Reframing International Health and Development:

Medical Mission in Ghana, c.1919-1983

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ABSTRACT

In analysing medical mission in Ghana this thesis argues for a new historical framework for twentieth-century international health which is not determined by the Cold War, the postwar growth of the international community or by imperial powers working in their former colonies. Instead, this thesis shows how the emergence and growth of national and international health in the Gold Coast (Ghana from 1957) between 1919 and 1983 was formed substantially through the local and global interests, funding and denominational cultures of medical mission. Most significantly, it will show how, in the independent nation-state of Ghana, Catholic medical mission grew massively because of large postwar streams of West German and Dutch Catholic aid, combined with patient fees, government contributions and support from international organisations. Continuities with colonial medical mission structures and ideas, especially the creation of a formal medical mission voluntary sector in the 1950s, existed alongside these large-scale changes in the postcolonial period. The concept of international health will be nuanced by analysing these under-explored actors, layers of governance and professional rivalries. Furthermore, the category of 'development' in colonial and postcolonial governance in Ghana, and in European humanitarianism, will be shown to have been formed in conjunction with the expansion of medical mission. Depending on various and conflicting interests, the medical mission-development connection in Ghana was identified with evangelism and proselytism, spiritual support for colonial rule, Africanisation, technical solutions and scientific expertise for postcolonial modernisation, as well as a site for postwar European reconstruction. Often these narratives were detached from the complex denominational friction, lived experiences and heterogenous perspectives of medical missions themselves. In bringing together these historiographies of international health, development, colonial and postcolonial governance and medical mission, simplistic historical periodisations in these particular literatures will be challenged and nuanced.

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LIST OF ABBREVIATIONS

AIC	African Initiated Church
AME Zion	American Methodist Episcopal Zion
BELRA	British Empire Leprosy Relief Association
CCGC	Christian Council of the Gold Coast
CDC	Centers for Disease Control (USA)
CMC	Christian Medical Commission
CMS	Church Missionary Society
CDWA	Colonial Welfare and Development Act
CDU	Christian Democratic Union (West Germany)
CIDA	Canadian International Development Agency
CHAG	Christian Health Association of Ghana
CPP	Convention People's Party (Ghana)
CRS	Catholic Relief Services
DFl.	Dutch Florins
DM	Deutschmarks
EMMS	Edinburgh Medical Missionary Society
FBO	Faith-Based Organisation
FRG	Federal Republic of Germany (West Germany)
FIDES	Fonds d'Investissement et de Développement Economique et Social
ICRC	International Committee of the Red Cross
IPPF	International Planned Parenthood Federation
KVP	Catholic People's Party (Netherlands)
LSTM	Liverpool School of Tropical Medicine
MEMISA	Medische Missie Actie (Netherlands)
MFU	Medical Field Units (Gold Coast/Ghana)
MMM	Memisa Medicus Mundi
MMS	Medical Mission Sisters
NGO	Non-Governmental Organisation
NLM	National Liberation Movement (Ghana)
NPP	Northern People's Party (Ghana)
OS	Oversea Service
PCG	Presbyterian Church of Ghana
PHC	Primary Health Care
PNDC	Provisional National Defence Council (Ghana)
PRAAD	Public Records and Administration Department (Ghana)
SDA	Seventh Day Adventist
SOAS	School of Oriental and African Studies
UMCA	Universities' Mission to Central Africa
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UP	United Party (Ghana)
VSO	Voluntary Overseas Service
WAMS	West African Medical Service
WCC	World Council of Churches
WHO	World Health Organisation

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Author's Declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as References.

INTRODUCTION

> The medical missionary candidate must be a realist. Dreams of romantic experience must be put aside and a life of strenuous, exacting and often humdrum daily work be prepared for, in which failure, disappointment, weariness, heart-sickness and loneliness of spirit will all play their part.
>
> 'The Medical Missionary Vocation'
> Edinburgh Medical Missionary Society (EMMS), 1946-55.

Medical missions weathered the storms of decolonisation.[1] Medical mission, as the EMMS wrote in the aftermath of the Second World War, required the combination of a Christian spiritual life and a practicing medical one working in an alien context. They also warned that medical missionaries had to be realists adapting constantly in complicated, difficult and unstable situations. Medical mission certainly did not match, the EMMS emphasised, with any of its romantic narratives.[2] Whilst not a full depiction of the huge variety of medical mission, the EMMS did capture an important quality of twentieth-century medical mission: survival. Amidst the transformations of colonialism and decolonisation, the emergence of international health, and the shifts of local, national and global politics, many medical missionaries survived through struggle. Consistently adapting to new contexts, medical missions retained and transformed their roles in modern African healthcare. These transformations were marked not only by missions holding on to old colonial institutions but also by entirely new streams of funding and personnel.

In exploring how medical missions grew in Ghana across the twentieth-century, their continuities and their changes, the complexity of their organisational alliances, the layers of stakeholders with which they engaged, and their relations with national health systems, this thesis will contribute to a wide range of historiographical themes. This thesis furthers the histories of international health, histories of development, histories of the creation of the colonial and postcolonial nation-states and its governance structures (and histories of colonialism more broadly defined), and histories of medical mission (including both histories of medicine and histories of mission). By combining analysis in each of these historiographical areas, this thesis is able to produce a novel contribution to historical research. Bringing these together has resulted in the creation of fresh and nuanced categories, and the discovery, analysis and comparison of rich but neglected

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[1] D. Maxwell, 'Post-colonial Christianity in Africa' in H. McLeod (ed.) *The Cambridge History of World Christianities c.1914-.c.2000* (Cambridge: Cambridge University Press, 2008) p.407 citing A. Hastings, *A History of African Christianity, 1950-1975* (Cambridge: Cambridge University Press, 1979) p.224.

[2] 'The Medical Missionary Vocation' Leaflet of Information to be Sent to Candidates, Edinburgh Medical Missionary Society 1946-55, 3/11 C 152, Acc.7548 Church of Scotland, National Library of Scotland (Edinburgh, UK).

archival stores. The outline of these historiographical contributions will be described in this section, with a more extensive discussion of medical mission concepts and historiography in the next section. This will be followed by analysis of the methods and sources used.

This thesis offers new perspectives in the history of international health through analysing medical mission. In the history of postcolonial international health, the adaptation and survival of medical missions beyond the end of empire has been often neglected and ignored. Missions appear in the histories of colonial medicine and even dominate narratives of the origins of modern African healthcare. However, in most histories on the period after the colonial divide, on the eras of independence, nationalism and African-initiated churches, the complexity, variety and survival of medical missions has been dismissed as a vestige of old empire. In the histories of medical mission represented in David Hardiman's *Healing Bodies, Saving Souls* the importance of medical mission is largely limited to the colonial era alone with only a final foray into postcolonial Nigeria in John Manton's last essay of the volume.[3] In histories of the postcolonial period, medical missions have been sidelined. In Lyn Schumaker's recent contribution to *A Global History of Medicine,* 'History of medicine in Sub-Saharan Africa', medical mission is mostly restricted to the colonial era. When Schumaker analyses 'post-colonial medicine', far greater significance is placed on the local professionalisation, expansion and Africanisation of medicine. This is done in the name of capturing 'wider African perspectives'. However, in doing so Schumaker overstates the distinctions between mission medicine, African national healthcare and international health.[4] Furthermore, she implies that African perspectives on medicine after decolonisation were non-traditional, anti-conservative and disconnected from the continuities with the historic mission churches, when this was far from the case.[5] Such divides in African and European perspectives and ruptures in common historical periodisations will be challenged in this thesis. This history of medical mission in Ghana between 1919 and 1983 will match up colonial with postcolonial and in doing so break conceptual ground in the study of international health and development.

This thesis will show through multi-layered histories of mission, medicine and the emergence of the decolonised nation-state, that international health was not simply determined by older colonial organisational networks; there were new forces emerging from complex international political changes. Beneath simple historical narratives of the international are complex local and regional politics that limited the extent of international forces and reshaped their meanings. This challenges the work of Brown, Cueto and Fee who focus on elite processes alone and thus periodise the history of international health in terms of simplistic

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[3] D. Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam-New York: Rodopi, 2006); J. Manton, 'Administering Leprosy Control in Ogoja Province, Nigeria, 1945-1967: A Case-Study in Government-Mission Relations' in D. Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam-New York: Rodopi, 2006) pp..307-332.

[4] L. Schumaker, 'History of Medicine in Sub-Saharan Africa' in M. Jackson, *A Global History of Medicine* (Oxford: Oxford University Press, 2018) pp.195-219.

[5] On Zimbabwean Pentecostals taking up the 'missionary mantle' see D. Maxwell, *African Gifts of the Spirit: Pentecostalism and the Rise of the Zimbabwean Transnational Religious Movement* (Athens: Ohio University Press, 2006) pp. 163-183, esp 181-182.

transitions between 'international health' and 'global health'. They describe how in the 1940s and 1950s the World Health Organisation (WHO) mobilised technical expertise amidst Cold War battles. After this, they suggest that there were powerful changes in the 1960s and 1970s when the WHO was influenced by decolonised African nations, socialist movements and 'new theories of development that emphasized long-term socio-economic growth rather than short-term technological intervention'. Then they argue that the WHO had transitioned by the 1980s from being the 'unquestioned leader of international health to being an organization in crisis' having to 'refashion itself as the…leader of global health initiatives as a strategy of survival'. At this point, it is contended that the main international health concern was that the WHO had to reckon with the increasing authority of the World Bank which focused on population control, nutrition and the shrinking of state power.[6] Yet, their exaggeration of the role of the WHO and of elite international actors has meant the neglect of transnational and regional networks and institutions which acted in ways not determined by simplistic stages of international health and global change. The diffusionist model for international health, in which Western and Euro-centric periods of change were disseminated outwards and simply received by African nations, does not stand up to scrutiny from a national or local perspective. This thesis will show how missionaries, medical missionaries, churches, Christian Governors and Christian Ghanaian doctors were agents in the construction of international health, they limited, facilitated and actively created its programmes and ideas, in ways not currently represented in historical research.

Medical missions facilitated and shaped international health. Local political cultures and structural features of a particular nation had implications for how international health was created. As will be examined in chapter 2, the voluntary sector of medical mission which emerged in the Gold Coast (Ghana from 1957) in the 1950s was formally affiliated with the state and expanded under its financial support. Given that medical missions were themselves long-term formal state actors, their ability to grow and build agendas shaped national and international trends. As Michael Jennings has shown for Tanzania, the formalisation process of medical missions in the 1950s and 1960s meant a long-term role in the postcolonial nation-state for the 'voluntary' sector.[7] Medical missions helped to determine what kind of development and modernisation was possible in Ghana after independence. As a result of the colonial legacies of a particular kind of statecraft in the Gold Coast, medical missions had significant power to limit as well as facilitate Ghanaian development. As will be explored in chapter 3, missions functioned as the necessary experts for the claims of the first President, Kwame Nkrumah, to a modern healthcare system. Medical missions' role in enabling national and international health continued to be a significant feature of global programmes such as smallpox eradication analysed in chapter 5 and Primary Health Care (PHC) analysed in chapter 6. Medical missions were both an

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[6] T. M. Brown, M. Cueto and E. Fee, 'The World Health Organization and the Transition from "International Health" to "Global" Public Health' *Am J Public Health* 96. 1 (January 2006) pp.62-72.

[7] M. Jennings, 'Common Counsel, Common Policy: Healthcare, Missions and the Rise of the 'Voluntary Sector' in Colonial Tanzania' *Development and Change* 44.4 (2013) pp.939-963, esp. 960-961; M. Jennings, 'The precariousness of the franchise state: Voluntary sector health services and international NGOs in Tanzania, 1960s - mid-1980s' *Social Science and Medicine* 141 (2015) pp.1-8.

active agent in the hollowing out and restriction of the postcolonial nation-state, and participants and surrogates of its most ambitious ideological projects. Thus, when historians such as Brown, Cueto and Fee, periodise international health in terms of the Cold War or the growth African nationalism, this does not fully register the complex internal dynamics of how these categories actually get constructed within national or institutional contexts.[8] Moreover, when structural adjustment occurred officially in Ghana in 1983 this did not mean that 'neoliberalism', the World Bank or the IMF suddenly determined every aspect of Ghanaian political life or their healthcare. As will be shown in chapter 6, amidst economic hardship, medical missions survived in this period, drawing on alternative funding streams to the old colonial powers and flourishing in their commitment to supposedly declining international health and development movements.

