their invisibility as active participants in shaping society up to the present day. Nurses' vital position in Western medical institutions, however, is clear. Nurses far outnumber doctors and other specialists. The necessity of nurses is so fundamental to the functioning of a modern medical institution that, as indicated in the 1950s example, a shortage of nurses could force institutions to close. Further, it is the nurses who see a patient day and night, and thereby stepping into his or her most intimate and basic space. In a hospital,

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[10] P. A. Twumasi, *Medical Systems in Ghana: A Study in Medical Sociology* (Accra: Ghana Publishing Corporation, 1975).

[11] To list a few recent works: Nancy Hunt, A *Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham & London: Duke University Press, 1999). Stephan F. Miescher, *Making Men in Ghana* (Bloomington & Indianapolis: Indiana University Press, 2005).

nurses are not only middle figures between doctors and patients, but they also shaped the patients' immediate environment. In Africa, the importance of nurses' qualitative role increased during colonial and post-colonial contexts, when nurses introduced and educated patients about Western medicine.

Thus far, Shula Marks's book on the history of nurses in South Africa is the most thorough study of nurses within African historiography. Marks provides a detailed account of how the South African nursing profession was "divided" by class, race, and gender since the late nineteenth century.[12] Much of what I explore in this study is similar to Marks's case, confirming that the colonial experience across the continent had some common threads.[13] More recently, Catherine Burns has conducted research on male nurses in South Africa, arguing that both white and black communities maintained the oppressed position of men in nursing.[14] Burns's study is innovative in the sense that it includes local values concerning masculinity and intimacy, in addition to European ones, to what shaped the nursing profession.[15] Nancy Hunt's book on medicalization in the Congo further unpacks these layered projections and the "meaning making" process of both the colonizers and colonized.[16] Hunt examines how "colonial medicine impinged on a *local* therapeutic and political economy, and how *local* Congolese . . . differently translated

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[12] Shula Marks, *Divided Sisterhood: Race, Class, and Gender in the South African Nursing Profession* (New York: St. Martin's Press, 1994).

[13] Of course, this impression may be the result of a lack of more detailed studies. Whether such a commentary holds true for non-British Africa, or colonies outside of the African continent is a question that demands more study.

[14] Catherine Burns, " 'A Man is a Clumsy Thing Who does not Know How to Handle a Sick Person': Aspects of the History of Masculinity and Race in the Shaping of Male Nursing in South Africa, 1900-1950," *Journal of Southern African Studies*, 24, no. 4 (December 1998), 695-717.

[15] I find Burns's generalization on values of "local black culture" somewhat problematic, as I will discuss later.

[16] Hunt, *Colonial Lexicon*, 10.

and reshaped" what was offered by colonial medicine.[17] According to Hunt, such processes were "mediated by middle figures and the 'entangled objects' of their work."[18] Recent scholars of African colonialism, such as Burns and Hunt, have set new trends in the field. They placed more emphasis on how Africans constructed and reconstructed their relationship with each other as a result of colonialism, than merely studying of how Africans dealt with their colonizers.[19] There have also been conscious efforts to avoid simple dichotomous analyses of hegemony/resistance and imposition/response, which seem to mask the complexity of the colonial situation.[20]

Although nurses became professionals in Ghana as artificial middle figures, initially a total construct of colonial imagination, there is no doubt that they were also subject to projections from both African communities and colonial officers. Indeed, nurses were not mere middle figures between Western medicine and the African population. Rather, Ghana's African nurses stood at the intersection of colonial and local ideas about medicine and healing, professionalization and legitimacy, modernity and the "traditional," gender and age, and caring and intimacy. The colonial officers expected African nurses literally to "bridge" the very real differences in ideas and organization that existed. How Ghanaians perceived nurses is less clear. In this study, I seek to uncover how colonial officers imagined nurses, and how the products of such colonial imagination came to be for Africans. I use African nurses as an entry point to trace the different lines that intersected at this node, rather than situating nurses within a "larger

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[17] Ibid., 8.
[18] Ibid., 160.
[19] Also see David Graeber, "Love Magic and Political Morality in Central Madagascar, 1875-1990," in *Gendered Colonialisms in African History*, ed. Nancy Rose Hunt, Tessie P Liu and Jean Quataert (Oxford: Blackwell, 1997), 94-117.
[20] Also see Nancy Rose Hunt, "Introduction," as well as Lynn Thomas, " 'Ngaitana (I will circumcise myself)': The Gender and Generational Politics of the 1956 Ban on Clitoridectomy in Meru, Kenya," both in *Gendered Colonialisms in African History*, ed. Nancy Rose Hunt, Tessie P Liu and Jean Quataert (Oxford: Blackwell, 1997), 1-15, and 16-41.

picture" of what they were expected to "mediate." In doing so I hope, at least partly, to depart from my own assumptions about how an individual compartmentalizes, understands, and make sense of his or her surroundings.

Reconstructing the dynamic and complex African individual, as well as his or her belonging to collective subjectivities, is a difficult task. Often subjectivities of the "other," the "subaltern," or the "colonized subjects," have been described as inaccessible and impossible to comprehend. Ultimately, I cannot argue that this is not true. Nonetheless, these "colonized subjects" left sizeable records. Indeed, the press in English-speaking West Africa is now over 150 years old and was in African hands almost from the beginning. According to Rosalynde Ainslie, by the 1930s, " the reading public was not merely a privileged coastal intelligentsia, but a relatively wide cross-section of the population."[21] The actual number of people who read newspapers is hard to measure. Although the literacy rate of the country did not reach twenty-five percent until the 1950s, these newspapers were packed with images and were read out aloud in groups.[22] Articles and images from newspapers form an important component of primary sources, providing access to popular culture.

Government administrative records were also crucial for this study. We should not assume that colonial documents are incapable of exposing African reactions. Hunt reminds us that Gyatri Spivak's point was not that "subalterns did not speak, but that historians, blind to their own 'representations,' did not see how their narratives worked to '*speak for*' rather than '*speak to*' subaltern speech, cries and laughter."[23] Hence, I use colonial administrative records not only to remold the evolving colonial medical strategies but also to trace how Africans might

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[21] Rosalynde Ainslie, *The Press in Africa* (New York: Walker and Co., 1966), 19.
[22] Kenda Mutongi, " 'Dear Dolly's' Advice: Representation of youth, Courtship, and Sexualities in Africa, 1960-1980," *International Journal of African Historical Studies* 33, no. 1 (2000), 22.
[23] Hunt, *Colonial Lexicon*, 160.

have reacted in specific situations. In addition to governmental documents, historian Stephan Addae's book offers a detailed institutional history of Western medicine in the region.[24]

Finally, I conducted informal conversations and in-depth interviews with elderly Ghanaians, some former nurses. What initially stirred my curiosity about African nurses were the repetitive comments made by older men and women in Ghana that Ghanaian nurses were "rude" and treated patients, "as if we were not humans."[25] Supposedly, this was not a recent phenomenon, but was "even worse back in the days."[26] Many Ghanaian university students shared this impression, even those who had no personal experiences of being admitted to a hospital. I wanted to trace the roots of this surprisingly homogeneous public memory, which today contributes to the negative perception of Western medical institutions in Ghana. Hence, I have taken a broad approach in examining the history of Ghanaian nurses by drawing on an array of sources. To appreciate the depth of the changes nurses brought, such characteristics are constantly juxtaposed by the most appropriate components of local culture. For this task, personal interviews, as well as the work by Ghanaian scholars, have proved invaluable.[27]

In the following section, I first historicize the emergence of the colonial fantasy, to train the African nurse as the perfect middle figure, in the 1920s. I compare some crucial differences in these imagined nurses from local ideas of nursing. Then, I present the powerful trend towards the professionalization of nursing during the 1940s and 1950s. This trend was characterized by a

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[24] Stephan Addae, *History of Western Medicine in Ghana: 1880-1960* (Durham: Durham Academic Press, 1997). For a similar, brief account on the history of nursing education in Ghana, see Mary Opare 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.

[25] Evelyn Naomi Abe, "The HIV/AIDS Experience in Ghana," independent study, University of Ghana, Legon, 2004.

[26] Ibid.

[27] Appiah-Kubi, *Man Cures, God Heals*. P. A. Twumasi, *Medical Sociology*. Kwame Gyekye, *African Cultural Values: An Introduction* (Accra: Sankofa, 1998).

sudden gender-switch of nursing candidates from men to women. Further, youth were preferred as candidates over older women. These changes did not correspond with the practice already established in hospitals, nor did they agree with dominant ideals in local culture. This tension caused the acute shortage of nurses in the 1950s.

I. The Making of the Nursing Profession: The "Concerned" Colonial Government

It was not until the 1920s that training African nurses and doctors received serious attention from the British colonial government. By this time, the Gold Coast was no longer the dreaded "white man's grave." The once high European mortality had declined thanks to the new understandings of sanitation and disease, and the colonial office began to develop a sense of responsibility towards the African population.[28] The colonial government became increasingly concerned with the "depopulation" of Africans, especially in the light of the recent recognition of the economic value of African health.[29] Officials listed "inter-tribal slave raiding and strife" and "disease" as causes.[30] The low birth rate and high infant mortality were of particular concern, which they accounted to venereal diseases.[31] Additionally, multiple "epidemics [had] swept over large tracts of country causing deaths running into hundreds of thousands, in area after area."[32] Moreover, most Africans were reluctant in seeking biomedical treatment, even when it was available.[33] In the eyes of colonial officers, the African population was rapidly deteriorating from largely preventable causes.

Further, an elite of educated Africans in the urban areas, the so-called intelligentsia, strongly advocated for Africans to take up higher positions in the government services including

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[28] In 1895, the European deaths-per-thousand was 206. This had dramatically declined, and was only 4.5 by 1925. Addae, *History of Western Medicine*, 52.

[29] Government of Gold Coast, *Correspondence Relating to the Training of Medical Students and Medical Assistants in British West Africa* (1924), 17, NAG-A, ADM 5/4/268.

[30] Ibid.

[31] *Correspondence*, 9, 17. Whether venereal disease was actually the primary cause of low birthrate and high infant mortality is questionable. Megan Vaughan points out that many syphilis cases in Uganda, which were thought to cause abortions and premature births, were likely misdiagnosis. Vaughan, *Curing their Ills*, 137, 138.

[32] *Correspondence*, 17.

[33] Indeed, when Governor Clifford arrived in the Gold Coast in 1912, he was surprised how little Africans utilized the medical service in comparison to his former experiences in Ceylon. Addae, *History of Western Medicine*, 27.

those in the Medical Service. A medical school had already opened in Dakar by the French colonial authorities, fueling the motivation of the Gold Coast intelligentsia and some colonial officers to follow the lead.[34]

Efforts to train African medical practitioners had been tried since the 1850s, though they only saw marginal success.[35] Schemes for organized training of African nurses were almost never mentioned. In 1921, there were sixty-four registered African nurses and nurses-in-training combined. These nurses received training on an apprenticeship system in large hospitals where European "nursing sisters" were stationed.[36] The instruction focused on practical skills on a need-base.[37] Training varied significantly, since only a local diploma was awarded upon completion.[38] Although not registered nor called nurses, it is most likely that there were many more Africans working as auxiliary staff at medical institutions. The European staff was small, and for the institutions to function, African workers must have received informal training from how to maintain a clean ward environment to perform simple medical procedures.[39] Thus, in varying degrees and range, both official and unofficial African nurses filled the voids left by European staff.