International health offered new opportunities for the construction and articulation of Christian mission and a fresh horizon of expectations for many different sorts of medical professionals who wanted to perform their faith and religious identities through healthcare. It was not only as patients but also within the complex hierarchies of missionary medical practice that Africans were integral and powerful.[9] Walima T. Kalusa has shown how medical auxiliaries ensured that Zambians themselves were able to shape missionary practices from within.[10] Furthermore, Matthew Heaton has explored Nigerian Psychiatrists and their global influence.[11] However, Heaton's work neglects the place of Christianity; for example, in the life of prominent Nigerian psychiatrist T. H. Lambo.[12] What is yet to be explored is how African, European and American health workers worked between and across the divides in mission, government and international health in the postcolonial world. As will be analysed in chapter 5, Christian Ghanaian doctors were also beginning their own forms of medical mission, shaping the available structures and theologies, and expressing their faith through international and national health organisations. Moreover, acting as intermediaries, some utilised their connections to the historic mission churches to facilitate international health programmes. American, African and European missionaries were joining international health organisations and mixing their medical missions with national and international health projects. In some cases, Ghanaian and American international

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[8] T. M. Brown, M. Cueto and E. Fee, 'The World Health Organization and the Transition from "International Health" to "Global" Public Health' *Am J Public Health* 96. 1 (January 2006) pp.62-72.

[9] On Ghanaian agency as patients see, J. Allman and V. Tashjian, *"I Will Not Eat Stone": A Women's History of Colonial Asante* (Portsmouth, N.H.: Heinemann, 2000).

[10] W. T. Kalusa, 'Missionaries, African Patients, and Negotiating Missionary Medicine at Kalene Hospital, Zambia, 1906–1935' *Journal of Southern African Studies 40.2* (2014).

[11] A. Patton Jr., *Physicians, Colonial Racism and Diaspora in West Africa* (University of Florida Press, 1996); M. M. Heaton, *Black Skin, White Coats: Nigerian Psychiatrists, Decolonization and the Globalization of Psychiatry* (Ohio: Ohio University Press, 2013).

[12] J. C. McGilvray to T. A. Lambo, 'Consultation on the Subject of Health and Salvation' (12 July 1966) 4215.0.3 World Council of Churches: Christian Medical Commission. History of the CMC 1-9, WCC Archives (Geneva, Switzerland); '3. T. Adioya Lambo: Traditional Healing and Scientific Medicine: Some General Problems of Adjustment' Master File of Material for Consultation on Health and Salvation' (Tubingen, 1967) 4215.0.3 World Council of Churches: Christian Medical Commission. History of the CMC 1-9, WCC Archives (Geneva, Switzerland).

health workers even viewed eradication campaigns as truer forms of Christian medicine than the historic work of medical missions.

The concept of international health will be complicated by exploring how medical mission in Ghana fit with its many layers, processes and framings. International health is a diverse and decentralised process that is constantly being remade in local contexts in parallel with international communities and networks.[13] Socrates Litsios, Jill Oliver and Matthew Bersagel Braley have studied the role of medical missions in international health, but in each of these the focus is entirely on the Christian Medical Commission (CMC) and their role in the creation of Christian Health Associations.[14] The CMC is a Geneva-based group working within the World Council of Churches (WCC) and in coordination with the WHO. In chapter 6, this thesis will analyse the CMC from perspective of Ghanaians and medical missions, examining how the CMC were part of the continuation of PHC in the 1980s. Analysing missions' independence and linkages with international health will show how movements like PHC could be successful on the ground in Ghana, when they might not be successful in the higher echelons of international health organisations. It was not only the Soviet Union and Halfdan Mahler's Scandinavians that supported PHC after 1978, it was also many medical missions across denominations. PHC was linked to medical missionaries' long-term ideas about development, community, holistic care and human spirituality. Yet, this thesis will also explore how medical missions' work within international health went deeper and further than that of the CMC alone. Ghanaian international health workers re-shaped visions of international health by their long-term experiences of medical mission structures and healthcare disparities in Ghana. Missions were involved in smallpox and measles control, and international food aid through their churches and clinics. Finally, it will be a central claim of this thesis that it was not only Protestants (who made up most of the CMC in Geneva) but Catholics funded by organisations such as Misereor and Memisa who worked with international health organisations, and especially the PHC movement, in Ghana.

Medical missions are yet to be thoroughly studied in their own terms or with all the continuities and changes across their full history. In contemporary discussions of international health the deep history of FBOs is often neglected or treated cursorily. As recent large-scale project published in *The Lancet* showed there are still sizeable proportions of church-based healthcare within the African health landscapes today. According to the study, the estimated national faith-based health networks (NFBHN) market share (with

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[13] S. Bhattacharya, 'Global and Local Histories of Medicine: Interpretative Challenges and Future Possibilities' in M. Jackson, *A Global History of Medicine* (Oxford: Oxford University Press, 2018) pp.243-262.

[14] S. Litsios, 'The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach' 94.11 *Am J Public Health* (November, 2004) pp.1884–1893; M. B. Braley, 'The Christian Medical Commission and the World Health Organization' E. L. Idler (ed.) *Religion as a Social Determinant of Public Health* (Oxford: Oxford University Press, 2014) pp.298-318; F. Dimmock, J. Olivier and Q. Wodon, 'Half a Century Young: The Christian Health Associations in Africa' MPRA Paper, *World Bank* (November 2012) pp.1-33.

regard to beds) is 42 per cent in Ghana with 104 health centres.[15] However, given the fear of religious evangelism or bias in international health, these structures are often described in ways detached from their history in medical mission. Reductive present-focused narratives have served to soften FBOs' distinctiveness.[16] Attempts to correct this historical myopia have faltered. Large histories of FBOs were attempted in a British government Department for International Department (DfiD) funded project at the University of Birmingham. The aim was to examine the role of religion in development since decolonisation but the resulting papers were ahistorical; they did not stretch back to independence as proposed.[17] By contrast, this thesis will show the deep historical antecedents of FBOs in medical mission, studying that past in its own terms.

As well as in international health, medical missions had a critical role in the emergence of the colonial state, the independent nation-state and their governance structures. As a result of state-mission linkages, colonial healthcare was shaped by medical missions. This thesis will build on recent historiographical interventions in this area. In 2012 Kathleen Vongsathorn critiqued earlier historiography on British colonial Africa which had suggested that: 'colonial government and missionary medicine occupied two relatively distinct spheres, and that government officials viewed medical missionaries with suspicion and distrust'. Against this backdrop, her research showed that 'missionaries and colonial government officials collaborated extensively and amicably in the treatment of leprosy in Uganda'.[18] In Anna Greenwood's edited volume on health work *Beyond the State*, authors highlighted the variety and extent of government-mission collaboration. Yolana Pringle showed that missions in Uganda between 1897 and 1940 collaborated a great deal with the Colonial Medical Service and that many Church Missionary Society doctors were also colonial medical officers. Pringle argues that there was a two-way process of exchange between mission and government, and that across the 1920s there was increased funding and equipment for missions.[19] In his chapter on colonial Malawi between 1891 and 1940 in Greenwood's edited volume, Markku Hokkanen argues that missionary physicians were connected to the Colonial Medical Service in their 'public health

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[15] J. Olivier, C. Tsimpo, R. Gemignani, M. Shojo, H. Coulombe, F. Dimmock, M. Cong Nguyen, H. Hines, E. J. Mills, J. L. Dieleman, A. Haakenstad, Q. Wodon, 'Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction' 368 *The Lancet* (July 7 2015) p.1768.

[16] On the importance of FBO uniqueness, see N. Grills, 'The Paradox of Multilateral Organizations Engaging with Faith-based Organizations' 15.4 *Global Governance: A Review of Multilateralism and International Organizations* (October-December 2009) pp.505-520.

[17] University of Birmingham, 'Research and Development Research Programme: Religion, politics and governance in India, Pakistan, Nigeria and Tanzania', *Policy Brief 12* (2011); M.Taylor 'Strengthening the Voice of the Poor: Faith-Based Organizations' Engagement in Policy Consultation Processes in Nigeria and Tanzania' *Working Paper 61* (2011).

[18] K. Vongsathorn, '"First and foremost the evangelist"? Mission and government priorities for the treatment of leprosy in Uganda, 1927-1948'*Journal of East African Studies 6.3* (August, 2012) pp.544–560.

[19] Y. Pringle, 'Crossing the Divide: Medical Missionaries and Government Service in Uganda, 1897-1940' in A. Greenwood (ed.) *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2015) pp.19-38.

campaigns, the division of labour, the exchanges of knowledge and materials and issues raised surrounding the ownership of African medical education'.[20] In contrast to histories that have suggested a simple transfer from pre-WW1 missionary medicine to post-WW1 government medicine, Hokkanen shows that in colonial Malawi there was a 'long history of many connections, relations and exchanges between government and mission medicine'.[21] Missions were given dominant roles in some key areas of health delivery; for example, the government had 'effectively conceded maternal and child healthcare service to the missions'.[22] In the first and second chapters, similar claims to these will be made for the Gold Coast.

Medical missions could act as a critical tool in the construction of national political authority in the colonial and postcolonial periods; moreover, Christian Governors had their own religious visions for mission, health and development. This thesis will build on the work of Karen Fields on the Watchtower movement and John McCracken on the Scottish Presbyterians in Malawi, which depict the early colonial state as similar to a medieval European states 'with the spiritual and material resources of the Church being used to bolster state authority'.[23] A similar nexus existed in the Gold Coast between the colonial government and the Scottish Presbyterians in the 1920s, with the Governor himself writing a book with missionaries on a Christian vision for development. Moreover, in the Gold Coast too as McCracken argues for Malawi, by the 1940s and into the 1950s rifts had emerged and this style of colonialism had been fractured.[24] However, the church and medical mission more widely continued to have a key position, and further Christian Governors emerged, taking active roles in constructions of mission, health and development. Furthermore, in the postcolonial period, as John Pobee and Rupe Simms have argued, independent Ghanaian political power relied on adapting Christianity to suit nationalists' needs.[25] As Adrian Hastings put it: 'African nationalism…

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[20] M. Hokkanen, 'The government medical service and British missions in colonial Malawi, 1891-1940: crucial collaboration, hidden conflicts' in A. Greenwood (ed.) *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2015) pp.39-63.

[21] M. Hokkanen, 'The government medical service and British missions in colonial Malawi, 1891-1940: crucial collaboration, hidden conflicts' in A. Greenwood (ed.) *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2015) pp.39-63.

[22] M. Jennings, 'Cooperation and Competition: Missions, the Colonial State and Construction a Health System in Colonial Tanganyika' in A. Greenwood (ed.) *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2015) pp.153-173.

[23] J. McCracken, 'Church and State in Malawi: The Role of the Scottish Presbyterian Missions, 1875-1965' *Christian Missionaries and the State in the Third World* (eds.) H. B. Hansen and M. Twaddle (James Currey, 2002) pp.176-193 citing K. E. Fields, *Revival and Rebellion in Colonial Central Africa* (Princeton N.J.: Princeton University Press, 1985) p. 41.

[24] J. McCracken, 'Church and State in Malawi: The Role of the Scottish Presbyterian Missions, 1875-1965' *Christian Missionaries and the State in the Third World* (eds.) H. B. Hansen and M. Twaddle (James Currey, 2002) pp.176-193.