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[34] Addae, *History of Western Medicine*, 173. *Correspondence*, 10-16.

[35] As European mortality declined, the colonial War Office's efforts to train African doctors tapered off in the late nineteenth century. Only two Africans had been sent abroad for medical training at the expense of the government, including the well-known Dr. Africanus Horton. Horton strongly advocated for continuing the training of Africans at government's expense, but in vein. Others obtained training in England, but at their own expense. Addae, *History of Western Medicine*, 172.

[36] European nurses had started to work on a regular basis in the late 1890s. By the 1920s, European nurses were based in the larger hospitals of Accra, Cape Coast, Sekondi, Kumasi, and later Koforidua. Addae, *History of Western* Medicine, 163-165.

[37] Only "very elementary anatomy and physiology, medical and surgical nursing, hygiene and first aid" were taught. Addae, *History of Western Medicine*, 164.

[38] Ibid.

[39] The number of European nurses barely exceeded 30 in 1940. Addae, *History of Western Medicine*, 165.

The intention to create facilities for more formal medical training received a positive response in the mid and late 1920s. Training African medical staff was the main topic of the Third Conference of senior members of the West African medical staff held in Accra, in 1925. Two years later, the Secretary of State for the British Colonies appointed a committee to determine further the feasibility of a domestic medical school. Although both of these initiatives strongly emphasized the need for medical assistants over doctors, they envisioned these "assistants" differently. The historic emergence of the modern nursing profession in Ghana can be traced to these events.

The Third Conference of the senior members of West African medical staff met at Accra, in December 1925. Its members included both directors and deputy directors of the Medical and Sanitary Services from Nigeria, Gold Coast, Sierra Leone, and a representative of The Gambia. Although the conference did not deny the possibility of training practitioners, it left detailed policies ambiguous, declaring that the time was not ready. The conference almost entirely focused on the training of medical assistants, due to the "immediate necessities."[40] The underlying idea was that "the health of the people as a whole [was] a long way below what it should be" and that these conditions were "largely preventable" with simple "modern means for combating disease and improving health."[41] Training African medical assistants was thought to provide an economic and quick solution to the problem.

The conference argued that "intelligent youth" was "available" for training, and advocated for strengthening the general education to produce more feasible candidates.[42] The conference imagined medical assistants as, essentially, "partial practitioners," whose level of

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[40] *Correspondence*, 17-19.
[41] Ibid.
[42] Ibid.

skills lied somewhere along the line between a layperson and a "full" medical practitioner. This continuum between the two was explicit in the fact that the conference proposed, "when the school is fully developed, it should be possible for those Medical Assistants to return and complete a recognized medical course . . . and obtain a diploma."[43] However, this sense of continuum between assistants and practitioners was completely objected by the Committee for the Training for Medical Practitioners.

In 1927, the Secretary of State appointed a committee to determine the viability of the construction of a domestic medical school.[44] The committee was chaired by the Colonial Secretary of the Gold Coast, and had a quite diverse membership. Among them were directors of Medical and Sanitary Services of Nigeria, Gold Coast and Sierra Leone, the principal of Achimota School (then the sole government-run Secondary School in the Gold Coast), and the principal of the medical college of Singapore. The committee compiled a report, published in 1928. This report also emphasized the importance of training African medical assistants over practitioners, though it fully supported constructing a "full-course medical school in West Africa" as a high priority.[45]

As the 1925 Conference, this report stressed the urgent need for medical assistants. The report stated that "for the rapid extension of medical service to the community, the provision of an Auxiliary Medical Staff is a more immediate necessity than that of fully qualified practitioners."[46] In this report, the role of "medical assistants" had clearly departed from that of

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[43] Ibid.
[44] Addae, *History of Western Medicine*, 175.
[45] Government of Gold Coast, *Report of the Committee Appointed by the Secretary of State for the establishment in West Africa of a College for the Training of Medical Practitioners and the Creation and training of an Auxiliary Service of Medical Assistants* (Accra: Government Printing Office, 1928), 6, NAG-A, ADM 5/3/26.
[46] Ibid., 9.

practitioners. When the Secretary of State asked the committee to consider training practitioners and assistants at the same institution, the committee entirely objected.[47] Training the two at the same facility would have enabled the two to share introductory courses. The committee, however, opposed this possibility on the grounds that such attempts for dual training had failed in other British colonies such as India and Singapore.[48] Along with the technical difficulties of training the two groups at the same institutions was the recognition that the two professions were of "an entirely separate basis and with a different scope."[49]

Indeed, the 1928 report reshaped the position of medical assistants. The report listed three main reasons why medical assistants were needed over practitioners. First, the candidates were "likely to be available in greater numbers."[50] Furthermore, "after training, [they] were more widely and at more reasonable cost [to] be distributed through out the Country."[51] Last, and most important for the committee, they "[lived] in closer touch with the people and thus [had] unrivalled advantages in inculcating among them a recognition of the benefits to be derived from modern medicine and sanitation."[52] Hence, here was the creation of a new profession that was not a mere assistant—a "partial" medical practitioner— but a nurse with new characteristics, such as practical mobility across the country and a role as an educator, to fit the local needs.

Colonial attempts of social reproduction lurked behind these training schemes. "Character training" was considered an "absolute essential" for a "reliable service."[53] Even Governor Guggisberg, who said that those who belonged to the intelligentsia were "at least equal

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[47] Ibid., 6.
[48] *Report of the Committee*, 6-8. Addae, *History of Western Medicine*, 175.
[49] *Report of the Committee*, 7, 8.
[50] Ibid.
[51] Ibid.
[52] Ibid.
[53] Ibid., 6.

to the type of European who is at present filling these [government's] appointments" in aspects of "character, education and technical, or professional training," emphasized the importance of character training.[54] But this was not a simple attempt to turn the "African character" into one of a European. Nurses were expected to remain in close "touch with the people" in order to "[inculcate] them . . . the benefits . . . [of] modern medicine and sanitation," while completing the intensive character training that involved living in "hostels under suitable house masters."[55]

To be sure, the subject of training African medical staffs and emphasizing assistants over practitioners did not go without controversy. Although the language of the 1925 Conference and the 1927 Committee was more pragmatic, this was not always true in the correspondence between colonial officers. These letters are filled with attempts to validate their opinions with their experience and knowledge of Africans, at times, resembling a competition. The information travelled from the "site," through and textured by individual colonial officers, to the "metropole."[56] In a sense, colonial officers, too, were middle-figures trying to understand, translate, and communicate about the "site" and its residents. For example, Dr. O'Hara May, the acting director of Medical and Sanitary Services, who had a "few years' experience of trying to teach Sanitary Inspectors and Vaccinators in the Gold Coast" argued against the construction of an university saying that even the qualified African candidates "wrote badly, read worse, and the speaking knowledge of the English language was crude . . . all of which made the absorption of knowledge very difficult."[57] Governor Guggisberg, who was "in sympathy with their [Gold

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[54] *Correspondence*, 11.
[55] *Report of the Committee*, 6, 8.
[56] The singular European metropole as an analytical tool is not sufficient in understanding the complex structure colonialism and local societies created. Nonetheless, in these correspondences, the colonial officers did imagine, or acted as they imagined, such single source of imposition.
[57] *Correspondence*, 6, 7.

Coast intelligentsia's] aspirations," strongly advocated for the training of African practitioners "judging from [his] experience of men of the intelligentsia class."[58]

This competition included a third party that did not write dispatches: the Gold Coast intelligentsia. Guggisberg, in support of the intelligentsia, noted that it was only natural that "the intelligentsia of this Country . . . [aspired] to any post in the Government Service."[59] He acknowledged that "they [wanted] a lead."[60] Voices opposing based their arguments on doubts of the Gold Coast Africans' capability, which were not unlike dismissals in efforts to maintain a lead. Dr. O'Hara May noted, "such an university would [not] be of very much use" for the Gold Coast Africans.[61] In his opinion, "the French natives" were more keen on education than ours, as one [could not] conceive the young male and female intelligentsia of [the] Gold Coast, or Ashanti enter in for competitive examination, the result . . . [of] intensive study under strict rules and discipline without pay."[62] Such ethnographic observation to validate a colonial officer's "on-site" knowledge was common. Of course, more practical matters such as expected increase in expenditure were also a concern. The proposal to focus on assistants over practitioners seemed to alleviate the concern on both African capability and cost.

The role of the African intelligentsia in this decision making process was not a marginal one. The intelligentsia class was greatly disappointed in the intensifying trend to focus on assistants over doctors. Governor Guggisberg sent two lengthy dispatches to the Secretary of State to call attention to the Gold Coast intelligentsia's "acute . . . desire for full recognition."[63] He noted that any attempt for training solely assistants was "doomed to failure in the Gold Coast

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[58] Ibid., 10.
[59] *Correspondence*, 10.
[60] Ibid., 13
[61] Ibid., 7.
[62] Ibid., 7, 8.
[63] Ibid., 12.

at any rate," because no African would come forth as candidates if that were the case.[64] This would be a huge problem because "such a class of medical practitioner [was] necessary."[65] Through these letters, one can glimpse of how colonial officers acted as if there was a single European source of imposition. They could, however, not ignore the African intelligentsia's opinion.

At any rate, this educational program for medical assistants or practitioners was never realized. The increasingly uncooperative attitude of other British colonies and eventual decline in the economic situation in Ghana during the 1930s were among the causes.[66] Addae adds that the in the intelligentsia's diminished "political enthusiasm" for the construction of the college also likely contributed to the demise of the proposal, further recognizing the role of intelligentsia in the decision making process.[67] Nonetheless, the 1928 Report provides a crucial look into the historical context—the colonial government concerned with the Gold Coast as a whole, including fears of African "depopulation," cost, African capability, and character—which led them to imagine cheap and convenient African nurses who were neither European nor too African.

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[64] Ibid., 12, 15.
[65] Ibid., 14.
[66] Addae, *History of Western Medicine*, 177.
[67] Ibid., 178.

II. Mobile Educators and Intimate Spaces: The Professional Nurses and Local Values

Before we proceed to the scene in 1945—when the first nursing school actually opened in Gold Coast—we need to further understand how the 1927 Committee imagined the new nursing profession, against the backdrop of the local values concerning healthcare and healing systems. After all, although the scheme drawn by the 1927 Committee did not materialize, the social forces and colonial imagination that molded it were in place. For Gold Coast Africans, these ideas were not dropped in a vacuum but within a complex web of local establishments and ideas surrounding health, healing, and nursing.

How did the 1927 Committee envision the new modern nurse? As mentioned, their role as educators and their economically feasible, and thus realistic mobility across the country, were among their important characteristics in the colonial perception. To allow for this mobility with legitimacy, a standardized proof of training was needed, and it was proposed that those who finished the training to receive a Certificate of Proficiency.[68] It was also planned that candidates would be drawn from the somewhat educated group of African youth, although there were Africans already working as nurses who might have better qualified in a practical sense. This report also embodied a trend that later intensified: gendered professionalization. The committee envisioned nurses as males. This gendered demand was still ambiguous, for the report left for the future the possibility of female candidates. Even though the curriculum was designed for men, the expectations for students were very similar to what later came to be associated with female nurses. Students were to be trained in "every aspect of caring and nursing," including the "complete experience in midwifery practice."[69]

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[68] *Report of the Committee*, 39.
[69] Ibid., 37, 38.

Formal and recognized training for the healing occupation and some mobility accompanying the healing process were nothing new in the local healing system. Different levels of knowledge and a variety of healers existed among the Akan and in other West African cultures. A formal training was required in order to become the ultimate diagnostician, a priest-healer. The methods and duration of this training varied, but it normally took about four years. These trainings often concluded with a community event that recognized the completion of his or her studies.[70] Although no certificates for proof were involved, through such public events, community members recognized the new priest healer's knowledge and skill as legitimate. Popular healers often held, some times with the help of their "attendants" and other "assistants," an organized establishment to treat their patients.[71] These establishments varied in size and organization. Some had extensively organized schedules and structures to examine and treat patients.[72] In this case, the sphere of the healer was quite beyond the immediate local community. It was not uncommon for a patient to travel some distance to see a renowned healer, creating some mobility in the process of healing.

These healing practitioners played numerous social roles: they acted as a "friend, priestess [or priest], doctor, social worker, advisory bureau, psychologist, psychiatrist, and philanthropist."[73] But interestingly, they did not nurse their patients. Although some healers had

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[70] Appiah-Kubi, *Man Cures, God Heals*, 37-39. Twumasi, *Medical Sociology*, 25-30.
[71] Appiah-Kubi, *Man Cures, God Heals*, 41-70. Quotes taken from 45.
[72] A few case studies of these larger establishments can be found in Appiah-Kubi, *Man Cures, God Heals*, 41-70. Addae argues that the "most important difference between the African and European approaches to medical care was an organizational one: European and other cultures founded hospitals, clinics and dispensaries or such equivalents, where the sick could be attended in an organized way. No such equivalents appear to form a part of the Ghanaian and West African healing methods." (Addae, *History of Western Medicine*, 11). This was not true. There were, certainly, variation in size and organization, but some Akan establishments were quite highly structured.
[73] Appiah-Kubi, *Man Cures, God Heals*, 30.

attendants and assistants, their duty was mainly to help the healer rather than the patient.[74] Twumasi describes that some shrines employed women to "look after the domestic duties" such as cleaning the shrine. These women were trained to avoid certain taboos, but they had little to do with the "professional activities at the shrine."[75] Who cared for and nursed the patients? Family members, overshadowed in published accounts by the diagnosing process and the flashy healing events, were responsible for cleaning, feeding, and caring for the sick. The nursing role of family members is rarely mentioned in even the more comprehensive literature on the local healing systems. When the patient had to be left with the healer, the designated family member visited, often multiple times a day, to care for the patient.[76] Some priest healers had established institutions that accepted the patient's "kinfolk" as a designated nurse.[77] Obviously, the nursing task was far from being professionalized in this system. Nursing occurred in very personal, intimate spaces and had little to no implications of information dissemination. The "nurse" and the patient were equally immersed in the healing process, and the "nurse" was as mobile as the patient. This was very different from what the 1927 Committee envisioned, where nurses were to become the educators of completely new symbolism and logic across the country, seeking out for patients. In this situation, nurses and what they practiced would have been foreign in most communities they worked.

The 1927 Committee imagined nurses as men. It was not only the nursing occupation that was dominated by men at the time. Generally speaking, African women were not as available and welcomed as men were in colonial spaces. This manifested in the gender ratio of Africans

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[74] Ibid., 41-70.
[75] Twumasi, *Medical Sociology*, 30.
[76] Indeed, it was only through the interviews with Akosia Naomi Amaniwah that I started to see the role of family members as nurses. Interviews and translation by Ransford Kwakye and Evelyn Naomi Abe, Akwasihu, September 16, 2005, and phone conversation, October 7, 2005.
[77] Appiah-Kubi, *Man Cures, God Heals*, 95.

who worked for Europeans, as well as African patients in Western medical institutions. The overwhelming majority of the salaried workers were also men, and so were the sick who were hospitalized.[78] Thus, colonial officers could only imagine training and hiring men, and women's involvement had to be kept as a future possibility.

It is difficult to reconstruct the local gender dynamics that accompanied the idea of nursing, which in itself was dynamic and complicated. It can be presumed that men working as nurses in colonial government hospital did not disagree too much, because, after all, they did take up such occupations. When I asked Mr. Kwame Baah about his experiences as a male nurse, he did not understand the significance of gender aspects of this this question.[79] Perhaps men as nurses had little problems with the local gender dynamics, because the patients were overwhelmingly men as well. It was generally accepted for a close family member of the same gender to take care of the sick. Mothers were exceptions; a mother could nurse her children regardless of their gender. Thus, men nursing other men of the same family did not contradict with the local gender values.[80] Yet, the new dynamics introduced by hospitals conflicted with ideas of intimacy associated with nursing because complete strangers cared for the sick in Western hospitals.

Catherine Burns, in her study of black male nurses in South Africa, emphasized that it was also the "indigenous ideas about the feminised work of intimate service and caring attention" as well as ideas of "African masculinity" that reinforced the oppressed position of men in the nursing profession.[81] This did not seem to be the case in Gold Coast, at least during the

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[78] Addae, *History of Western Medicine*, 163.
[79] Mr. Kwame Baah, interview by Evelyn Naomi Abe, Mamobi, Accra, September 4, 2005, and September 15, 2005.
[80] Akosia Naomi Amaniwah, October 7, 2005.
[81] Burns, "A Man is a Clumsy Thing." 715-716.

first half of the twentieth century. Burns's study points to many difficult questions historians face in reconstructing ideas about gender: whose voice counts, for how long, and for how much? Burns uses a remark made by an elite African who considered nursing as a woman's job in order to speculate about the gendered ideas of the local African communities.[82] This seems to disregard the differences that might have existed within the local African communities concerning social status and age, as well as the dynamic nature of socially constructed ideas. While this elite patriarch might had to draw his power from the local societal structure, to regard his gendered values as that of the local black community as whole, seems inadequate. This is increasingly problematic in a colonial context where an elite could also be the group most influenced by colonial values.

After all, the scheme proposed by the 1927 Committee did not materialize. Nonetheless the social forces and colonial imagination, which was to shape the modern nurses, were in full practice. The urgent need to spread some form of medicine across the country manifested itself in the increased medical expenditure.[83] This led to construction of new hospitals and dispensaries.[84] Efforts were made to train more registered nurses at larger centers, such as the Gold Coast Hospital (later Korle Bu Hospital) in Accra. This strengthened the nursing staff, but not by very much, because significant proportions of trained nurses resigned their positions, not content with the low pay or the difficult menial labor.[85] As candidates were increasingly drawn from an educated group of Africans, expectations conflicted with the actual pay and work. The traveling dispensaries and mass disease eradication campaigns, which begun in the mid1920s,

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[82] Ibid.
[83] Addae, *History of Western Medicine*, 29.
[84] The number of hospitals and dispensaries dramatically increased in the 1920s and the 1930s. There were approximately 110 hospital beds available for Africans in 1915, and by 1935, this number had jumped to 977. Addae, *History of Western Medicine*, 29.
[85] Ibid., 163, 165.

demonstrated the need for mobility. While the motor traveling dispensary did not go beyond the experimental phase, the mass disease eradication campaigns became one of the governments' main methods to address African diseases.[86] These campaigns, which "tracked down endemic diseases" such as yaws and trypanosomiasis, were in full practice well into the 1940s.[87] These campaigns created a new space for healing, or rather "curing" and "preventing" which had little to do with institutions or nurses. The "eradication team" would often set up a temporal shelter, where local residents had to pass through one by one to be systematically examined and receive vaccination or other injections.[88]

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[86] Ibid., 57.
[87] Ibid., 29, 30.
[88] The practice of mass eradication campaigns probably changed over time, but the core factors, such as the mobile eradication team and their factory-like operation, remained essentially the same. Frequently, the practice involved very dehumanizing moments. See Vaughan, *Curing their Ills*, 49-53 for a detailed description of a "session" in Nigeria in 1951.

III. The Wave of Professionalization

The healthcare policies of the Gold Coast government saw little changes during the 1930s and the 1940s. The 1920s' intent to expand and elaborate medical services persisted, although in the 1930s, almost no new hospitals or facilities were built due to financial difficulties of the depression and the Second World War.[89] An important change during the 1930s was the significant rise in popularity of Western medicine among Africans. The number of African patients increased exponentially.[90] Female patients increased, though most of the times, well over half of the patients remained men.[91] The over-representation of men was especially true among inpatients.[92] Western medicine created new feminized spaces as well. Child welfare and antenatal clinics became popular, attracting each year more visitors.[93] By the end of the 1940s, attending a welfare center had become so popular among some mothers that it took on a new meaning as a "pleasant social event."[94] More women were trained as nurses to attend these spaces.[95]

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[89] Addae, *History of Western Medicine*, 62.
[90] In 1915, about fifty thousand African patients were seen, and in 1935, more than two hundred and seventy patients were treated. Addae, *History of Western Medicine*, 29.
[91] The Medical Department of the Gold Coast, *Report of the Medical Department for the year 1945*(Accra: Government Printing Office, 1946), 16 and 17, NAG-A, ADM 5/1/122.
[92] Ibid.
[93] *1945 Report of the Department*, 2. Also see the Medical Department of the Gold Coast, *report of the Medical Department for the year 1946*(Accra: Government Printing Office, 1947), 5, NAG-A, ADM 5/1/123, and Addae, *History of Western Medicine*, 148-158.
[94] Medical Department of the Gold Coast, *report of the Medical Department for the year 1947*(Accra: Government Printing Office, 1948), 14, NAG-A, ADM 5/1/124.
[95] There are very few documents of the "un-registered" nurses, both men and women. But, it is clear that there were significant number of women nurses by this time, because when students of the nurses training college entered their clinical training at various hospitals in the late 1940s, older female nurses attending the female wards was quite common. Cynthia Blavo, interview by Evelyn Naomi Abe, McCarthy Hills, Accra, September 1, 2005, and September 9, 2005. Harrietta Owusu, interview by Evelyn Naomi Abe, McCarthy Hills, Accra, September 10, 2005.