[25] R. Simms, '"I am a Non-Denominational Christian and a Marxist Socialist": A Gramscian Analysis of the Convention People's Party and Kwame Nkrumah's Use of Religion' *Sociology of Religion* 64.4 (2003) pp.463-477; J. S. Pobee, *Kwame Nkrumah and the Church in Ghana, 1949-1966: A Study in the Relationship between the Socialist Government of Kwame Nkrumah and the Protestant Christian churches in Ghana* (Asempa, 1988) pp.49-53, 94-95.

has hardly existed except where it has been ethnically based, linguistically held together and biblically watered'.[26] The significance of biblical literacy has been linked to the emergence of nation-states across historical research and no less for the history of decolonisation. Moreover, certain types of Christian religiosity have been linked to certain kinds of statecraft. Paul Gifford has shown how postcolonial patrimonialism gave a context in which Pentecostalism flourished in Ghana.[27] This thesis will further these histories by showing how medical mission ensured simultaneously that parts of the state were vulnerable to external forces and also how it enabled the independent nation-state's development ambitions to function at all. From close relationships with particular governments, to challenges posed to independent Ghanaian control, missions had complex role within colonialism and the emergence of the nation-state. Pioneering missions allowed the state to stretch across the land mass of Ghana into its Northern Territories which were largely ungovernable. In addition, the Africanisation of the medical missions reshaped these connections, ensuring that the churches had significant political power within the Ghanaian postcolonial state. Churches could challenge the power of the Presidency and ecumenical organisations even helped to support the political career of Kofi Busia who became Prime Minister in the late 1960s.[28]

Yet, the state and its governance structures are only one aspect of what colonialism in the Gold Coast and postcolonial nationalism in Ghana meant. Colonialism's definition should go beyond formal politics and the tools of statecraft, to include how ideas, material cultures, identities and body practices changed in response to perceptions of racial, environmental and physical difference; perceptions which were constructed within unequal cultural encounters. Moreover, the challenges to colonialism made by Africans across the twentieth-century cannot be conceived only in terms of formal political organisation, such as nationalist liberation forces or campaigns for self-government. Attacks on colonialism also took the form of cultural empowerment, contesting the meanings of difference and identity in newspapers and novels, taking agency within the creation of knowledge about Africa and Africans in science and law, and subverting the economic and racial hierarchies in settings such as hospitals and schools.[29] In historical analysis, medical missions often figure as supporters, creators and disseminators of colonialism. Yet, as work by Andrew Porter, Patrick

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[26] A. Hastings, *The Construction of Nationhood: Ethnicity, Religion and Nationalism* (Cambridge: Cambridge University Press, 1997) p.163.

[27] P. Gifford, *Ghana's New Christianity: Pentecostalism in a Globalizing African Economy* (Indianapolis: Indiana University Press, 2004).

[28] Busia was the leader of the opposition Party to Nkrumah's Convention People's Party (CPP) and his research work was supported by the World Council of Churches when he was in exile from Ghana as it became a one-party state in the 1960s; K. A. Busia, *Urban Churches in Britain: A Question of Relevance* (London: Lutterworth Press, 1966).

[29] F. Cooper, *Colonialism in Question: Theory, Knowledge, History* (Berkeley: University of California Press, 2005) pp. 23-24; B. N. Lawrance, E. L. Osborn and R. L. Roberts, *Intermediaries, Interpreters and Clerks: African Employees in the Making of Colonial Africa* (University of Wisconsin Press, 2008); S. Newell, *The Power to Name: A History of Anonymity in Colonial West Africa* (2013).

Harries and David Maxwell has shown, missions also could nuance the very cultures of colonialism that historians expect them to maintain.[30]

This thesis will further the historiography of colonialism by utilising sophisticated categorisations of missionary culture and 'Africanisation', combining them with attention to the histories of international and development. This thesis will show how mission, international health and development could be used to maintain the racialised cultures of colonialism, and also how they could challenge the hierarchies of colonialism. Sometimes this benefitted 'nationalists' and other times it benefitted other political formations. Especially significant was how missions figured in 'Africanisation'; there was some voluntary empowering of Ghanaian leadership in mission institutions between 1920s and the 1980s, as well as some Africanisation which occurred out of necessity. This thesis will also examine how the 'Africanisation' process was limited by expatriate missionaries keeping power over their hierarchies and also benefitted by their training of nurses and community health workers. Whilst a major problem for 'Africanisation' was the lack of Ghanaian doctors (especially following their exodus in the late 1970s), this thesis will show how key Ghanaian Christian doctors working within international health programmes ensured some significant postwar Africanisation of healthcare and development. In this there were battles over perceptions of the type of 'African-ness' that was being empowered and whether it was based in historic missionary or 'African initiated' Christianity, traditional religion, pan-African unity or older norms of cooperation with missions and the colonial state.

Presenting a history of medical missions through colonialism and decolonisation also shows how medical missions were more significant to 'development', for a far longer time, than has been currently recognised in historical research. Between 1919 and 1983 medical mission consistently grew within Ghanaian development: from under the colonial state and the beginning of large-scale development agenda in 1919, to beyond the disintegration of the postcolonial state in the late 1970s and structural adjustment in 1983. This argument is in contrast to Sabine Clarke's presentation of colonial development, especially in the postwar era in East Africa, which suggests that for all British postwar colonial contexts, technical and scientific research agendas drove the development responses to social and political issues.[31] This thesis will argue instead that religious and Christian ideological motivations were vital in British colonial development from after the First World War and particularly in the massive expansion of healthcare in Ghana in the 1950s. As a result of their sustained role, medical mission's patterns, issues and qualities were critical in forming the structures of Ghanaian health between the 1920s and 1980s. Together missions defined what was expected and the extent

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[30] P. Harries and D. Maxwell, 'Introduction: The Spiritual in the Secular' in P. Harries and D. Maxwell (eds.) *The Spiritual in the Secular: Missionaries and Knowledge about Africa* (Wm. B. Eerdmans Publishing Co., 2012); A. Porter, *Religion versus Empire? British Protestant Missionaries and Overseas Expansion, 1700-1914* (Manchester: Manchester University Press, 2004).

[31] S. Clarke, 'The Research Council System and the Politics of Medical and Agricultural Research for the British Colonial Empire, 1940–52' *Medical History* 57.3 (July 2013) pp.338-358; S. Clarke, 'A Technocratic Imperial State? The Colonial Office and Scientific Research, 1940-1960' *Twentieth Century British History* 18.4 (January 2007) pp. 453-480.

of what was possible for healthcare in the postcolonial nation-state. Furthermore, they also became a more homogenous lobbying power through a formalisation process in the 1950s and through ecumenical organisations such as the CMC institution, the Christian Health Association of Ghana (CHAG). From the 1960s well into the 1980s, medical missions were promoting their development models alongside governments and international organisations.

In Ghana, the interconnection between colonial development and mission had long-term consequences. Yolana Pringle argues that in Uganda in 1939, when government no longer needed the missionaries and emphasised their own agendas, collaboration 'ceased almost entirely'.[32] This was certainly not the case in the Gold Coast. Beyond independence, medical missions in the Gold Coast had close relationships with national governments. As will be detailed in chapter 2, a key aspect of this was the formal 'voluntary' sector of medical missions which had become deeply embedded by the mid-1950s. From this foundation, medical missions continued to build their role well into the 1980s. As chapter 3 will show, by 1966 and the coup against the first President of Ghana, Kwame Nkrumah, there had been consistent large scale spending on healthcare resulting in 34 mission hospitals and 39 government ones.[33] Through this missions shaped colonial and postcolonial conceptions of development, and figured in contests over claims to its definition. Walter Bruchhausen has argued that over the twentieth-century medical missionaries transitioned from being conceptualised in terms of 'charity' to being conceptualised in terms of 'development', and that missions had not wanted to be part of the colonial health care system.[34] Yet, this thesis will show how in the Gold Coast and Ghana, medical mission figured within ideas of development from 1919 onwards and were bound up with colonial health care. The emergence of postwar international health and development organisations were part of the reconstruction of the relation between missionaries and development, rather than its initiation.

In the evolving tensions between missionary interests and state sovereignty between 1919 and 1983, this thesis will show how, depending on the utility to African nationalists, international health organisations and European political leaders, mission-development connections were reimagined in a variety of contested ways. It will be argued in chapter 1 that in the colonial development agendas of Gordon Guggisberg in the interwar period, Scottish Presbyterian medical missions provided a spiritual and religious support for key concepts in human development and for the extension of the state. Missions' relation to development was conceived in terms of leadership for racial progress and the production of norms of domesticity through

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[32] Y. Pringle, 'Crossing the Divide: Medical Missionaries and Government Service in Uganda, 1897-1940' in A. Greenwood (ed.) *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2015) pp.19-38.

[33] 'Table 8: Distribution of Hospitals, Health Centres and Other Fixed Clinics by the Type of Institution and Region' *Republic of Ghana: Annual Report of the Medical Services of Ghana 1967* p.64, ACS0.1.48 (Liverpool School of Hygiene and Tropical Medicine).

[34] Bruchhausen's focus on Catholic medical missions is the cause of this limitation in his argument; W. Bruchhausen, 'From Charity to Development: Christian International Health Organizations, 1945-1978' *Hygiea Internationalis: An Interdisciplinary Journal for the History of Public Health* 13.1 (December 2016) pp.117-134.

maternal and child health. In chapter 2 it will show how in the late colonial development plans of the 1950s, medical missions were recast as a formal voluntary sector, a type of liberal associational life which would bolster democracy and also enhance state social provision. This more widely connected all denominations of missions and the Scottish Presbyterians were detached from the process, having chosen to be no longer defined by their role in social improvement. Then in chapter 3, it will look at how in Nkrumah's Ghana of the late 1950s and 1960s, nationalists and socialists had to navigate the mission-development in order to gain political power and claim sovereignty. Missions could be derided as colonial stooges or lauded as experts and agents of modernity for the independent state. Choosing to perform one or the other narrative about missions depended on the context and personal utility of the identification for individual political actors and groups.

Medical missionaries' relationship to development was conceptualised by various actors and claims to particular narratives of this relationship could prove useful. In 2009, John Manton analysed how missionary leprosy control in Ogoja in Nigeria in the 1940s contributed to the creation of 'modernity'. He showed how the land-extensive aspect of leprosy settlement meant that Catholic missions gained a stake in the 'delineation and policing of strategic and contested borders between ethnic groups' and became part of the strategy of colonial extension. Through this 'modern' medical work, missions produced local identities, they reconstructed local space, and specifically they 'helped to constitute ethnicity in an absolute relation with concepts of territory and ownership'. Thus, in a context of political change, the ways in which missions formulated concepts of development led to 'novel strategies for bargaining, discriminating and petitioning'.[35] This thesis will build on these insights from Manton, and show how medical missions in the context of rapid changes in Ghana also reconfigured and contributed to the construction of key categories within international health and development. Moreover, it was also contests over the concept of 'medical mission' itself in relation to development that had significant effects. A stake in certain meanings and expressions of medical mission could be a powerful weapon in national and international health in the Gold Coast and the nation-state of Ghana.

Crucial to this thesis will be analysing how West German Catholic organisation Misereor and the Dutch Catholic organisation Mimesa constructed the mission-development relationship in terms of European humanitarianism, with effects that were far-reaching. This thesis will describe multiple levels of activities at international and national level, sometimes in parallel and acting in concert episodically. To understand these complexities, we need new conceptual categories which facilitate new types research. Forming these categories and challenging monolithic notions of international health and development led to unexpectedly rich caches of archival material in repositories that have not been systematically used by history of health and international development. Notably, as yet unexplored in historical research, West German and Dutch Catholic medical mission will be examined from chapter 4 onwards. This postwar development initiative was entirely new and comprised a massive stream of funding from individual churches, large 'lenten' campaigns

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[35] J. Manton, 'Making Modernity with Medicine: Mission, State and Community in Leprosy Control, Ogoja Province, Nigeria, 1945-50' in H. Ebrahimnejad (ed.) *The Development of Medicine in Non-Western Countries* (London: Routledge, 2008) pp.160-183.

and government grants. It facilitated an expansion of Catholic medical mission in Ghana from the late 1950s onwards. Building on the growth of Catholic medical mission in the late 1940s and 1950s in the Gold Coast, from around 1959 the church and state in West Germany and the Netherlands funded Catholic healthcare in Ghana massively. As will be detailed in chapter 4, West German and Dutch Catholics, including the Federal President, imagined and expressed the medical missionary relation to development in terms of shared European humanitarianism, shared suffering during and after the war and the restoration of European nationalism. This shift was not determined by Cold War concerns, by old colonial links or by the emergence of the international health community.[36]

National and international health and development were effected by the continuities and significant changes of medical mission on a large scale, particularly that of Catholic medical mission. Yet, these West German and Dutch aid activities did not operate in isolation from wider political, economic and development trends. Grounded within the structural continuities of medical mission and Ghanaian political culture, this new and significant change had long-term and wide-reaching consequences for international health, US development aid and Ghanaian healthcare. Explored in chapter 5, the long-term effect of these forms of European Catholic medical mission was that in Ghana, the Catholic Relief Services enabled USAID to link to West German aid, using church networks and Catholic medical mission to distribute large quantities of food aid for decades. This was part of the larger process of the (controversial) inclusion of Catholics in mainstream US political culture, encouraging links between ascendant Catholic internationalism and American Cold War aims. Finally, as will be analysed in chapter 6, a key long-term effect of Catholic medical mission expansion was that the PHC movement was continued by medical missions, particularly Catholics, on the ground in Ghana. Not only was the CMC financed partly by West German Catholic aid but CHAG had a membership which was over two-thirds Catholic by the 1980s. In 1970s and 1980s Ghana, Catholic medical mission dominated healthcare and drove specific agendas that can only be categorised and understood by challenging the current boundaries of historical analysis of international health and development.