The increase in demand called for more nurses. Efforts to train more registered nurses from the 1920s had persisted, and training happened at larger hospitals.[96] By the 1940s, however, the supply of nurses was not sufficient for the government's medical institutions. The registered nurses in need were slightly different from those of the late 1920s. By the 1940s there were more than thirty hospitals, while there were no more than thirty-three European nurses.[97] Subsequently, the leading positions usually occupied by European nurses experienced a severe shortage; there were simply not enough Europeans.[98] By the early 1940s, it was not rare that some of the "most capable" African nurses undertook duties usually assigned to European nursing sisters. These African nurses were called the "temporary nursing sisters."[99] Also, there was significant mobility of human resources between the government hospitals and the military; nurses were borrowed from the Army and the Royal Air Force when necessary.[100]

Hence, the demand created an opportunity for African nurses to advance, at least temporary. The medical department was hesitant in allowing African nurses permanently to take up positions with "added responsibility" without proper qualifications, or the controlled training process administered by Europeans.[101] Nonetheless, the 1940s medical department was more enthusiastic about training African staff. Holding examination and awarding certificates became a popular practice. In the early 1940s, Dr. J. Balfour Kirk, the Director of the Medical Service,

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[96] Addae, *History of Western Medicine*, 165.
[97] Addae, *History of Western Medicine*, 81, 165, and 166.
[98] Apparently, nursing in the Gold Coast was not a popular profession among European women. The Medical Department wrote in 1945: "Owing to . . . sickness, retirements, leave, etc., there has been a constant, serious shortage of European nursing Staff." The Medical Department of the Gold Coast, *Report of the Medical Department for the year* 1944 (Accra: Government Printing Office, 1945), 1, NAG-A, ADM 5/1/121. *1945 Report of the Department*, 4.
[99] Ibid. Also see the Gold Coast Medical Department, *African Nurses—Proposal for appointment of, as Temporary Staff Nurses* (1944), NAG-A, CSO 11/1/471.
[100] The practice of biomedicine in West Africa was closely related to the operation of military power. This subject demands more study.
[101] *1944 Report of the Department*, 1.

took the lead in conceptualizing a nurses' training school.[102] This plan materialized, and the first nursing training college opened in Kumasi, 1945.

The first nurses' training college had inherited the basic characteristics of the 1928 Report, although there were important changes and further elaborations. Most obviously, the space was strongly gendered. Now, nurses had to be women. Candidates were selected from an educated group of young Africans. The notion of character training remained important, all "pupil nurses" had to live in a hostel.[103] The training scheme was impressively comprehensive; the students underwent a broad learning experience, including practical nursing skills, manners, leadership skills, and life in general.[104] The nurses were expected to be mobile as they followed the need of hospitals across the country. Still their professional space remained largely confined to the insides of hospital building. The older apprenticeship training system endured for a while due to practical needs, though, the department envisioned that, one day, " all pupil nurses [would] enter the Nursing Training School."[105] A tone of de-legitimization was quick to enter the discourse about the apprenticeship training. The 1945 Department Report described the apprentice system as something belonging to "the past" and placed it in quotation marks, questioning its appropriateness and legitimacy.[106]

The Medical Department described the opening of the nursing training college as an

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[102] Addae, *History of Western Medicine*, 166.
[103] *1945 Report of the Department*, 5.
[104] The Gold Coast Medical Department, *Recreation Facilities at the Midwives and Nurses Hostels* (1947), NAG-A, CSO 11/4/22; Nurses Training College, *Commemorative Brochure: Golden Jubilee Celebrations of the Nurses Training College, Korle Bu, Accra, Ghana 1945-1995*(1955); and Mrs. Blavo, September 1, 2005, September 9, 2005, and phone conversation, November 2, 2005.
[105] Ibid.
[106] *1945 Report of the Department*, 5, 15.

"experiment" that was "extremely interesting."[107] Initially, a lot was try and error. The laek of planning was fixed as problems arose. In the same year as the college opened, it was proposed to move the facilities from Kumasi to Accra. This should take advantage of the more extensive facilities of the Gold Coast Hospital in Accra, unavailable at Kumasi hospitals for some time.[108] After some delay, the college and hostel in Accra indeed opened in 1948.[109] Additionally, it quickly became unrealistic solely to depend on Achimota Secondary School graduates for candidates. Achimota had few female students, and not all intended to become nurses.[110] As a temporary solution, competitive examinations were held to select qualified post-primary (Standard VII) students, who were enrolled in a pre-nursing program at Achimota for one year.[111] The college nursing course took four years and four months to complete, in addition to the year at Achimota if the candidate had not graduated from a secondary school.[112]

Despite these efforts, it took a while before the college reached its maximum capacity of hundred and seventy students. In 1945, the opening year of the college, only seven students enrolled. By 1946, the total number of students of all level had increased to forty, excluding another forty students who were in the post-primary program at Achimota. Numbers rapidly increased: there were ninety-seven students enrolled in 1948, and hundred and thirty by 1949.[113] In 1948, the first four graduates passed the final examination, and became the first African State

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[107] Ibid.
[108] Ibid.
[109] The Medical Department of the Gold Coast, *Report of the Medical Department for the year* 1948 (Accra: Government Printing Office, 1949), 1, NAG-A, ADM 5/1/125.
[110] Teaching seemed to be a quite popular among educated women. Some also went abroad to further their studies in various fields, such as law. Cynthia Blavo, September 9, 2005. Harrietta Owusu, September 10, 2005.
[111] *1945 Report of the Department*, 5.
[112] *1946 Repot of the Department*, 12.
[113] The Medical Department of the Gold Coast, *Report of the Medical Department for the year 1949* (Accra: Government Printing Office, 1950), 22, NAG-A, ADM 5/1/126.

Registered Nurses (SRNs).[114] Enrollment grew steadily; by the 1950s approximately thirty students completed their studies annually. These students instantly obtained leadership positions at hospitals; they occupied a higher rank than any nurses trained through the apprentice program.

The 1940s were indeed the decade that transformed the nursing occupation. Never before was the word "profession" so frequently used in the discourse about nursing. In 1946, the Legislative Council passed the Nurses Ordinance to come into effect in 1947. The ordinance established a "Nurses' Board" which had the "power to regulate training," "lay down standards," and to "take such measure as [were] necessary in the interests of the profession as a whole."[115] The Director of Medical Service chaired the Nurses' Board.[116] Its membership consisted of the Deputy Director of the Medical Services, two medical practitioners, a matron, a sister tutor, and three other nurses who held qualifications recognized by the General Nursing Council for England and Wales.[117] Now, nursing was fully recognized as a standardized profession that formed its own community, which needed centralized control. The objective of the Nurses Ordinance was to "ensure an adequate standard of professional proficiency among nurses without interfering with the interest of any nurse already lawfully carrying on practice."[118] As the Ordinance's full name indicated, one of the main objections was to "register" all nurses across the country. This was a strong move to re-define the source of legitimacy, skills, and knowledge a nurse possessed. Prior to the ordinance, individual nurses drew their legitimacy from local and even personal, reputation and trust. Now legitimacy was to stem from each nurse's relationship with the centralized Nurses' Board controlled by the state, symbolized in the

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[114] *1948 Report of the Department*, 5.
[115] *1946 Report of the Department*, 12.
[116] Government of Gold Coast, *An Ordinance to Provide for the Registration and Training of Nurses and to Regulate their Practice* (1945), 2, NAG-A, CSO 11/1/643.
[117] Ibid.
[118] *Ordinance* (1945), 10.

registration process.

There was a range of nurses who could register, for it was not the intent of the ordinance to loose any existing nurses in the face of staff shortages. The Legislative Council was well aware that not all, if not even most, of the practicing nurses were registered at the time. Hence, not only those who had any sort of qualification issued by the United Kingdom or Gold Coast, but also those who had "habitually practiced nursing over a period of immediately preceding the commencement of this Ordinance of not less than five years and who furnish[ed] to the satisfaction of the Board evidence of good character and competency in such practice and applied for registration within six months" could request for registration, as long as the necessary documents, photographs, proof of identity, and appropriate fee were submitted.[119] Quickly, however, the position of non-registered nurses diminished in status at the medical institutions. Upon the installation of the ordinance, any nurse who was not registered was to be strictly prohibited from working as a nurse. A fine of five pounds had to be paid for such an offense.[120]

The ordinance further specialized the nursing profession. It broadly defined that " 'nursing' [meant] both surgical and medical nursing and special branches of nursing . . . but [did] not include attendance on a woman for purpose concerned with child-birth," and prohibited anyone from practicing nursing outside "the meaning of this Ordinance."[121] Furthermore, the Nurses Register kept track of each nurse's specialty, and prohibited them from practicing another "type of nursing" than the one for "which he or she [had been] registered." [122]

The ordinance ensured that information about registration would be publicly available. If one's application was accepted, the Nurses' Board issued a certificate of registration with an

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[119] Ibid., 4.
[120] Ibid., 4, 5, 9.
[121] Ibid., 1, 2.
[122] Ibid., 9.

affixed photograph of the, now "registered," nurse.[123] Depending on his or her specialty, nurses were to wear the appropriate uniform and badges.[124] Moreover, "as soon as practicable after the first day of January of each year," the ordinance read, "a list of all persons registered" had to be "[published] annually in the *Gazette*."[125] Having been gazetted served as the "*prima facie* evidence" about a nurse's registration, and let do the creation of a country-wide employment opportunities for these nurses.[126]

The Nurses Ordinance became the ultimate source of legitimacy for nurses and the subsequent Nurses' Board established regulations to benefit the "profession as a whole."[127] The only higher authority above the Nurses' Board was the state. Any complaints to the board's decision had to be filed as an appeal "in accordance with rules made by the Chief Justice, to the Supreme Court."[128]

The ordinance further described rules and regulation. "Malpractice, incompetence, negligence, misconduct or habitual drunkenness, disobeying any regulation from time to time in force, or on conviction of a criminal offence, " as well as any other reason "the Board [thought] fit," could lead to the removal of one's name from the "Nurses Register."[129] When a nurse wished to start working, or move his or her residence, the board had to be notified.[130] How effectively these rules were applied, we do not know. The ordinance took into consideration different urban and rural contexts stating that the provisions of unlawful nursing should only be

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[123] Ibid., 5.
[124] Ibid., 8, 9.
[125] Ibid.
[126] Ibid.
[127] *1946 Reporot of the Medical Department*, 12.
[128] *Ordinance* (1945), 8.
[129] Ibid., 6, 7.
[130] Ibid., 9.

enforced in larger towns, such as Accra, Kumasi, Cape Coast, and Sekondi-Takoradi.[131] Theoretically, the ordinance was in effect by January 1st, 1947.[132] Yet the board's meetings were not even mentioned in the annual reports until 1951, and we do not know whether meetings took place in the proceeding years. Five meetings were held in 1951.[133]

The 1940s brought a rapid transformation of the nursing profession, although its roots can be traced back to the late 1920s. Major characteristics of this professionalizing trend included building the centralized nurses training college and passing an ordinance that defined and regulated the "profession as a whole" across the country.[134] This transformation was triggered by the urgent need for Africans to fill the leading nursing positions, due to the rapid increase in African patients.

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[131] The other "towns" included Akuse, Axim, Dunkwa, Keta, Kibi, Koforidual, Nsawam, Oda, Saltpond, Tarkwa, Winneba, Sunyani, and Tamale. *Ordinance* (1945), 10.
[132] *1947 Report of the Medical Department*, 1.
[133] The Medical Department of the Gold Coast, *Report of the Medical Department for the year 1951* (Accra: Government Printing Office, 1953), 19, NAG-A, ADM 5/1/128.
[134] Quotes from *1946 Report of the Medical Department*, 12.

IV. Independence

During the 1950s, the Gold Coast underwent dramatic political changes. The first general elections were held in 1951. The Convention People's Party (CPP) led by Kwame Nkrumah became the first African party to govern the country. Six years later, the country gained complete independence. The new nation, Ghana, was among the first former European colonies to achieve independence under an African leader, an important watershed in the history of the African continent. Health of the African population became one of the primary concerns of the new African government.