Overall, this thesis will combine analysis of the historiography of international health, development and the emergence of the colonial state and the independent nation-state (and colonialism defined more broadly), providing an entirely new history of the role of medical mission. Sunil Amrith's history of international health is restricted because of its dependence on the sociological category of 'secularisation'.[37] Theological and missionary concepts of medicine were not the preserve of only anti-modern colonials or of anti-scientific African communities. They are a complex and vital feature of how international and national health were constructed over the last century in Ghana. The legacies of the ideas and identities of medical missions

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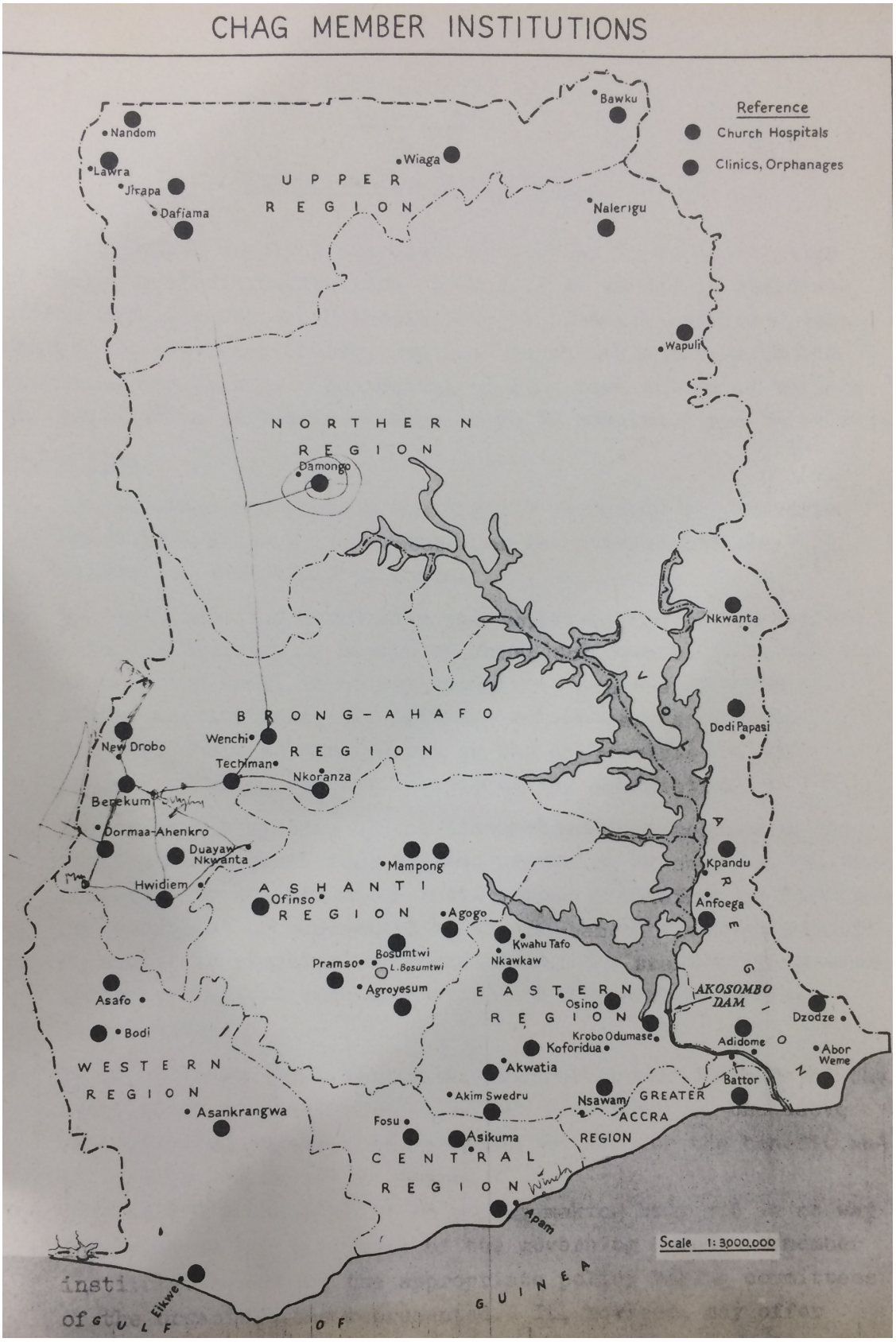
[36] This emergence was presented as a new international order, postwar, but was frequently unable to avoid the contagion of imperialism in situations where extensive European colonies remained in place around the world.

[37] S. Amrith, *Decolonizing International Health: India and Southeast Asia 1930-65* (Palgrave Macmillan UK, 2006).

effected Ghana even beyond the end of 'development', the supposed end of 'international health' and the economic and political disintegration of the nation-state from the late 1970s. Medical mission and their Christian practices and ideas of development had a long and significant history for national and international health, which is currently neglected by historians.



Map I: The Growth of Medical Mission in Ghana

Ghana with CHAG Member Institutions (1976) MMMP 17731, MEMISA archives, Katholiek Documentatie Centrum, Nijmegen, Netherlands.

i. CONCEPTS AND HISTORIES OF MEDICAL MISSION

Medical mission has been categorised and conceptualised in many ways across the twentieth-century. The EMMS description of the medical missionary at the beginning of this chapter is certainly overly simplistic. Not every medical missionary worked in the two types of institutions depicted by the EMMS, nor were they all men as the EMMS also had suggested.[38] There were many competing types of missions of different denominations, genders, congregations, traditions, backgrounds, nationalities and ethnicities. Medical missionaries have been seen as evangelists, technical experts, modernisers, accessories to colonialism, spearheads of imperial extension, anti-colonial advocates, individualists, communitarians, moral reformers, domestic social engineers, supernatural healers and pure scientists. Their medical work has been conceived as a penitential offering for colonialism, a way of creating a captive audience for evangelism and a means by which to remake African identities.[39] Colonial officials could view medical mission as distinct from their work, a support to them, a gap-filler where they could not venture or even a challenge to their control. Equally, African nationalists within the same political Party, committee or even individual, had varying, contradictory and oscillating perspectives on medical missions.

Until around the 1960s historical studies of medical missions, mostly written by participants and usually lacking wider context, had been hagiographical or derisive. Volumes on the medical missionary David Livingstone filled Victorian shelves with tales of adventure and colonial paternalism. The story was of the light of modern medicine beating back the hordes of darkness and simultaneously spreading the Good News of Christ's triumph over death. Colonial Governors also wrote histories including medical missionary work and critiquing or lauding their role. Practical issues with proselytism and state provision were combined with rudimentary psychological and racial theory. In the 1960s, interest in missionaries was picked up by social historians who aimed to examine the relationship between the church, modernity and social change, without deriding or lauding mission. In 1963 R. T. Parsons published *The Churches and Ghana Society* in which the focus was on the effect on mission of imperial policy changes. He argued that collaboration in development work between missionaries and the colonial government had been pioneered in Nigeria in 1949, and afterwards copied in the Gold Coast stemming from a report by Sir Sydney Phillipson.[40] By the 1970s, relations between medicine and colonialism were being explored within the historical work of I. R. Phimister in the 1970s. Phimister addressed older narratives of colonial medical benevolence and argued that

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[38] 'The Medical Missionary Vocation' Leaflet of Information to be Sent to Candidates, Edinburgh Medical Missionary Society 1946-55, 3/11 C 152, Acc.7548 Church of Scotland, National Library of Scotland (Edinburgh, UK).

[39] S. Doyle, 'Missionary Medicine and Primary Health Care in Uganda: Implications for Universal Health Care in A. Medcalf, S. Bhattacharya, H. Momen, M. Saavedra and M. Jones (eds.) Africa' *Health for All: The Journey to Universal Health Coverage* (Hyderabad, India: Orient Blackswan, 2015) p.73.

[40] The actual change produced by Phillipson's report was to shift Colonial Office thinking about institutionalising and funding missions; there was not such a great change in Governors and colonial officers in the colonies themselves; R. T. Parsons, *The Churches and Ghana Society, 1918-1955* (Brill, 1963) pp.148-150.

healthcare generally was meagre compared to the diseases that colonialism wrought on Africans. Furthermore, in the mid-1970s Richard Gray examined the fear of disease in Africa and linked colonial medicine to the construction of social differences.[41]

In Britain and the US a group of historians became more interested in the study of healing in the churches in the late 1970s and early 1980s, and examined medical missions by their own terms. In the Ecclesiastical History Society's conference in 1981/2, Terence Ranger opened up historical study of missionary perspectives in themselves, rather than more simplistically as handmaidens of colonialism. For example, Ranger argued that the Universities' Mission to Central Africa (UMCA) had rational, scientific and evangelistic approaches to medical mission which were: 'explicitly opposed to colonial capitalism'.[42] Rangers' approach gave attention to the historical significance of mission and the complexity of their relations with the state. In taking medical missions' role seriously, analysing their aims and their limited successes, without composing a triumphalist narrative, Ranger set the context in which later historians could study them.[43]

In the next key transition within the history of medical mission in the late 1980s and 1990s there was greater interest in the cultural effect of mission, particularly in the work of Megan Vaughan. There was a widening approach to 'colonialism' and on the culture of colonialism beyond the particular practices of the colonial state. In 1987 Norman Etherington critiqued the argument of K. David Patterson and G. W. Hartwig that African and European healers were in intense conflict by showing how they worked together in some mid-Victorian medical missions.[44] This was an important statement challenging categories and racial boundaries that had been placed around medical missionaries by historians. Megan Vaughan in 1991 built on Etherington and Ranger in her seminal chapter 'The Great Dispensary in the Sky' in *Curing Their Ills*. Part of the reason Vaughan was so significant was that her approach drew from Michel Foucault and Edward Said. Vaughan's history was embedded in the 'cultural turn' which informed her analysis of discourses on 'the African', systems of representations and the construction of subjectivities which led to identifying the combination of biomedical power with the healing of the soul in medical mission. Vaughan argued that missionary medicine was 'involved in the attempt to create particular subjectivities through its practice' and

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[41] T. O. Ranger, 'Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900-1945' 15B *Soc. Sci. Med.* (1981) pp.261-277.

[42] T. O. Ranger, 'Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900-1945' 15B *Soc. Sci. Med.* (1981) pp.261-277.

[43] It must be noted that Ranger also briefly showed that missions had not disappeared with postcolonialism but remained within the state.

[44] G. W. Hartwig and K. D. Patterson, *Disease in African History* (Durham N.C., 1978) p.4 cited in N. Etherington, 'Missionary Doctors and African Healers in Mid-Victorian South Africa' 19 *South African Historical Journal* (1987) pp. 77-91.

that these were distinct, though not completely, from the subjectivities that secular medicine was trying to create.[45]

Debating the place of social control, historians in the late 1990s and early 2000s explored the relations of exchange between medical missions and their patients. Using innovations in the history of social control, regimes of power, techniques for disciplining bodies, gendered and racial norms, historians following Vaughan examined medical missions' cultural encounters more closely. In 1997, Jean and John Comaroff, pioneers of cultural histories of mission, wrote a chapter on medical mission in the second volume of their series *Of Revelation and Revolution* on South Africa. In this they argued that in medicine the 'physical separations' of racialised, civilising mission were most often breached; that in their healthcare, Nonconformist missionaries entered into a space of contest and exchange over the body with the Southern Tswana. The Comaroffs emphasised that it was in this medical space that both missions and Africans were unusually receptive to 'the other' . On the other hand, the Comaroffs suggested that once the dividing lines between the 'pioneers of scientific healing' and 'those purveyors of the Spirit' had been drawn in the late nineteenth-century (when 'technicist biomedicine' took over from 'heroic healing' and became more specialised and regulated), this did lead to clashes with the Southern Tswana. The Tswana did not wish to 'separate the practices of priest and doctor' and so split off from these historic missions to begin their own Christian movements in which religious ministry treated the body and soul together.[46] This built on Ranger's argument in 1982 that by repudiating all medicine, Pentecostalism abolished the dichotomy between diseases of God and those of man.