In 1951, when the British governor appointed Nkrumah as leader of government business, much of the administrative machinery transformed as well. This included the conversion of the medical department into the ministry of health.[135] Two Africans, Mr. K. A. Gbedemah and Dr. Eustace Akwei headed the new ministry.[136] Only few months after the new constitution was implemented, the government assigned a committee to enquire the health needs of the country.[137] Governor Arden-Clarke appointed this committee, which was chaired by Sir John Maude, a former secretary of the ministry of health in Britain. The committee also included Dr. Albert Lorenzen, a principal British medical officer, Dr. George Albert Clarke, who had served as the director of medical services in Sudan and other countries, and finally, Mr. K. G.

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[135] Initially, the medical department came under the supervision of the newly created ministry of health and labor. Later in 1953, the medical department merged with the ministry of health. *1951 Report of the Medical Department*, 1. The Ministry of Health of the Gold Coast, *Report of the Ministry of Health for the year 1953* (Accra: Government Printing Office, 1955), 1, NAG-A, ADM 5/1/130.

[136] Addae, *History of Western Medicine*, 69.

[137] *1951 Report of the Medical Department*, 1. The Medical Department of the Gold Coast, *Report of the Medical Department for the year 1952* (Accra: Government Printing Office, 1954), 1, NAG-A, ADM 5/1/129.

Konuah, a well known lay Ghanaian.[138] The commissioners began their work in February 1952, and completed a report by July. Their work included visiting health institutions located in different regions, altogether more than forty-five places.[139] The committee asked other non-specialists for input. At a conference in Accra, the commission requested the press to inform readers that the commission was willing to consider constructive suggestions. As a result, many letters were received, and in some cases, the writers were invited for discussions with the commission.[140] Addae called the commission's work as the "most exhaustive study on medical matters ever undertaken in the colony's history."[141]

In essence, the report was very similar to the approaches of the 1920s colonial government. The basic idea was to spread Western medicine across the country in whatever forms possible. To achieve this, the report suggested strengthening the so-called Medical Field Units (MFU) and increasing rural health centers. These measures required to increase subordinate medical staff, because it was auxiliary people, such as nurses, who run both the MFU and health centers.[142] The report also proposed to put a halt on building new hospitals because of the shortage in subordinate medical staff and financial restraints. Rather, the committee recommended improving existing hospitals. Subsequently, the ministry focused on strengthening subordinate staff, recruiting young women into the nursing profession.

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[138] *1951 Report of the Medical Department*, 1. Addae, *History of Western Medicine*, 70.
[139] These included Bwaku and Nandom in the north, Takoradi in the west and Keta in the east. Addae, *History of Western Medicine*, 70.
[140] Ibid.
[141] Ibid.
[142] Various mass disease eradication campaigns had merged into one entity called the MFU in the late 1940s. MFU was a mobile unit designed to carry out campaign-like healthcare delivery primarily in rural areas. Health centers provided basic medical care, and referred patients who needed more complex treatment to the closest hospital. Both MFU and health centers were directed by doctors, but carried out by subordinate staff such as nurses.

Still, government health expenditure significantly decreased during the early 1950s, mainly because no additional hospitals were built. This did not mean, however, that healthcare was not a major concern for the government. Annual reports became more detailed and doubled in length compared to those produced by the former British colonial medical department. Interestingly, while the government decided not to build any new hospitals, other institutions such as mission societies, mining companies, and private practitioners, did exactly the opposite. The government encouraged these organizations by providing financial support. While only two new government hospitals were built during the 1950s, four quasi government hospitals, twenty-four mission hospitals, and ten mine and other private hospitals were constructed.[143] This challenges Vaughan's assessment that most Africans encountered Western medicine as a part of the state.[144] In Ghana, many Africans also met Western medicine through non-state organizations, such as missionary and mine hospitals. Although the recipient of subsidies and influenced by the by state policies, these entities took different approach concerning healthcare. Missionary hospitals were equally, if not more, concerned about healing "souls" in addition to physical illnesses. Hence, missionary hospitals actively introduced innovations unrelated to health; Agogo Hospital founded by the Basal Mission not only have a choir but also a brass band.[145] On the contrary, mine and other commercial hospitals were solely concerned with the subsistence of their workforce and had little interests in social engineering.

The self-rule government and the 1952 report enforced "Africanization," as well as an emphasis on preventive methods over curative ones. Africanization meant replacing European staff with Africans. This was carried out in all government posts during the 1950s and early

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[143] Addae, *History of Western Medicine*, 74-75.
[144] Vaughan, "Health and Hegemony," 200.
[145] "Presbyterian Church of Ghana: Opening and Dedication of the Agogo Eben-Ezer Presbyterian Church" (October, 1981).

1960s. To achieve this, many Africans were sent abroad with financial support from the government for further education. The ministry of health enjoyed the most prioritized position when it came to awarding government scholarships to study abroad.[146] Not only doctors, but also nurses traveled to Britain annually.[147] Since foreign "specialists" were still invited to shape actual policies and structures of establishments, the process of Africanization rarely challenged the colonial structures, even after the complete independence of 1957.

One of the distinguishing characteristics of the 1952 report was its suggestion to shift from overly curative medical strategies to more preventive ones. Along with new educational schemes, there were some conscious efforts to focus on preventive means. For example, the ministry was well aware that the Volta River Project would increase the incidence of trypanosomiasis as well as other health risks. The ministry considered these "anticipated" and "most serious," and affirmed that "means to combat it [were] planned."[148] Some public health experts associated the increased risks of trypanosomiasis with building larger roads and suggested further research.[149] However, these modest attempts to shape developmental plans around public health issues were soon buried under the increasing enthusiasm for more

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[146] In 1958, the ministry was awarded with most scholarships, amounting to 40 out of the 131 that were approved. In 1959, the ministry received 56 out of 172, and 20 out of 31 approved extensions. The Ghana Public Service Commission, *Annual report of the Public Service Commission for the year 1958* and *1959* (Accra: Government Printing Office, 1959 and 1960), 9 and 11, NAG-A, ADM 5/1/135 and 136, respectively.

[147] About a couple of SRNs were sent to Britain annually.

[148] *1954 Report of the Ministry of Health*, 47. Trypanosomiasis is an infectious disease, including African sleeping sickness, caused by microorganism trypanosomes. Environmental alteration is known to increase incidents of the disease. Schistosomiasis, too, is a parasitic disease associated with alteration of the environment. Indeed, both incidents of trypanosomiasis and schistosomiasis increased upon the completion of the Volta dam in 1965. This trend persists today.

[149] Ibid., 48.

qualitative and ambiguous approaches, such as "educating" the African public. By the 1960s, preventive medicine had become a synonym for education.

Indeed, Ghana's independent government incorporated the African public education on Western understandings of medicine and sanitation into the duties of the healthcare machinery. Educational tasks were added to the duties of rural health centers along with the curative treatments. Subjects were further ramified; for example, nutrition was soon added to sanitation and birthing.[150] Interestingly, these educational schemes on preventive methods often targeted women. Once these educational schemes were in place—although it is doubtful whether these programs operated as smoothly as anticipated—healthcare officials started to blame unsanitary conditions and other "unhealthy" practices on faulty Africans, describing them as "ignorant" and "uncooperative."[151]

When the country gained complete independence, concern over healthcare intensified even more. In 1961, the government launched another survey under the leadership of Dr. Brachott, an Israeli, to determine Ghana's health needs. Brachott contributed the health aspects to the ten-year developmental program, including a countrywide hospital plan that took rural health service into consideration, and training program for medical and paramedical staff.[152] This plan reflected the patriarchic role of the government. For instance, it directed to keep a "hawk's eye on environmental sanitation, child and maternal welfare, food and nutrition."[153] Nkrumah's government also relied on the construction of new medical facilities to project positive images of its development efforts. Community members were invited to visit these facilities and witness

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[150] *1951 Report of the Medical Department*, 10-11.
[151] Ibid. See also newspaper reports in the *Daily Graphic*, such as " Help Clean Kumasi," October 20, 1960, 7, and "Cleanliness—It must be the Concern of Whole Nation," October 28, 1960, 10-11.
[152] Addae, *History of Western Medicine*, 76, 77.
[153] Ibid.

the elaborate opening ceremonies, of which a large public later saw photographs in newspapers.[154] Nkrumah's government emphasized its commitment to the health needs of Ghana and asked Ghanaians to "cooperate" with its mission.[155]

The envisioned form of African health also had nationalistic implications closely tied to ideas of economic production. The following article printed in *Daily Graphic* illustrates this point:

> The prosperity of a country depends to a great extent on the health of its citizenry. Money alone cannot produce a box of matches at Akim Oda. Men and women must work to produce the matches . . . . [Therefore, the] level of productivity of a nation is in spite of the degree automation directly determined by the manpower available . . . [M]anpower means the available healthy workers who really earn their pay-packets and whose efforts help achieve the maximum possible level of production.[156]

To be healthy and productive was now the duty of a patriotic citizen. Implied in such reporting was the message that every Ghanaian counted to make a truly successful nation. The medical department showed a similar concern over the high incidence of abortion, considered it "unsatisfactorily high, bearing in mind that each abortion represents an infant lost to the country as well as to the family."[157]

In 1961, the ministry invited Marjorie Houghton, former member of the General Nursing Council of England and Wales, to evaluate Ghana's nurses training programs. This revealed that the scheme, as well as examination procedure used in Ghana, had been barely updated from the GNC schemes of the 1920s. Two years later, with further cooperation from World Health Organization (WHO) and United Nations Children's Fund (UNICEF), the first university

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[154] "New Hospital opened at Wa," *Daily Graphic*, September 14, 1955. See also photograph of the minister of health on his inspection tour, October 20, 1960, 1, and the article, "Nkoranza gets health center," October 21, 1960.
[155] "New Hospital opened at Wa," *Daily Graphic*, September 14, 1955.
[156] "Lets Make Ghana Land of Able Man," *Daily Graphic*, 7, October 26, 1960.
[157] *1953 Report of the Ministry of Health*, 61.

program for nurses in Africa was established at the University of Ghana.[158] External influences remained to be the primary force in planning and establishing new institutions.

To expand medical services was one of the major concerns of the new African government, although their basic approach did not differ greatly from the British colonial government. Moreover, even though the ministry instituted a vigorous program of Africanization of the medical staff, this did little to change the policy making processes of the healthcare system. Foreign specialists continued recommending means of healthcare delivery specific to West Africa, such as the MFU and rural health centers. Ghana's new government kept inviting "experienced" foreigners to instruct on developmental plans. In the case of nurses' training schemes, once such plans were materialized, they soon became outdated in the eyes of foreign specialists. Therefore, in terms of institutional structures, colonial medicine remained quite "colonial," even after independence.

[158] Mary Opare and Judy E. Mill. "Nursing Education in Ghana," 939-943.

V. The Ghanaian Nurses: from Colonial Imagination to Ghanaian Culture

The professionalizing trend in nursing responded to local needs. These were, however, also awkward foreign answers designed by British colonial officers who only understood nursing and the local culture in their own terms. This was especially true in the case of the nurses training college. For the Gold Coast Medical Department, the opening of the college was an experiment guided by the "experienced" specialists from England, who knew little, and probably cared little, about local cultures.[159] Here I focus on how these imported changes were processed and what they came to be, rather why the colonial government introduced these changes.