In the late 1990s, at the same time as medical missions were being depicted as social and cultural engineers, they were also being set in the context of the colonial damage to African society, particularly with regard to the spread of disease. The Comaroffs concluded their argument in 1997 by setting missions within the wider context of colonialism and European modernity. They argued that the medical mission process of categorising and disciplining bodies had a critical effect at a time of flux in the construction of the modernist self in Europe. Medical missions had the effect of subtly convincing European publics that there was a comprehensible biological, individual self which could be understood in contrast to the unregulated African female body. They framed this within a damning picture of the colonial effect on health. This damage had already been shown by Hartwig and Patterson in the late 1970s, but here the Comaroffs were linking it to the missionary myth of 'humane imperialism' and the rational, regulated European self.[47]

Though they were no longer considered simply as 'handmaidens of colonialism' the historical work of the late 1990s and early 2000s challenged the idea that missions were separate from the colonial state. In linking

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[45] M. Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge: Polity Press/Basil Blackwell, 1991) pp.4, 23, 56-57 and 65.

[46] J. Comaroff and J. Comaroff, *Of Revelation and Revolution, Volume 2: The Dialectics of Modernity of a South African Frontier* (Chicago: University of Chicago Press, 1997) pp.323-364.

[47] J. Comaroff and J. Comaroff, *Of Revelation and Revolution, Volume 2: The Dialectics of Modernity of a South African Frontier* (Chicago: University of Chicago Press, 1997) pp.323-364, 405-415.

missions to Belgian colonialism, Nancy Rose Hunt also fiercely critiqued the portrayal of mission medicine as 'benevolent, persuasive, sentimental' and 'soft', and colonial medicine in the form of government and private doctors as 'coercive' and 'strong'. Instead, she flipped this dichotomy, arguing that: 'Colonial evangelism was not soft, "the" colonial state was not (always) strong'. Hunt tracked how mission-state relations were constantly changing and how Yakusu missionaries could be as involved in 'sanitary modalities' in child and maternal health work, as formal agents of the state in disease control programmes.[48] Moreover, in 2002, Osaak Olumwallah showed how missionaries had access to areas for medical interventions in Kenya that because of previously brutal tax policies, the colonial state struggled to enter.[49] Nevertheless, the implication remained that under colonialism missionaries had a context which was safe for their expansion and survival, and that after this they faltered. Elizabeth Isichei in her *History of Christianity in Africa* had shown how in 1995, medical missions wanted to cling on to their hospitals and institutions against the wishes of the independent state.[50]

Around the mid-2000s historians emphasised missions' heterogeneity and their uneasy relationships with Empire as well as postcolonial nationalists. In 2004, in his seminal work on British Protestant mission, Andrew Porter concluded that for missions: 'The extent of their determination, the universal sweep of their theology, the global extent of their contacts and their consciousness, deserve more acknowledgement than they have generally received'.[51] Porter's argument was not only that missions were often directly in conflict with colonialism, but also to show that a range of different pressures, such as politics, theology and economics, could distance them from or draw them close to empire. Crucially, in contrast to many of the historians in the 1990s, central to Porter's claims was that missionaries own determinations, their contacts, their theological narrative and their own imaginations, mattered in their relations with empire.[52] Whilst Megan Vaughan's work in *Curing their Ills* was genre-defining, unfortunately it had sidelined how the UMCA viewed their identities, understood their social control and imagined power in their own theological terms. In his chapter in 2005 on decolonization, David Maxwell argued that the 'sheer diversity' of missions with regards to nationality, class, theology, denomination and historical context, could only result in complex relations with the state. As Adrian Hastings had put it, there was never such a 'degree of unity on the

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[48] N. R. Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham and London: Duke University Press, 1999) p.161.

[49] O. A. Olumwallah, *Dis-Ease in the Colonial State: Medicine, Society and Change among the AbaNyole of Western Kenya* (Westport, CT: Greenwood, 2002) pp.162-185, 223.

[50] E. Isichei, *A History of Christianity in Africa: From Antiquity to the Present* (W.B. Eerdmans Publishing Company, 1995) p.334.

[51] A. Porter, *Religion versus Empire? British Protestant Missionaries and Overseas Expansion, 1700-1914* (Manchester: Manchester University Press, 2004) p.330.

[52] A. Porter, *Religion versus Empire? British Protestant Missionaries and Overseas Expansion, 1700-1914* (Manchester: Manchester University Press, 2004) pp.316-330.

ecclesiastical side' to presuppose such a 'fusing'.[53] Maxwell extended these arguments to begin exploring how missions fit within the history of African decolonisation and the postcolonial independent African church - subjects still largely un-researched.[54]

The main result of the transition in historical argument in the mid-2000s was that a plethora of studies of mission organisations themselves emerged - these showed how much missions were shaped by cultural encounters. From 2005 onwards, work on missionary anthropology, photography, narratives and science abounded. The focus on a variety of regions and peoples extended how medical mission was studied, for example in Hardiman's 2007 volume on medical mission in Hong Kong, China, Eritrea and elsewhere. These new histories did not ignore the older models of social control and cultural exchange but they situated them within more complicated pictures of missionary life, practice and geography.[55] For example, in 2005, Jamie S. Scott and Gareth Griffiths produced an edited volume on range of texts, books, reading practices, textual dissemination and reception, and travel writing.[56] These were linked to missionary agendas for 'conversion and control'. Material histories of 'books and bodices' in missions in colonial south India were pushing the boundaries of the kinds of sources previously utilised.[57] This field continued to grow and in 2012 Patrick Harries, David Maxwell, and many authors used these new areas, such as studies of missionary anthropology, ethnography and science, to interrogate older questions about the divide between missions and indigenous people. The unintended consequences of mission such as in their translation of languages, increasingly featured in historical research. Similarly to Jeffrey Cox's work on the various competing 'master narratives' of mission in Scott and Griffiths' book, Maxwell and Harries emphasised the complexity of the empirical and 'ordered knowledge' of missionaries, and the range of their tropes. Missions, they argued, 'developed new ways of understanding their situation, and in the process they brought African ways of ordering and understanding the natural environment to the attention of the world'.[58] Thus, African

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[53] A. Hastings, 'The Churches and Democracy: Reviewing a Relationship', in P. Gifford (ed.) *The Christian Churches and the Democratization of Africa* (Leiden, 1995) p.40 cited in D. Maxwell, 'Decolonization' in N. Etherington (ed.) *Mission and Empire* (Oxford: Oxford University Press, 2005) p.287.

[54] D. Maxwell, 'Decolonization' in N. Etherington (ed.) *Mission and Empire* (Oxford: Oxford University Press, 2005) pp.285-306; D. Maxwell, 'Post-colonial Christianity in Africa' in H. McLeod (ed.) *The Cambridge History of World Christianities c.1914-.c.2000* (Cambridge: Cambridge University Press, 2008) pp.401-421.

[55] D. Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam-New York: Rodopi, 2006).

[56] J. S. Scott and G. Griffiths (eds.) *Mixed Messages: Materiality, Textuality, Missions* (New York: Palgrave Macmillan, 2005); B. Anderson, *Imagined Communities: Reflections on the Spread and Origin of Nationalism* (Verso, 1993); R. Chartier, *The Order of Books: Readers, Authors and Libraries in Europe Between the 14th and 18th Centuries* (Stanford: Stanford University Press, 1992).

[57] E. F. Kent, 'Books and Bodices: Material Culture and Protestant Missions in Colonial South India' in J. S. Scott and G. Griffiths (eds.) *Mixed Messages: Materiality, Textuality, Missions* (New York: Palgrave Macmillan, 2005) pp.67-88.

[58] P. Harries and D. Maxwell, 'Introduction: The Spiritual in the Secular' in P. Harries and D. Maxwell (eds.) *The Spiritual in the Secular: Missionaries and Knowledge about Africa* (Wm. B. Eerdmans Publishing Co., 2012) pp.1-29.

knowledge, expertise and intermediaries were in dynamic relation with internal mission concerns. In taking theology, missionary science, personal experiences and denominational differences seriously, the result was closer attention to how missions themselves were redefined by their encounters in the field - as well as how they imposed their views.[59]

This thesis will build on historical work on missions' cultural encounters and heterogeneity by analysing how medical mission emerged in diverse and complex ways in the Gold Coast and Ghana between 1919 and 1983. In spite of innovation, histories of Ghana have remained focused generally on state healthcare and on individual missions, ignoring the role of culture, theology and politics. In 1978 and 1981, K. D. Patterson's history of medicine in Ghana drew together state records and statistics to map how Ghanaian health changed.[60] Patterson built on the work of David Scott, the director of the Medical Field Units (MFUs) in Ghana in the 1950s and early 1960s, which collated the incidence of disease in Ghana since the early 1900s.[61] After this there was a large gap in the history of Ghanaian medicine until Stephen Addae, a Ghanaian physician, compiled his three volume history which was fully completed in 2012 for a Ghanaian press. Addae's history aimed at recording the basic history of the MFUs, diseases, sanitation, health surveys, colonial medical policies and medical staff. This was combined with a simple history of the 'principal' Ghanaian medical personalities and events, as well as a history of a variety of key institutions. Whilst incredibly detailed, in Addae's account medicine operates in isolation from culture and politics, in a sphere of rationality and technocratic innovation.[62] As medical historians have continually shown, medical culture changes over time by factors that are not only the result of rational decision making but include politics, economics, identities, materiality and ideas. In medical mission especially, the categories of medicine and theology could be transcended and their boundaries could be blurred. In the Gold Coast and Ghana, medical missionary culture operated at many levels and had a variety of layered norms, ideas, politics, encounters and financial choices. These all shaped the kind of medicine and mission that were produced and the kinds of national and international health that were possible.

This thesis will also go beyond the current histories of medical mission in Ghana which have focused on isolated examples and single institutions; in doing so this thesis reveals processes such as the dominance of Catholic medical mission in Ghana that have previously been ignored. First, Barbra Mann Wall's work on

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[59] C. M. Good, *The Steamer Parish: the rise and fall of missionary medicine on an African frontier* (Chicago: University of Chicago Press, 2004) cited in J. Manton, 'Book Review: The Steamer Parish: the rise and fall of missionary medicine on an African frontier' 49.3 *Medical History* (July 2005) pp.381-382.

[60] K. D. Patterson, *Health in Colonial Ghana: disease, medicine, and socio-economic change, 1900–1955* (Waltham, Mass., Crossroads Press, 1981)

[61] D. Scott, *Epidemic Disease in Ghana, 1901-1960* (Oxford: Oxford University Press, 1965).

[62] S. Addae, *Medical Histories Volume 1: From Primitive to Modern Medicine (1850-2000)* (Accra: Eureka Foundation, 2012); S. Addae, *Medical Histories Volume II: Diseases, Medical Institutions, and Biographies* (Accra: Eureka Foundation, 2012); S. Addae, *Medical Histories Volume III: Principal Medical Events and Personalities* (Accra: Eureka Foundation, 2012), these editions were accessed by the Author in the University of Ghana bookshop and are not widely available.

the Holy Family Hospital at Berekum in Ghana published in 2015 has described some of their hierarchies, the diseases they had to treat, their maternal health aims, their nurse training programmes for Ghanaians, as well as how Holy Family hospital was financed.[63] Yet, all this remains disconnected from what these low level processes meant within the local, regional, national and international context, or within longer term changes in medical mission. By contrast with Mann Wall's history, Pascal Schmid's work on the Protestant Basel Mission's Agogo Hospital, published as an article in 2014, shows how the hospital pushed ahead with PHC reforms in the 1970s and how it changed over the decades.[64] Whilst the detailed focus on this hospital provides important analysis on how a single institutional fit within local and national frameworks, these conclusions are largely disconnected from international and inter-denominational processes.[65] Extending beyond their work, this thesis will explore the many types of competing and cooperating denominations which emerged in colonial Gold Coast and postcolonial Ghana, and how mission identities and theologies linked to statecraft. By utilising sophisticated historical categories of medical mission, this thesis offers an original argument within the field, combining the historiography of medical mission with those of international health and development. As a result, previously unrecognised processes, such as the dominance of Catholic healthcare within postwar Ghanaian medical mission can be highlighted, their rich archives can be explored and their extensive effects can be analysed.

ii. METHOD AND SOURCES

New questions, historiographical combinations and categories have led to the finding of under- and unexplored archives for this thesis. Using a wide range of medium-sized medical mission archives as well as official state materials have been necessary to map the many complex voices that make up a history which is local, regional, national and international. By comparing material from several different mission and church archives, alongside the records of state and international organisations' archives, a complex picture of the past can emerge. For exploring Dutch and West German Catholic mission in Ghana this is particularly clear. The result of analysing a wide array of types of evidence shows exactly how new streams of funding, resources and interests were determined by Dutch and West German national reconstruction after the Second World War. This was a change in both medical mission, Ghanaian national health and international health which was not represented in the records of high-level organisations like the WHO or national government

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[63] B. Mann Wall, *Into Africa: A Transnational History of Catholic Medical Missions and Social Change* (New Brunswick, NJ: Rutgers University Press, 2015).

[64] P. Schmid, 'Mission Medicine in a Decolonising Healthcare System, Agogo Hospital, Ghana, 1945-1980' *Ghana Studies* 15/16 (2014) pp.287-331.

[65] Schmid extensively furthers this work on the Agogo hospital and the Basel mission in his recent book, P. Schmid, *Medicine, Faith and Politics in Agogo: A History of Health Care Delivery in Rural Ghana, ca.1925 to 1980* (Lit Verlag GmbH & Co. KG Wien, Zürich, 2018).

stores like the US National Archives. By not relying on high-level archives like these, it is possible to reframe the historical concepts of international health and development by attention to their layers and parts that cut in directions different to the 'hegemonic' or more visible global imaginaries of the time. Moreover, it can show how development and international health programmes were not used simply for their original purposes; concepts and practices were remade and reimagined amidst the expectations and constraints of various contexts and concerns.

In chapter 4, which details the emergence of Catholic medical mission in Ghana driven by West German and Dutch Catholic humanitarianism, the necessary combination of types of evidence is especially apparent. Arguments about German development visions were evidenced with analysis of German articles and speeches from newspapers and magazines such as *Der Spiegel*. These show how narratives of German postwar restoration, shared European humanitarianism and shared human suffering were motivators for the creation, funding and continued support of the Catholic aid organisation Misereor. In the Misereor archives in Aachen (Germany), the financial information, letters and policy reports on West German Catholic funding to Ghana and to the Medical Mission Sisters (MMS) were available. These described how development narratives in Germany operated on the ground in Ghana, how decisions were made and how Ghanaians and medical missions adapted European agendas for their own concerns. To compare these everyday realities and local concerns with international changes, in Philadelphia (USA) interviews were conducted with the MMS and their institutional archives examined. These responses also emphasised the significance of Dutch funding and staffing from MEMISA. Added to these were interviews with missionaries who had been involved in MEMISA and Dutch Catholic mission in Ghana. These were corroborated with written comments from the annual reports of the Catholic hospitals collected by MEMISA stored in the Katholiek Documentatie Centrum in Nijmegen, Netherlands. In addition, international networks were examined in national context by exploring the private archives of the National Catholic Secretariat in Accra (Ghana); listed there were all the Catholic hospitals in Ghana in 1982, showing how funding was distributed, how extensive it was and who benefitted most. Moreover, deepening the analysis of the national and international context, further papers on Misereor and Catholic missionary relations with the CMC and CHAG were accessed at the archives of the WCC in Geneva and SOAS in London. This was all set in an analysis of national health records and Parliamentary Assembly debates from the University of Ghana, Korle Bu Library (Accra), the British Library and the London School of Hygiene and Tropical Medicine

Triangulating historical sources - simultaneously using written and spoken, public and private, ephemeral and published medias - can also offer a course which does not rest on official narrative but can be critiqued for reliability. The problem with the focus on official records, published documents and statistics or institutional reports is that they can privilege the perspective of elites, of the colonial state and of those who are able to print, disseminate and store their output in archives. Using only national public archives and private institutional ones can steer historians toward repeating the narratives of the powerful or those of a small, visible minority who had an interest in posterity. For African Studies, Jan Vansina challenged this sort of history in 1965 with his work on oral tradition, which offered the opportunity to include a wider range of

actors in histories by arguing that interviews and orality should be permissible historical evidence.[66] Interviews, recollections and the analysis of memories, both oral and written, will be a feature of this thesis. These will be used to challenge official historical narratives and empower the voices of forgotten actors. They are not more pure than other documentary forms of evidence and they show much about how a particular group or individual constructs the past from the perspective of the present. However, interviews do not inform the historian on the present alone. As with many other forms of evidence utilised by historians after the cultural turn in the 1980s, when analysed carefully and critically with other sources they can be used to find traces, shapes and patterns of neglected pasts.

This thesis will utilise a plethora of types of media and literary genres which recorded and expressed medical missionary encounters and interactions. These include but are not limited to: inspirational writing, autobiography, correspondence, funeral brochures, unpublished anthropology and ethnography, documentaries, magazine and journal articles, travel diaries and memoirs. These offer contrasting and new perspectives, angles and performances into key historical processes. With regard to the newspapers, as Emma Hunter writes for East African newspapers, they 'constituted spaces in which new identities and new political formations were imagined and critiqued'. In the long-running free Gold Coast presses, Africans could articulate challenges to the state. These newspapers offer insight into literate non-elites Africans who were outside of political power but could voice critique in the public sphere. For example, chapter 1 and chapter 2 show their critiques of which missions and types of development were seen as legitimate and which were not.[67] By contrast, as will be shown in chapter 3, in the first era of postcolonial Ghana these spaces were used to reconstruct Christian liturgy for the purposes of Ghanaian nationalism. Also mission newspapers and magazines offered missionaries a platform on which to read and write their transnational identities within ecclesiastical and eschatological narratives. Finally, as will be analysed in chapter 4, in postwar Germany regional newspapers provided a space for the construction of national identities and suffering bodies in relation to mission, development and Ghana.

Though other types of sources will be utilised, much of the evidential basis of this thesis will be in written reports retrieved from public and private archives. The legislative council debates, parliamentary assemblies, annual health reports of the Gold Coast and Ghana are all currently under-explored by historians. For example, the parliamentary assembly records have not been considered at all by historians of medicine and health in Ghana. These sets of documents are available in Balme Library at the University of Ghana, the library of Korle Bu Teaching Hospital in Accra, the Liverpool School of Tropical Medicine and the British Library. They give a detailed picture of how political and national changes were experience and acted in by the colonial and postcolonial state. The parliamentary records are largely complete for the 1950s and 1960s

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[66] For example, on rumour as historical evidence, see L. White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley: University of California Press, 2000); J. Vansina, *Oral Tradition as History* (Kenya: East African Educational Publishers, 1985).

[67] E. Hunter, *Political Thought and the Public Sphere in Tanzania: Freedom, Democracy and Citizenship in the Era of Decolonization* (Cambridge: Cambridge University Press, 2015) pp.22-28.

when the state was functioning fairly effectively, but tail off in the 1970s and are entirely absent for most of the decade, not returning until the 1990s. Coups, revolutions and burning down of stores, meant that the Ghanaian state has struggled to impose much of a narrative on historical accounts. The effect of this incomplete record is that the early parts of this thesis can analyse in more depth exactly the effect of policies, missions and processes; whereas, in later parts of the thesis, this is unavailable. Thus, only certain kinds of arguments can be made about the 1970s and 1980s and these rely more missionary and international health records and on interviews, than they do on the nation-state's perspective itself. The fragile postcolonial nation has not been able to exert the kind of technologies of rule over information that other nation-states in Europe historically have been able to do.[68] However, especially combined with the archives of medical missions and international organisations, these incomplete parliamentary papers remain a rich but neglected repository for historical enquiries to carve fresh paths and challenge older categories.

[68] J. Allman, 'Phantoms of the Archive: Kwame Nkrumah, a Nazi Pilot Named Hanna and the Contingencies of Postcolonial History Writing' *The American Historical Review* 118.1 (February 2018) pp.104-129.

Chapter 1

'CHRISTIAN CHARACTER' AND HUMAN DEVELOPMENT: MEDICAL MISSIONARIES IN THE GOLD COAST, 1919-1942

Much scholarly ink has been spilt historicising 'development': to show what it was, who it benefitted, what it meant to different people depending on location, who was involved and what were its consequences. Tracing its nineteenth-century origins to its centrality in post-Second World War international planning and African nationalist manifestos, historians have tracked development's use in both the soft and hard forms of colonial and postcolonial power.[69] There are a variety of different ways in which development has been understood and practiced. Frederick Cooper and Randall Packard have argued that its amorphous quality is actually what makes 'development' so useful in bringing together diverse interests under one umbrella.[70] Moreover, as James Ferguson argues, development can function as an 'anti-politics machine' depoliticising poverty and making it subject to technical solutions.[71] Joseph Hodge has shown how this was the case during colonialism too, in which development was produced out of the confluence of scientific expertise and bureaucratic solutions for human and environmental progress, though with continually changing rationales. These projects were often continued by the same colonial 'experts' or in the same structures in the postcolonial era.[72] Furthermore, as Cooper has argued, African nationalists did not attack these presumptions, on the contrary their legitimacy to rule was invested in their ability to be better at producing a farther-reaching development. The catch-all term became the raison d'être in many emerging postcolonial states because they challenged the limits that colonial government placed on 'development' but not on the concept itself.[73]

It was not only its breadth that made development important - it was also because of its more narrow usage in specific traditions and contexts of ideas and practice. Robert Shenton and Michael Cowen in their

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[69] J. M. Hodge and G. Hödl, 'Introduction' in J. M. Hodge, G. Hödl and Martina Kopf, *Developing Africa: Concepts and Practices in Twentieth-Century Colonialism* (Manchester and N.Y, Manchester University Press, 2014) pp.1-34.

[70] F. Cooper and R. Packard, 'Introduction' in F. Cooper and R. Packard (eds.) *International Development and the Social Sciences: Essays on the History and Politics of Knowledge* (Berkeley: University of California Press, 1997) p.7 cited in J. M. Hodge and G. Hödl, 'Introduction' in J. M. Hodge, G. Hödl and Martina Kopf, *Developing Africa: Concepts and Practices in Twentieth-Century Colonialism* (Manchester and N.Y, Manchester University Press, 2014) p. 2.

[71] J. Ferguson, *The Anti-Politics Machine: "Development", Depoliticization and Bureaucratic in Lesotho* (Cambridge University Press, 1990).

[72] J. M. Hodge, *Triumph of the Expert: Agrarian Doctrines of Development and the Legacies of British Colonialism* (Athens: Ohio University Press, 2007) pp.1-20; J. M. Hodge, 'British Colonial Expertise, Postcolonial Careering and the Early History of International Development' *Journal of Modern European History* 8.1 (April 2010) pp.24-26.

[73] F. Cooper, *Africa Since 1940: The Past of the Present* (Cambridge: Cambridge University Press, 2002) pp.38-65.

history of development argue that the concept had a specific trajectory formed by the Saint-Simonians, the Catholic theologian Cardinal Newman, and the industrial improvement work of Joseph Chamberlain.[74] Whilst their history suffers from a narrow, unilinear conception of the history of ideas, it still holds that there were specific traditions of development. Development could be about human progress and civilisation or it could be about environmental and industrial productivity, sometimes these linked as in Hodge's context and sometimes they were separate.[75] It could be seen as a spontaneous process, a structural driving force for change, or it could be seen as a programme of government intervention. Furthermore, it could be imagined differently in different imperial contexts depending on how colonists themselves were shaped by cultural encounters with non-Europeans. For example, Richard Drayton has shown there was a tradition of agrarian Christian development knowledge that emerged out of interaction between the nineteenth-century colonial world and enlightened natural scientific study.[76] Concepts like development were moulded by the particular contexts in which they were practiced as well as in European colonial offices.

Historians are yet to study in-depth the place of religion in the emergence of development in Africa. In the seminal volume *Development in Africa* (2014) which was produced from a workshop drawing together historians across the field at a conference in Vienna in 2011, there is no contribution dedicated to the place of religion. This is not to discredit the volume overall which provides a vital foundation for work on the subject. For example, following Cooper and Packard, the definition of development in the Hodge, Kopf and Hodl's introduction is a valuable starting place for exploring these variations further. They describe development 'as a conscious process of ideas, interventions and practices - one filled with contradictions and fuelled by crises, but also amorphous enough to encompass a wide spectrum of expressions and experiences'.[77] Moreover, analysis of the undertones of Christian thought and local Christian development projects are registered in Emma Hunter's important work on the Tanzanian concept of Maendeleo.[78] This furthered the 1978 work of J. Y. D. Peel on the Yoruba concept of development (which included its Christian formation).[79] However, the expressions and experiences of development in Africa in the volume are mostly restricted to the secular, both for economic and rural productivity and for human and social progress. In Walter Schicho's piece on French and British educational development, he argues that the Gold Coast Governor, Gordon Guggisberg, actively

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[74] M. Cowen and R. W. Shenton, *Doctrines of Development* (Routledge, 1996).