To Ghanaians, the nurses training college and what it represented appeared as a direct import from Britain: new and foreign. Much was strange about the college, not just enrolling young daughters but also seeing them learn to nurse strangers. When visiting Mrs. Cynthia Blavo, one of the first SRNs in Ghana, at her comfortable house in McCarthy Hills, in the outskirts of Accra, she recalled that it was the "British nurses" that "came down and . . . [started the] SRN training."[160] The nurses training scheme seemed odd even to her and her parents, who had received more European education than most Africans. To her parents, who decided that their daughter should enter the college, foreignness signified a positive change. According to the daughter, they thought "if people would come all the way from Britain and such for something," it had to be "a good thing to enter."[161] Mrs. Blavo and Mrs. Harrietta Owusu, another pioneer of SRN training, saw in foreignness the potential of upward social mobility and opportunities eventually to "travel."[162] This was not just a wishful thinking. After completing their SRN

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[159] *1945 Report of the Department*, 5.
[160] Cynthia Blavo, McCarthy Hills, September 9, 2005.
[161] Ibid.
[162] Cynthia Blavo, McCarthy Hills, September 9, 2005. Harrietta Owusu, McCarthy Hills, September 10, 2005.

training at the college, both Mrs. Blavo and Mrs. Owusu went to Britain to continue their education.[163]

Yet by late the 1940s, the majority of nurses were still men. Male nurses experienced little friction with local values, because their patients were often men as well. At that time, the colonial discourse on professional nurses considered the possibility of both genders. For example, the 1945 Nurses' Ordinance always used for a nurse male *and* female pronouns. There was, however, a steady and powerful trend to feminize the profession. Most important, the new training college only accepted female students. While authorities expressed much concern about overcoming local cultural barriers and enrolling more "girls," they did not discuss about further training of male nurses. There was a shared understanding among colonial officers and African leaders that nurses in a "modern setting" had to be women.[164] In the after-war period, even the apprenticeship training system accepted primarily, if not only, women as candidates.[165] The European mistresses and, on occasions, visiting lecturers taught the college's "comprehensive" curriculum which included gendered manners, such as how to walk like a lady.[166] The ideals of the nursing profession steadily merged with imported ideas of a sophisticated and professional femininity.

Catherine Burns's study, which argues that it was both the "local black cultures" and colonial ideas that maintained the oppressed position of male nurses in South Africa, is more

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[163] Ibid.

[164] Addae writes: "so long as male nurses continued to dominate the nursing profession among the Africans, there was little hope that African nurses of high caliber might ever replace the highly professional European nurses." Addae, *History of Western Medicine*, 166. Twumasi, questioning the dismissal of male nurses, advocated to train them for administrative positions. He could not envision men remaining in the nursing field. Twumasi, *Medical Sociology*, 80.

[165] For instance, in 1949, the Kumasi Hospital accepted 334 women to be trained as nurses and midwives. There was no word about training any men. *1949 Report of the Medical Department*, 21.

[166] Mrs. Blavo, McCarthy Hills, September 10th.

applicable here, despite a gap in time. Although I find some of Burns's generalization about African ideas of masculinity problematic, it is interesting to note that both in South Africa and Ghana African elites effortlessly adapted such gendered ideals. Although a South African patriarch from Xhosa family insisted that he did not know of any trained male nurses, Burns notes that, from his circumstances, it is "extremely difficult to believe" that he was actually unaware of African male nurses.[167] In the case of Ghana, too, there is a sense that male nurses began to be ignored even while they were still the majority.

The new SRNs challenged the older gender division of men only nursing men and women only nursing women. The SRN training scheme sought to produce the all-mighty nurse who had at least minimal exposure to all fields of nursing. Mrs. Blavo recalled her first encounters of nursing men with laughter. "In those days," she noted, "they [the college] wanted you to have a comprehensive experience in nursing . . . experience in nursing men, nursing women, an elderly person, nursing children, and so and so. And this is why, [laughter] I came to work in the male wards." [168]

The gender of the new SRNs was not the only innovation with the existing dynamics of the hospitals. Almost all women working as nurses were older women who had already become mothers.[169] Most SRNs, however, had barely reached the age of twenty. Every SRN instantly assumed a commanding position over the older nurses. Both Mrs. Blavo and Mrs. Owusu admitted, with considerable understatement that this situation created an "awkward" atmosphere and "some friction."[170]

In fact, the QRNs' discontent resulted in multiple strikes, some of them quite large,

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[167] Burns, *A Man is a Clumsy Thing*, 715.
[168] Mrs. Blavo, September 1, 2005.
[169] Mrs. Blavo, September 1, 2005, and September 9, 2005. Mrs. Owusu, September 10, 2005.
[170] Ibid.

forcing hospitals to compromise their services. Many nurses who participated in the strikes were fired. Mrs. Blavo remembered one strike at Effia Nkwanta in 1952. Mrs. Blavo had just graduated and was in charge of the maternity ward of the hospital. There was a sit-down strike, "instigated by the Trade Union," because the QRNs were "agitating over the business of SRNs coming and taking over the hospital."[171] According to Mrs. Blavo, such strikes were common as SRNs were newcomers to different regions of the country. Mrs. Owusu also vaguely recalled a few similar incidences.[172] Not all QRNs participated in strikes, although there was a sense of insecurity among many of them. Mrs. Blavo's older sister who was a QRN, thought that " it was over" when the number of SRNs increased.[173] Quitting nursing she became a health visitor.[174] Many male nurses who had previously worked at government hospitals sought employment at private hospitals, further causing shortages of the nursing staff in government hospitals. Men left because their standing significantly worsened as female nurses became the expected norm of government hospitals.[175]

Although these strikes are vivid in the memories of former nurses, they are never mentioned in departmental reports. Instead, according to the official records, young nurses were constantly taking maternity leave, or altogether leaving the profession due to marriage, causing the great shortage of nurses.[176] Professor Mary Opare, the current chair of the Nursing Department at the University of Ghana, sees in the "militarization" of the nursing profession, which prohibited female nurses from getting married, the cause for the acute nurse' shortage in

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[171] Mrs. Blavo, September 9, 2005.
[172] Mrs. Owusu, September 10, 2005.
[173] Mrs. Blavo, September 9, 2005.
[174] Ibid.
[175] *1954 Report of the Ministry of Health*, 89.
[176] *1953 Report of the Ministry of Health*, 58. *1954 Report of the Ministry of Health*, 74.

the 1950s.[177] While Mrs. Blavo did not remember this rule, Mrs. Owusu remembered "something like that" for the QRNs.[178] In any case many nurses did take maternity leave. In 1954, out of the hundred and forty-eight female nurses and midwives, ninety-eight were on maternity leave, and an additional seventy-three had applied to qualify for a it.[179] It was not uncommon that, in a given hospital, half of the nurses were on maternity leave. Strangely, nobody proposed to hire more men or older women to compensate for such losses. Employing young women as nurses continued; "wastage" eventually declined.[180]

Since SRN candidates came from the upper echelon of the social stratum, they were shocked about having to perform the menial aspects of the nursing. In those days, nursing work included tasks, such as cleaning linens and toilets, cleaning and packing medical instruments, and disinfecting the operating theater. Mrs. Blavo stated that one of the most memorable events of her life was the first practical training at Kumasi Hospital. Students were assigned to different wards, and she was to assist the maternity ward. Unfortunately, three patients died in the maternity ward that day. Mrs. Blavo and three other nursing students were asked to wash the linen soaked with blood and bodily fluids that resulted from the unsuccessful deliveries. They had no choice but to follow the orders. When they finished, all four students ran into the toilets to cry. Returning to the college, she discovered that her colleagues' experiences corresponded with hers. The young trainees experienced a sense of humiliation, many resigned.[181]

Replacing SRNs with older nurses did not always result in more efficiency, because some of the well-educated were not equally well-trained. At times, the need-based apprenticeship

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[177] Professor Mary Opare, interviewed by Evelyn Naomi Abe, Legon, August 29, 2005.
[178] Mrs. Blavo, September 9, 2005. Mrs. Owusu, September 10, 2005.
[179] *1954 Report of the Ministry of Health*, 148.
[180] Addae, *History of Western Medicine*, 166.
[181] Mrs. Blavo, November 2, 2005.

training produced specialized and extremely experienced nurses who could perform quite complicated medical procedures. Mrs. Blavo explained that doctors, "back in the days," were "lucky" to work with experienced QRNs.[182] Some QRNs had been "working in the operating theater for many years, [that] they could even operate." Doctors could rely on such seasoned nurses "to carry out certain treatments."[183] The SRN training, on the contrary, aimed to produce the well-rounded nurse, who had to constantly move from ward to ward, and from hospital to hospital, without the opportunity to specialize in any field of medicine.

Another trend in the post-war period was relevant to the history of the nursing profession; Africans became consumers. Nancy Hunt suggests that Africans consumed not only commodities but also "images, stories, newspapers, cartoons, movies, and music."[184] Indeed, it was frequently such commercial and government representations that mediated the new nursing figures to Africans, and thereby normalized and popularized concepts associated with nurses. The state and foreign companies frequently contributed to such presentations. In 1953 the Gold Coast's ministry of health prepared a booklet and proposed a feature film called "Theresa," to illustrate the life of a modern female nurse.[185] Newspapers and other popular publications printed captivating articles and images of new hospitals and health centers, often featuring a female nurse (figure 1).[186] The *Ghanaian Nurse*, the official magazine of the registered nurses, usually refered to a nurse as a "she" and also published many images of female nurses (figure 2).[187]

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[182] Mrs. Blavo, September 9, 2005.
[183] Ibid.
[184] Hunt, "Gendered History," 5.
[185] *1953 Report of the Ministry of Health*, 3.
[186] "The 'Mother of New Brighton,'" *Drum* 4, no. 6 (September, 1955)."New Hospital opened at Wa," *Daily Graphic*, September 14, 1955; "Doctors hail new institute plan," *Daily Graphic*, October 14, 1960; and "Nkoranza gets health center," *Daily Graphic*, 11, October 21, 1960.
[187] *The Ghanaian Nurse*, ed. Ayodele Akiwumi (Korle-Bu, Ghana, 1969 and 1970).

Articles in this magazine were directed to women as well.[188] A booklet prepared by the nursing college in the 1950s, called "Who is Who in Nursing" introduced twenty six Ghanaian female nurses, while only one male nurse.[189] The physical structures that surrounded many nurses also helped present the new nursing profession in a legitimate manner. The new training college was "modern in design and stood in extensive grounds" near Korle Bu Hospital, Accra (figure 3).[190] Young women from secondary schools had the opportunity of touring the college and hostels, in order to see the "great" accommodations that awaited student nurses.[191] SRNs wore white uniforms, and were called "sisters" as the expatriate nurses, while QRNs wore blue uniforms.[192] The popularity of the SRN training increased in the course of the 1950s. Soon, there were more applicants than could be admitted.[193]

While it is appropriate to use the term "indigenization" for how African healing systems internalized aspects of Western medicine such as injections, I hesitate to call the process of normalizing the presence of female nurses as indigenization. While, it was Africans who actively chose what, when, and how to incorporate aspects of Western medicine into their local healing systems, these new nursing figures were rather imposed. Africans had little choice but to cope with such innovations. This did not mean that Africans were mere receptors of these ideas. Nor were all QRN strikes in vein. Some QRNs were given important administrative positions in the Registered Nurses Association that formed in 1960 . QRNs eventually succeeded in abolishing the different uniforms; later both SRNs and QRNs would wear green uniforms, although with a

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[188] Ibid.
[189] "Who is Who in Nursing: A 10th Anniversary Publication of the West African College of Nursing" (n.d.). Personal paper of Mrs. Cynthia Blavo.
[190] Addae, *History of Western Medicine*, 166.
[191] "Commemorative Brochure: Golden Jubilee Celebrations of the nurses Training College, Korle Bu, Accra, Ghana 1945-1995" (n.d.). Personal papers of Mrs. Cynthia Blavo.
[192] Mrs. Blavo, September 1, 2005.
[193] *1950 Report of the Medical Department*, 10.

different cap.[194] Ambitious QRNs had opportunities to take a two year concentrated course to qualify as SRNs.[195] Moreover, some older QRNs who had "served with distinction" were given recognition, and were promoted.[196] Thus, the resulting structure surrounding nurses was a negotiated one. Nurses contested, but could not eliminate, these introduced changes.

How effective were Ghanaian nurses as mediators? How did nurses themselves understand Western medicine and traditional medicine, and European ways and African ways? Did they, in fact, effectively "inculcate" the "benefits of modern medicine" to Africans? It seems that there was a wide range in how individual nurses understood such ideas. Furthermore, the increase in popularity of biomedicine among Africans was not always the result of "education." The reality was always more complex.

Each nurse understood Western medicine and traditional medicine differently, although, obviously, they all had general confidence in Western medicine. Mrs. Owusu had few good things to say about local healing practices because," [her] father was a minister." On the contrary, Mr. Baa, a former military male nurse, thought that local herbal remedies were as good as, if not superior, to biomedicine. Today Mr. Baa owns a tidy store of herbal medicine in the Mamobi neighborhood of Accra. For him, both biomedicine and local medicine have their own merits and shortcomings. Namely, Western medicine does not always completely cure illnesses such as typhoid:

> when [people] get typhoid, [they] go to the hospital, get treated, but later on, it (typhoid) will develop again. . . . but when you give them (the patients) the herbal product . . . it (the herbs) will cure it.[197]

According to Mr. Baa, because no "machinery" was used to produce herbal medicine, the quality

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[194] Mrs. Blavo, September 1, 2005.
[195] Ibid.
[196] Ibid.
[197] Mr. Kwame Baa, September 15, 2005.

of products could not always be trusted.[198] Although herbal medicine was never prescribed in a hospital setting, Mr. Baa some times recommended certain remedies to his patients. Such transactions between nurses and patients must have been largely invisible from colonial officers or even Ghanaian doctors who dismissed local healing methods. In their eyes, Mr. Baa would have represented a terrible middle figure.

It is harder to determine how Mrs. Blavo felt about local healing remedies, because her opinion changed according to the story she was telling. In general, she thought many herbal remedies had something to offer, although like Mr. Baa, she suggested that not all could be trusted. When it came to the so-called magico-religious components of the local healing system, her opinion fluctuated.[199] She spoke of shrines and priest-healers with bitterness when she recalled how patients seek treatments at hospitals after "things didn't turn out well" at the shrines.[200] Hospitals could not always cure illnesses, but, in her words, at least patients received "more than what they were receiving" at the shrines.[201] Occassionally, however, she showed deep respect and awe for the work of healers and the invisible forces of a supernatural world. She described how it was not until a patient utilized a charm medicine given by a healer that she was able to give birth to a child that lived. Mrs. Blavo regretted following the rigid hospital rules and not allowing the father of an expecting mother to stay in the labor ward. "Thinking back," Mrs. Blavo said, "we should've allowed him to stay. . . . Because he probably had a reason, maybe witchcraft, maybe something . . . [because when] he left, the woman and the baby died," with no apparent reason.[202]

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[198] Ibid.
[199] I borrow this term from Twumasi, *Medical Sociology*, 10-11.
[200] Mrs. Blavo, September 9, 2005.
[201] Ibid.
[202] Ibid.

How well did these nurses, then, act as mediators of Western medicine? Among the middle to upper class Africans, education, state, newspapers, and foreign companies played a role in popularizing ideas of Western medicine and hospitals in general. Workers of government services and foreign industries, "as part of the job contract," were "expected by [their] employers to seek medical aid from the services of scientific medical institutions."[203] After mid 1950s, newspapers published many educational articles about health.[204] Further, they were packed with advertisements for health products that promoted a new understanding (figure 4).[205]

Generally, the speedy increase of confidence in biomedicine among Africans, who did not belong to the intelligentsia, nor had few ties with government or foreign companies, was not so much the result of educational efforts, but rather the outcome of their personal experience. Seeing or experiencing the effectiveness of biomedicine, rather than merely learning about it, was key to Africans' willingness to participate in treatments. For example, yaws eradication campaigns gained Africans' "confidence and appreciation" fairly quickly because their effectiveness was easy to observe, and residents of villages under the campaign had little choice but to undergo the required treatment.[206] This led some Medical Officers to think that "casual

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[203] Twumasi, *Medical Sociology*, 45.

[204] "Eat More Local Food, Says Whitby," *Daily Graphic*, 4, October 25, 1960; "Start Weaning When Child is 3 Months," *Daily Graphic*, 9, October 26, 1960; "Don't Forget . . . 'Prevention is Better Than Cure,'" *Daily Graphic*, October 28, 1960; and "Good Food Makes All the Difference," *Daily Graphic*, 12, October 28, 1960.

[205] "Stop That Cough! (Advertisement by Zubes)," *Daily Graphic*, 11, September 14 1955; "Pains in the Back (an advertisement of De Witt's Pills)," *Daily Graphic*, October 18, 1955; "The Gift of Health (Advertisement by Ovaltine)," *Daily Graphic*, 10, October 10, 1960; "S. S. Pills (Advertisement by S. S. Pills)," *Daily Graphic*, 6, October 14, 1960; and "Babies grow strong on Heinz Baby Foods (Advertisement by Heinz Baby Foods)," *Daily Graphic*, 12, October 28th, 1960.

[206] Yaws is an infectious disease common in the tropics and is caused by a microorganism (*Treponema pertenue*). The infection is characterized by raspberry-like sores on hands, feet, and face, and when severe, it may cause destruction of bones and joints. Symptoms of yaws are highly visible and can be cured fairly easily. This was not true for all illnesses, even after the

voluntary treatment" was not enough to combat endemic disease, because it was not until Africans were required to undergo treatment that they were convinced of the effectiveness of Western medicine.[207] Addae makes a similar argument in explaining what led mothers to utilize welfare centers, although with a different tone. He argues that because African mothers were largely "illiterate," they needed "something tangible" to understand the "superiority" of Western medicine.[208] "Tangible" things were easily observable things that happened within the personal domain, such as seeing their "own or the neighbour's child cured of high fever."[209]

At any rate, it was not so much the logic of modern science but the observation that it "worked" that convinced Africans. As the potency of the Western medicine became recognized, many Africans looked for biomedical remedies while still consulting local healers. In this sense, visiting a Western medical practitioner appeared to be a "mere addition" to the pre-existing multiple healing systems. At least based on a close reading of the colonial medical records, even the forceful operation of disease eradication campaigns have had little impact on the African understanding of health and medicine.

This is not to say that African middle figures were insignificant in popularizing Western medicine. My argument is, rather, that the definition of "middle figures" needs to be extended. While colonial officers imagined a single convenient occupation to "educate" Africans on the understandings of health, for Africans, there were myriad middle figures who connected Western medicine to their personal lives. Middle figures created by the colonial government, such as nurses and medical assistants, made possible the operation of medicine in local contexts, while,

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establishment of the School of Tropical Medicine in Liverpool. Western medicine brought visible positive effects for some illnesses, but not for others. *1944 Report*, 2. Quotes from *1945 Report of the Medical Department*, 4.

[207] Quotes from *1944 Report of the Medical Department*, 2.

[208] Addae, *History of Western Medicine*, 150, 151.

[209] Ibid..

for many Africans at the time, it took additional middle figure(s) to be convinced of the benefits of biomedicine. The cascade of information transfer needed ultimately to have a personal impact on Africans in order to to become convinced of the "benefits" of Western medicine.

There was still a great deal of diversity in Africans' enthusiasm towards Western medicine, which has persisted until today. In the mid twentieth century, hospitals or any form of Western medicine had yet to be introduced in many rural areas. Moreover, even those who lived in urban areas with well-established facilities did not always utilize them. A medical officer of "an important municipal centre" wrote:

> It is surprising and not a little disappointing to find that, in this centre of so much education and enlightenment, there still exists a desire among Africans to take their sickness to the local fetish or herbalist while right in his own town there exists a fine modern hospital. It is notably so with maternity cases who receive the most extraordinarily cruel and primitive treatment before being brought to hospital *in extremis*. Such cases are not confined to bush villages, but many come from the town itself.[210]

The medical department noted that, "similar reports were received from many centers."[211] Still the general increase in demand for Western medicine continued.

Once a patient was admitted into a hospital, it was the nurses who mediated this foreign environment for the patient. In this context, nurses were literally the educators and promoters of a new culture. For many patients, visiting a Western medical institution, let alone being admitted as an inpatient, was a profoundly new experience. Nurses had to teach patients from how to use a toilet to why a diabetic patient had to be on a strict diet. Dispersing visitors—some of whom must had been the kinfolk designated "nurses" of the patients—at the scheduled time was also the professional nurses' task. It is not difficult to imagine that friction arose between the patients, their family members, and nurses.

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[210] *1945 Report of the Medical Department*, 13.
[211] Ibid.

Moreover, medical resources were never completely sufficient, and not all operations at hospitals in the 1950s and 1960s were very effective. The overly bureaucratic procedures frequently kept nurses from actually nursing. For example, at the shift change, nurses were required to undergo a procedure called "handing," when all equipments and instruments used in a ward had to be inspected. If anything was missing, corresponding costs were deducted from the head nurse's pay.[212] Additionally, head nurses were required to leave a detailed record of every patient before finishing a shift. This often kept them from actually "nursing" patients.[213]

By the mid to late 1950s, the new young female nurse figure permeated Ghanaian popular culture. Some elite Africans now expected intimate caring from the stranger nurses. Such qualities of nurses became inextricably meshed into the ideas of womanliness. Interestingly, nursing ideals were described as innate qualities of women who took up the nursing profession. As a result, a curious form of comparison emerged. Ghanaian nurses were depicted as rude and power-hungry, while European nurses were thought to naturally carry qualities such as compassion. The following *Daily Graphic* article printed in 1955 deserves quotation to illustrate this comparison.

> In other countries, I understand girls who take up nursing as a profession, have every feeling and sympathy of the sufferer. They feel that the unfortunate being such as finds his way into hospital, needs comforting apart form specialized medical care. That he needs friendly understanding from those who tend him, cannot be over-emphasized. This I think, is equality without which one cannot fit in well into the nursing profession. Unfortunately, some of our nurses seem to lack this qualification. To them, it seems, nursing is just another job . . . One cannot say whether this has to do with their training but the impression given by some nurses is alarming. The significance of being a professional nurse, as their attitude shows clearly, is to have power over the sick, show off when people need their help and to take advantage of the disadvantage of the sufferer.[214]

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[212] Mrs. Blavo, September 1, 2005.
[213] Ibid.
[214] "Florence Nightingale would turn in her grave," *Daily Graphic*, 14, October 14, 1955.