[75] J. M. Hodge, *Triumph of the Expert: Agrarian Doctrines of Development and the Legacies of British Colonialism* (Athens: Ohio University Press, 2007) pp.1-20.

[76] R. Drayton, *Nature's Government: Science, Imperial Britain and the 'Improvement of the World'* (Orient Blackswan, 2005).

[77] J. M. Hodge and G. Hödl, 'Introduction' in J. M. Hodge, G. Hödl and Martina Kopf, *Developing Africa: Concepts and Practices in Twentieth-Century Colonialism* (Manchester and N.Y, Manchester University Press, 2014) pp.1-34.

[78] E. Hunter, 'A History of *maendeleo*: the concept of "development" in Tangayika's late colonial public sphere' in J. M. Hodge, G. Hödl and Martina Kopf, *Developing Africa: Concepts and Practices in Twentieth-Century Colonialism* (Manchester and N.Y, Manchester University Press, 2014) pp.87-108.

[79] J. Y. D. Peel, 'Qluja: A Yoruba concept of development' 14.2 *The Journal of Development Studies* (1978) pp.139-165.

'ran contrary to the intentions and strategies of the Christian missions'.[80] This is overstated and Schicho's article encapsulates a commonly exaggerated distinction between the state and missions, and also between colonial human development and Christian theologies of progress in colonial Africa.

This chapter will add to this debate by showing the significance of Christian theology, medical missionaries, Christian colonial governance and Christian African leaders to the emergence of development policy within the Gold Coast. In doing so, it will argue that previous histories have obscured the significance of religion across the long history of development by letting only certain actors speak in their work. Christianity was not only important in development's early Victorian manifestations or in late twentieth-century FBOs but also in colonial Africa. Building on recent work on mission-government interconnection and critiquing histories of development, this chapter will explore the concept of 'Christian character' within the history of human development in the Gold Coast between 1919 and 1942. It will also examine how the practices of the medical missions emerged within this context of Christian developmentalism. The vision of development in the colonial Gold Coast emerged out of medical missionary interactions, encounters and collaborations.

The main focus of the chapter will be on Governor Gordon Guggisberg's transformation of the Gold Coast between 1919 and 1927 and his work with the Scottish Presbyterian missions, the Phelps Stokes Commission and the Christian African educator J. E. K. Aggrey to formulate a Christian vision for development and health. In the second half, this chapter will explore how medical missionaries outside of the centres of power aimed to reconstruct the African family with Presbyterian domestic norms. The focus of this half of the chapter will be in analysing the expansion of the child and maternal health sector in the Gold Coast, produced by Presbyterian missions with Guggisberg's support. After 1927, when Guggisberg left, for a variety of reasons there was a proliferation of other medical actors in this area. The Catholic church had huge increases in their share of maternal and child health work. By 1942 the Red Cross was an even greater health provider for mothers and children than the colonial state.

i. 'I COME THAT THEY MAY HAVE LIFE': GOVERNOR GORDON GUGGISBERG, J. E. K. AGGREY, PRESBYTERIAN MEDICAL MISSION AND HUMAN DEVELOPMENT IN THE GOLD COAST, 1919-1927

Medical mission began in the Gold Coast in the nineteenth-century but it was minimal in formal professional forms and almost entirely created for the care of the missionaries themselves.[81] The first mission doctor, C. F.

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[80] W. Schicho, '"Keystone of Progress" and *Mise en Valeur d'Ensemble: British and French Colonial Discourses on Education For Development in The Interwar Period'* in J. M. Hodge, G. Hödl and M. Kopf (eds.) *Developing Africa,* p. 229.

[81] Generally, the material focus of the early missions in the Gold Coast was on conversion, primary education and basic industries, especially cocoa production.

Heinze of the Basel mission, died six weeks after his arrival in 1832. This untimely demise discouraged any further discussions of a professional medical mission presence until 1865 when a Gold Coast government medical officer pushed the missions to provide their own doctor, having spent a lot of his time keeping missionaries healthy. After the 1882 health survey of the Gold Coast by the Basel Mission, Dr. Rudolf Fisch was posted to Aburi on the Gold Coast in 1885 and Dr. Alfred Eckhardt to Christiansborg in 1887. With Eckhardt and his nurse dying within four years, Fisch was left responsible for all missionary health and the fledgling outpatient clinics for locals at Aburi and Abokobi. By 1900, there was even some in-patient accommodation at the mission house at Aburi provided, but formal medical work was not the key feature of Protestant missionary practice and evangelism that it was in other areas of nineteenth-century colonial Africa.[82]

The colonial state had also begun medical work in the Gold Coast in the nineteenth-century. Beginning with the Bowdich missions to Ashanti in 1817 and again during the war with the Ashanti in 1863 and 1864, the British colonial government had a medical presence on the Gold Coast. However, until the formal establishment of the colony in 1874 this was minimal, mostly for the military and entirely for Europeans. In 1878 the first civil colonial hospital was founded and more followed by 1880. Moreover, between the 1890s and the early 1900s, the British population tripled. In the 1890s there was some concern to improve sanitation in the towns, with Governor Griffith proposing raising duties in 1891, but these efforts did not flourish until 1908-1912 when the West African Medical Service (WAMS) began a concerted effort at creating indigenous medical and sanitary services. From 1912, Governor Clifford had aimed to extend the medical services to the local populations beyond administrative stations and in 1916 sent his criticism of the exclusion from basic medicine of tax-paying Africans to the Secretary of State for the Colonies. He hoped to create a major African hospital, but these efforts were halted by the First World War. Nevertheless, in 1917 he began creating dispensary schemes, drawing many Africans in as both patients and auxiliaries.[83] These efforts received little help from the Colonial Office. Development was largely aided to promote financial self-sufficiency for the colonies, until the 1930s when there was change in Colonial Office strategy and leadership. Up to the 1930s there were loans and funds being created for colonial development especially in the poorer areas of East Africa; however, there was not a root change from West African supervisory model

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[82] On the other hand, there was medical work of an informal type, see S. Addae, *Medical Histories Volume I: From Primitive to Modern Medicine 1850-2000* (Accra: Eureka Foundation, 2012) pp.12-17; N. Smith, *The Presbyterian Church of Ghana, 1835-1960: A Younger Church in a Changing Society* (Accra: Ghana Universities Press, 1966) pp. 183-189; C. Pettitt, *Dr. Livingstone, I presume? Missionaries, Journalists, Explorers and Empire* (London: Profile Books, 2007). See alsoC. H. Grundmann, 'Mission and Healing in Historical Perspective' *International Bulletin of Missionary Research, 32.4* (October 2008) pp.185-188; D. Hardiman, 'Introduction' in D. Hardiman, *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam-New York, NY: Rodopi, 2006) pp.10-20.

[83] S. Addae, *Medical Histories Volume 1: From Primitive to Modern Medicine (1850-2000)* (Accra: Eureka Foundation, 2012), pp.19, 23-24 and 29-33.

of pre-First World War policy.[84] If Clifford could not raise the funds himself, then his development agenda suffered. By contrast, his successor Guggisberg was able to find his own money.

Major expansion in development and healthcare in the Gold Coast began under Governor Gordon Guggisberg in the 1920s. The turning point in Gold Coast healthcare came in research, education, infant welfare, curative care, sanitation and immunisation, with Guggisberg and the medical officer, Percy Selwyn-Clarke, in 1919. Whilst the colonies were formally in the possession of the Crown and thus the Colonial Office, Governors like Guggisberg had considerable room to make their own agenda - especially if they could source their own funds. As Stephen Constantine argues, the pre-First World War West African model of 'limited Imperial government assistance' was the basis for policy-making into the 1920s and 1930s and that in spite of bureaucratic changes, ideas did not shift and 'Colonial Office permanent staff (still) framed their requests for Treasury financial aid in those traditional terms…primarily to secure the future financial self-sufficiency of the Territories'. Moreover, Constantine writes, 'the efficacy of such a strategy inevitably depended on the ability of colonies to raise their own capital'. It was thus areas without such independent opportunities that relied on the Crown in the interwar period. One of the options for this, other than local taxation and private investment, was to raise loans on the London market which in the interwar period, which according to Constantine, was one of 'the largest sources of loan capital for the Colonial Empire and much larger than Imperial government expenditure.[85] Guggisberg borrowed large sums on the London stock market to pay for roads, harbours, schools and hospitals - one for £4,000,000 at 6 per cent in 1920, another for £4,628,000 at 4.5 per cent in 1925. Whilst the colony debt in 1927 was at £11,000,000 it was considered to be financially sound.[86]

Export rises and taxes benefitted Guggisberg's development agenda. There were also immediate improvements in export revenue at the outset of Guggisberg's tenure. In 1920 total exports and imports reaching £26,000,000 which was an increase of £8,500,000 from 1919. Moreover, in 1920 the value of those imports had increased by over 77 per cent since 1919, rising from around £8,000,000 to around £14,000,000. This was both a result of the increased cost of commodities and increased quantities, for example, in 1920 the value of cotton goods imported doubled from the 1919 level to around £4,000,000. This continued with the total trade between 1920-1926 being double that of 1913 to 1919, and revenue improving by 100 per cent. In spite of a slump in cocoa, revenue increased by over £1,000,000 from 1919 to 1920.[87] Moreover, the cocoa price recovered and in the 1920s was consistently around £50 a ton, reaching £80 and even £120,

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[84] S. Constantine, *The Making of British Colonial Development Policy 1914-1940* (Frank Cass and Company Ltd., 1984) pp.21, 302-304.

[85] As Constantine summarises: 'Between the wars, as before 1914, Colonial Office staff expected colonial development schemes to be initiated by colonial governments' Constantine, *The Making of British Colonial Development Policy 1914-1940*, pp.83, 286-305.

[86] F. M. Bourret, *Ghana: The Road to Independence, 1919-1957* (London: Oxford University Press, 1960) pp.26-32.

[87] H.E. Governor Guggisberg, 'A Review of 1920: Speech in the Legislative Council' *Gold Coast Pioneer* 1.1 (Accra: February 1921) pp.10-11, NEWS8145, NP000449727, British Library (Boston Spa, UK).

compared with an average of £20 to £30 a ton in the 1930s. Though it must be noted that the 1920-3 depression did mean that the initial development plan costing £24,000,000 had to be reduced to £16,648,848.[88] Thus, Guggisberg was able to build on Clifford's legacy and develop the Gold Coast into his own vision of a model colony.[89] This also meant that Guggisberg had considerable independent agency to decide how development was formed in the Gold Coast. The result was that his battle with actors on the ground in the colony mattered more in the actual creation of development policy than negotiations with Colonial Office and Treasury mandarins who were formally in charge.

Between 1919 and when Guggisberg stepped down in 1927, there was huge spending on hospital, dispensary and public health improvements. From the 1st January, 1920 and the 31st March, 1927 there were sixteen new 'African Hospitals' built and three European ones. Sixteen of these facilities were built by the Public Works Department and they ranged in size from the massive 220-bed Gold Coast Hospital in Accra (costing £254,343) to the smallest form which had 'a ward of from 4 to 12 beds, operating theatre, dispensary, offices, stores, and mortuary'. Additions (in many cases the doubling of accommodation) were also made to twelve of the old hospitals, such as in Kumasi where the extension was so large it effectively amounted to a new hospital. An extra twenty dispensaries were also built.[90] In 1915, £25,118 16s. 5d. was spent by the Public Works Department on sanitation, with additional £53,117 2s. 5d. by the head of sanitation, and £1570 4s. 9d. on sleeping sickness prevention.[91] In 1919 Medical, Sanitation and Research Department spending was totalling £121,000 by 1926 it had risen to 294,000 and in 1927 it was at £305,000. Between 1925 and 1927 this spending, combined with that of water supplies, town improvements special anti-plague measures, electric light, hospitals and dispensaries, amounted to between 16.2 and 17.7 per cent of total revenue. This was estimated at £670,000 for 1926-1927 and then £755,000 for 1927-1928 or around 18 per cent of total revenue.[92] By the end of Guggisberg's tenure, the healthcare infrastructure in the Gold

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[88] F. M. Bourret, *Ghana: The Road to Independence, 1919-1957* (London: Oxford University Press, 1960) pp.26-32.

[89] M. A. Havinden and D. Meredith, *Colonialism and Development: Britain and its Tropical Colonies, 1850-1960* (New York: Routledge, 1993) p.158.

[90] 'Construction of Hospitals and Dispensaries, 1920-1927' *Gold Coast Colony Legislative Council Debates No. 1 Session 1927-8,* pp.135-140, Balme Library, University of Ghana (Accra, Ghana).