Clearly, the author of this article expected comforting "friendly understanding" from professional female nurses. Interestingly, the patient in this article was depicted as a man. "Other countries" referred to the Western world, as we can infer from the title of this article: "Florence Nightingale would turn in her grave." Nightingale was a British nurse known for her dedicated work during the Crimean War in the 1850s. Nightingale is remembered for her compassionate and courageous qualities, affectionately called "the Lady with the Lamp." Such European nurses were viewed as natural carriers of caring and compassionate qualities, which in this article was intertwined with general feminine ideals.

The stereotype that African nurses were rude, although not always depicted in pair with their European counterparts, was not uncommon. The *Daily Graphic* even printed a reader's letter commenting on the Florence Nightingale article. The reader affirmed that the presentation of such bad attitudes of nurses "could not be truer." [215] Even today, Ghanaian nurses are often characterized as rude, while such a negative judgment does not exist for Ghanaian doctors.

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[215] "Nurses must be sympathetic," *Daily Graphic*, 3, October 20, 1955.

Conclusion

This study presents a history of African nurses in Ghana. The emergence of the colonial imagination to train African nurses as convenient mediators of Western medicine was traced back to the 1920s. Actual professionalization of nurses took place in the 1940s and continued into the 1950s and 1960s. This trend introduced gender, age, and social status as selection criteria for nursing students; young educated women were strongly preferred. None of the three criteria corresponded with the practice in already established hospitals, nor did they completely fit with dominant ideals of local culture. There was significant social discomfort with several innovations: women nursing men, younger nurses taking care of older patients, and younger nurses instructing their older colleagues. The menial tasks of nursing frequently disappointed the new professional graduates, often the daughters from elite families. Nonetheless, the continued production of pictures and practices of discourses normalized the notion of the young African women as a nurse. Images of nurses became inextricably intertwined with ideas of modernity during the 1950s and 1960s, although replacing older nurses, male or female, with younger and better-trained women did not always result in more efficiency. On the contrary, many of these young women, after they obtained positions within hospitals, took maternity leave or left the profession altogether due to marriage and pregnancy. Additionally, many older nurses (QRNs) were not content with their subordinate position to the less experienced new nurses (SRNs), who as graduates of the nurses training college took over leadership roles. Many QRNs left, and some were also fired as a result of their protest. As the female nurse became the norm, opportunities for male nurses were increasingly limited in the government hospitals. Some male nurses resigned, while others moved to the more lucrative private practice. Hence, there was an acute shortage of both SRNs and QRNs during the 1950s in the government hospitals. The state and

the press played a crucial role in familiarizing the public with the image of the young female nurse. Male nurses gradually lost their space within the discourse on nurses, and their actual proportion also dramatically declined.

The colonial government imagined a convenient figure that was neither too African nor too European in order to educate the African population. The reality was never so simple. Not only was there a wide range in how different nurses understood biomedicine and "traditional" medicine, but there were also a large number of middle figures mediating Western medicine to Africans. The permeation of Western medicine into individual African lives was indeed a process; there were multiple transactions with countless middle figures. For Africans who did not belong to the intelligentsia, nor had few ties with the government or foreign companies, the information transfer had to have a personal impact on an individual to be convinced of the effectiveness of biomedicine. Even at this stage, it was not the scientific logics that ultimately convinced Africans, but rather their own observations that certain biomedical procedures worked. Thus, biomedicine was often a mere addition to local remedies; Africans explored treatment options in hospitals and dispensaries as those offered by a herbalist.

If the biomedical procedure was a mere addition to local healing procedures, did this also apply to Western medicine as a healthcare system? Nurses embodied, along with the Western medical system's tendency to isolate and objectify ideas of health, a crucial difference between the operation of Western medical system and local healing practices in an African context. Receiving medicine and other instructions from a diagnostician who was a stranger was not an uncommon practice in African culture. Once the potency of biomedicine was realized, many Africans did not hesitate to seek Western medical care. Yet, most Africans continued to avoid being admitted to a hospital as inpatients. In fact, many loathed and feared hospitals, and did

anything to avoid them. The inpatient experience, where the patient lost control over the most basic everyday habits due to reasons unclear to the patient, and even worse, when physically reduced due to illness, represented one of the most "colonial" moments of colonial medicine. It was nurses, rather than doctors, who shaped and mediated such colonial environments for the patients. Moreover, medical resources in Ghana were never completely adequate, and the number of nurses was never sufficient. This created further discontent among patients, who felt that "nurses never had time for them."[216] Hence, not only did professional nurses in Ghana reflect the changing social divisions along gender, age, and class as explained by Marks, but Ghanaian nurses also created a new division between the nurses and the sick.[217] While the kinfolk nurse and the patient were equally immersed in the healing processes in local healing systems, in hospitals, nurses were strangers who controlled the process of curing. Whether such a "dividing" effect is also present in other colonial and post-colonial top-to-bottom innovations deserves further research.

This study mainly focuses on the practice of Western medicine within larger government hospitals. In actuality, however, this was the exception rather than the norm. Until well into the latter half of the twentieth century, biomedical procedures in Ghana happened in temporary camps as part of disease eradication campaigns. Furthermore, it was not only the government but also churches, mines, and private practitioners that provided Western healthcare. Although these entities were often subsidized and influenced by the state, they had significantly different approaches. The variety of institutions offered alternatives when the treatment of male nurses worsened in the government hospitals; they moved to other entities for employment. Moreover, the evolution of Western medicine was often linked to the operation of the military. Hence, for a

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[216] Evelyn Naomi Abe, "HIV/AIDS in Ghana."
[217] Marks, *Divided Sisterhood.*

more complete examination of how Western medicine in colonial Ghana, a close study of medical campaigns and their relationship with military operations would be required.

The changes embodied and practiced by nurses were irreversible. In the light of these transformations, which sometimes involved painful and dehumanizing experiences for African patients, I disagree with Kwame Anthony Appiah's assessment that colonialism was "an essentially shallow penetration."[218] Rather, it was an incomplete penetration. The profession did not always divide but also connect people. Mrs. Blavo recalled with fond memories her early years in nursing when she found herself in an awkward position. "All those who [were] working under me," she recollected, were "much older than me . . . they were my mothers."[219] This could create "some friction," as she noted with considerable understatement. Nonetheless, as a young graduate Mrs. Blavo learned from these older women, who "told [her] a lot of things about themselves . . . about their work, and their families, and their children, the problems they had in their marriages." This happened with patients as well. One late night, Mrs. Blavo came across a group of female patients sitting on the veranda. They were supposed to be in bed by that time. As the night nurse, she tried to assert her authority: "[I] kept on saying . . . 'go to bed, go to bed. You need to have some rest.'" But her words were far from commanding; she actually wanted to listen. The patients were talking about their husbands and problems they encountered in marriage. "So anytime I [had] to come and say, 'go to bed' as a senior nurse," Mrs. Blavo laughed and continued, "[I] said, 'you should go to bed,' [while I] stood there listening." The patients did not take her words seriously, because they knew that the young senior nurse

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[218] Kwame Anthony Appiah, *In My Father's House: Africa in Philosophy of Culture* (New York: Oxford University Press, 1992), 56, 8

[219] Mrs. Blavo, September 1, 2005.

desperately wanted to hear their stories. Smiling, Mrs. Blavo commented: " I learned everything about life doing nursing."[220]

[220] Ibid.

FIGURES

THE "MOTHER OF NEW BRIGHTON"

MASTERPIECE IN BRONZE

Sister Dora has earned this name for her 35 years of nursing before retiring

Figure 1.1. An image from 1955 issue of *Drum*
"The 'Mother' of New Brighton," *Drum*, 4, no. 6 (September 155), 5.

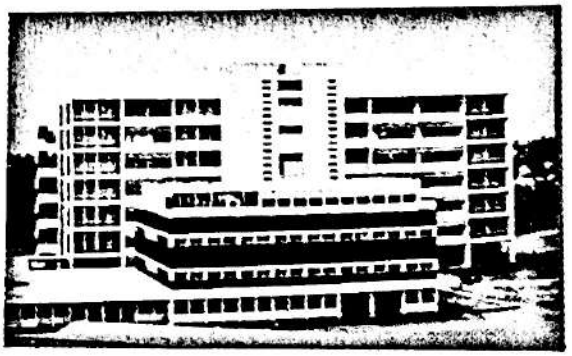
Figure 1.2. An image from "Korle Bu Hospital:1923-1973, Golden Jubilee Souvenir"

Figure 1.3. An image from "Commemorative Brochure: Golden Jubilee Celebrations of the Nurses Training College, Korle Bu, Accra, Ghana 1945-1955"

Figure 2. The 1970 cover of *The Ghanaian Nurse*

Figure 3.1. The modern appearance of the Korle Bu Hospital, from "Korle Bu Hospital: 1923-1973, Golden Jubilee Souvenir"

Figure 3.2. Another image of the hospital from "Korle Bu Hospital: 1923-1973, Golden Jubilee Souvenir"



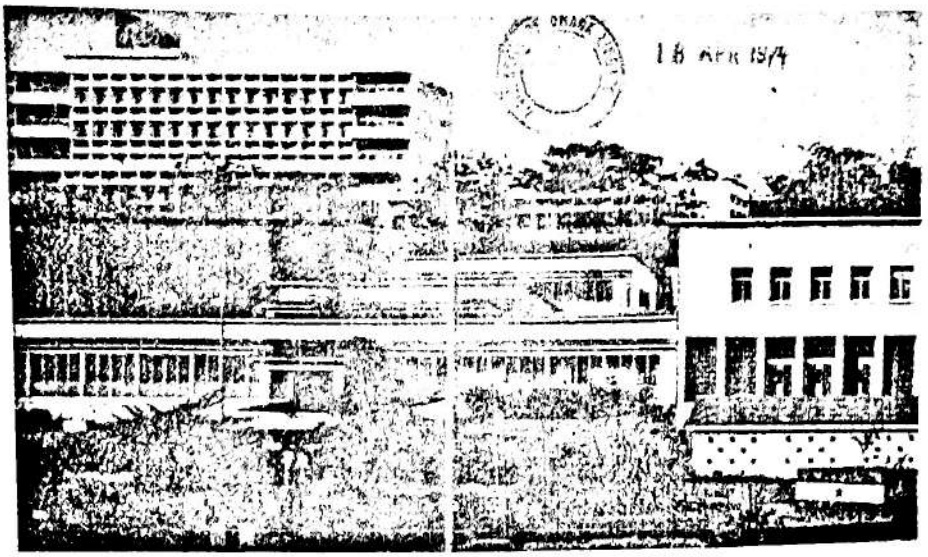


Figure 3.3. An image of Effia Nkwanta Hospital, from the 1969 issue of *The Ghanaian Nurse*

Figure 4. "Pains in the Back (an advertisement of De Witt's Pills)," *Daily Graphic*, October 18, 1955.

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