[91] 'Health' *Gold Coast Colony Legislative Council Debates Session 1916-17* (Accra: Government Press, 1917) p.154, Balme Library, University of Ghana (Accra, Ghana).

[92] In Ceylon's colonial government budget, health received a similar priority between 1921 and 1937; M. Jones, *Health Policy in Britain's Model Colony: Ceylon (1900-1948)* (Andhra Pradesh, India: Orient Longman, 2003), pp.42, 47, 52-60, 75-78, 152. However, there were exceptions and neglected diseases, people and places. Jones shows this well in her work on Jamaica. In the Gold Coast, N. J. K. Brukum has shown how medical work and infrastructure generally in the Northern Territories was 'under-developed' throughout the Guggisberg years. See M. Jones, *Public Health in Jamaica, 1850-1940: Neglect, Philanthropy and Development* (University of the West Indies Press, 2013) and N. J. K. Brukum, 'Sir Gordon Guggisberg and Socio-Economic Development of Northern Ghana, 1919-1927' *Transactions of the Historical Society of Ghana: New Series 9* (2005), pp.1-15.

Coast had well more than doubled and there were around 37 hospitals with around 800 beds.[93] This was all in the context of expansion of railways by 233 lines and 250 further lines surveyed costing £5,948,000, and 3338 miles of road were built bringing the amount up to 4688, and by 1928 the Takoradi harbour opened having cost a total of £3,230,912.[94]

Given the limited financial backing of the Colonial Office, Guggisberg's cooperation or conflict with local Europeans, missionaries, Africans and the WAMS in the creation of this healthcare development were more significant than those in the metropole. Local relations were critical because, even on the eve of the Second World War, the administrative division of the African colonial service (including District Officers and central secretariat) only numbered around 1,200 men.[95] Colonies could not administratively spread much beyond their capitals or, in the Gold Coast, much beyond the South and Asante. With the Gold Coast colonial government stretched across a large land mass, relations with non-European and non-state actors were vital. How Guggisberg conducted and imagined these communities could shape how 'development' was managed and executed, and who was involved. First, relations with chiefs were particularly significant because the Gold Coast followed an 'indirect rule' system, as made famous by Lord Lugard in Nigeria where resources were scarce and Islamic communities large in the North particularly.[96] Second, Guggisberg had to negotiate with local Europeans who resisted when he tried to add more African doctors to their notoriously racist healthcare service.[97]

A key group to which Guggisberg had to link was that of the medical missions, especially the Scottish Presbyterians. In the Gold Coast alone there were 162 missionaries in 1908, dropping to 66 in 1919 because of the expulsion of the Basel Mission in 1917.[98] This was as a result of the British colonial government's fear

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[93] 'Review of Public Health Work, 1920-1927' 3rd March 1927, *Gold Coast Colony Legislative Council Debates No. 1 Session 1927-8,* pp.185-186, Balme Library, University of Ghana (Accra, Ghana).

[94] F. M. Bourret, *Ghana: The Road to Independence, 1919-1957* (London: Oxford University Press, 1960) p.29.

[95] J. W. Cell, 'Colonial Rule' in J. Brown and Wm. R. Louis (eds.) *The Oxford History of the British Empire: Volume IV: The Twentieth Century* (Oxford: Oxford University Press, 1999) pp.232-255.

[96] Wm. R. Louis, 'Introduction' in J. Brown and Wm. R. Louis (eds.) *The Oxford History of the British Empire: Volume IV: The Twentieth Century* (Oxford: Oxford University Press, 1999) pp.1-47.

[97] The government sent the African, Dr. Tagoe, to take charge of the hospital and operating theatre at Dunkwa in 1927. Tagoe was greeted by formal protest from Dunkwa's local Europeans. The state demanded that Tagoe remain in place in order to 'give the lie direct to any possible assertion by ill-advised persons that any British Government shows any racial prejudice in dealing with the governed'. At the time, there were only three African medical officers out of the sixty-seven total Medical staff in the WAMS. 'The Case of Dr. Edward Tagoe' *Gold Coast Colony Legislative Council Debates No. 1 Session 1927-8,* pp.188-189, Balme Library, University of Ghana (Accra, Ghana). See also, A. Patton Jr., *Physicians, Colonial Racism, and Diaspora in West Africa* (Florida: University Press of Florida, 1996) pp.156-157; R. Johnson, "An All White Institution": Defending Private Practice and the Formation of the West African Medical Staff ' *Medical History 54.2* (2010) pp.237-254.

[98] *Government of the Gold Coast: Medical and Sanitary Report for the Year 1908* (Gold Coast: Printed by the Government Printer, 1909) p.6, Korle Bu Teaching Hospital Library (Accra, Ghana); *Government of the Gold Coast: Report on the Medical Department for the Year 1920* (Gold Coast: Government Press, Accra, 1921) p.9, Korle Bu Teaching Hospital Library (Accra, Ghana).

that even Swiss missionaries could be German spies. The Basel and the Bremen missions (amongst the Ewe in Togoland) were forced to leave the Gold Coast indefinitely; it would be a decade before many would return. On the eve of the First World War the medical mission facility at Aburi had been consistently visited by Europeans and Africans and there were plans to turn it into a major hospital. This progress was arrested by the evictions. The Germans were replaced by Scottish Presbyterians in 1919 who were cut from a similar theological cloth but struggled to staff even the small Aburi hospital.[99] The Presbyterians had to be given financial support from the government in order to send to the Gold Coast mission two women mission doctors.[100] Yet, with this support and basis they were able to expand. The two initial missionaries became part of a wider shift amongst mission and state toward the creation of child welfare clinics. There were 66 missionaries in 1919, by 1927-8 there were 152, by 1935 there were 274; as will be shown in later chapters growth continued after the Second World War with 1946 in 499 and 658 in 1951.[101] Given their focus on key areas of healthcare, Guggisberg had to work closely with them in order to create his own vision for development. He shrewdly shored up support at the outset of his development agenda, by tying himself politically and theologically to missionaries.

At the same time as he was empowering the Presbyterian missions, Guggisberg restricted Catholic missions until convinced of their loyalty. Up to 1926 there was struggle and negotiation between Guggisberg and the Presbyterians, and the Catholic missions. In 1906 a White Fathers Catholic mission post in the Northern Territories of the Gold Coast had been founded by the 'Vicarde Apostolique du Soudan' (later Ouagadougou) but had since not developed independently.[102]. Tension arose in 1924 when the Gold Coast government had decided to set up schools in the North with Protestant missions, which L. Barsalau noted would have been harmful to the already financially struggling Catholic mission. In order to stop this 'invasion protestante' the White Fathers attempted to expand their schools and missions in spite of a lack of finances and personnel. Immediately they encountered government opposition who, according to Barsalau, were concerned that French missionaries might be spies in the service of the neighbouring colony. Thus, the White Fathers appealed to Rome to separate them from the Haute Volta diocese and create an autonomous mission at Navrongo. The Gold Coast government responded immediately to this, offering to send one

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[99] N. Smith, *The Presbyterian Church of Ghana, 1835-1960: A Younger Church in a Changing Society* (Accra: Ghana Universities Press, 1966), pp.183-189.

[100] Gold Coast Mission Council (19th July, 1921-20th August 1927) pp.42-97, Gold Coast. Minutes of Mission Council 1918-27, D51, Acc.7548. Church of Scotland, National Library of Scotland (Edinburgh, UK).

[101] *Government of the Gold Coast Report on the Medical Department for the Year 1920* (Gold Coast: Government Press, Accra, 1921) p.9, Korle Bu Teaching Hospital (Accra, Ghana); *Gold Coast Colony Report on the Medical and Sanitary Department for the Financial Year 1928-1929* (Gold Coast: Government Press, Accra, 1929) p.15, Korle Bu Teaching Hospital (Accra, Ghana); *Report on the Medical Department for the Year 1947* (Accra: Government Printing Office, 1948) p.12, Korle Bu Teaching Hospital (Accra, Ghana); *Report on the Medical Department for the Year 1951* (Accra: Government Printing Office, 1952) pp.2-3, Korle Bu Teaching Hospital (Accra, Ghana).

[102] Rapport 1925, Navrongo (38/12), La Nuova Seria (1893-1938), Archivio Generale della Sacra Congregation de Propaganda Fide (Vatican City, Rome).

hundred pounds in a grant when it had been completed. In June 1927 the White Fathers Catholic mission became the 'Prefecture Apostolique de Navrongo'. After this there were few conflicts with the government who were described by the Catholics as assuring their liberty of conscience.[103] It was only in non-religious training that the Governor demanded 'final control'. By 1930 the mission had expanded and had a medical dispensary in every mission station which gave government employees free treatment. The Catholic mission had also been able to set up a special leprosy centre at Navrongo. Nevertheless, the Presbyterians still had power over the French missions. A. G. Fraser was deployed to inspect the Catholic mission schools - though he was very positive about the progress that was being made.[104]

Guggisberg's relationship with the Scottish Presbyterian mission became incredibly close and led to the formation of a shared vision for Christian development. In 1919, A. W. Wilkie became the head of the Scottish Presbyterian mission in the Gold Coast that took over from the Basel mission. Guggisberg, Wilkie and Fraser (who oversaw educational development) became close allies. In Wilkie's diary he describes several dinners with the Governor and one meeting where they discussed how medicine would be developed in the Gold Coast at Guggisberg's bedside whilst he was suffering from an illness. Across his time as Governor, Guggisberg became personally and formally linked to missionaries, even writing books and reports with them, partly because he himself was a practising Anglican. As well as drawing the government into mission, Wilkie also joined the board of visitors for the colonial hospitals, this in addition to his more formally ecclesiastical duties travelling widely assessing disease outbreaks and standards in mission schools.[105] His relationship and shared theology with Guggisberg was important for the hospitals, schools and clinics that were built, how they were managed, who they were to service and what kinds of African citizens were desired. In Guggisberg's own writing as well as in private conversations this theological and political tie was emphasised. It was consolidated and disseminated in order to proclaim the kind of Christian statesman he wanted to be. Crucially, Walter Schicho far overstates the case when he argues that for Guggisberg character-training was to be 'imported by the coloniser…(and that) Neither the traditional authorities, nor the Christian missionaries, were granted the capacity to train leaders'. Guggisberg was not hostile to missionaries and was in fact very interested in drawing them in as well as furthering the universal aspects of their work by bringing in more Christian leaders. Again, unlike in interwar Ceylon where the state

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[103] This nuances Benedict Der's historical account of Northern Ghana in which he argues that it was not until pro-Catholic district commissioners were installed that the White Fathers could expand; B. Der, 'Church-State relations in Northern Ghana, 1906-1940' *Transactions of the Historical Society of Ghana* 15.1 (June 1974) pp.41-61.

[104] L. Barsalau, 'Rapport Quinquennial à la sacrée congregation de la Propagande' (Navrongo, 22 October 1930) La Nuova Seria (1893-1938), Archivio Generale della Sacra Congregation de Propaganda Fide (Vatican City, Rome).

[105] There is sadly no detail in Wilkie's diary as to exactly how he assessed standards or what came of his reports. Merely the extent of his travelling is documented; A. W. Wilkie, Gold Coast. Scottish Mission Record Book 1918-1938, D55, Acc. 7548, Church of Scotland, National Library of Scotland (Edinburgh, UK).

produced healthcare development without missionaries, in the Gold Coast Protestant ideals and staff were a critical feature of Guggisberg's vision of development in a model colony.[106]

Guggisberg and the Presbyterian missionaries constructed a specific Christian practice and vision for human development. In 1929 Guggisberg published on the 'development of a race' with Fraser. In this work they laid out a vision for universal development in which Africans would be incorporated into the worldwide Christian church. From there the 'race' would be re-engineered by the terms of the 'abundant' life offered in Christ, as described in the Gospel of John. Guggisberg envisaged this form of Christian human development to be the true outworking of policies of 'trusteeship' and the colonial civilising mission. Guggisberg wrote that:

> Accepting trusteeship as our policy, it is advisable to have a clear idea of what the development of a people means. In the highest sense the development of a people should be based on the Christian ideal…A. W. Wilkie, the experienced missionary and educator said…"…in the words of our Lord: 'I am come that they might have life, and that they might have it abundantly…'"…Nothing could more adequately express the highest and widest meaning of the word development as applied to the people.[107]

In this description, development as 'applied to the people' is expressed in terms of the highest ideals of Christian evangelism, to invite the stranger into the fold of the church. They wrote little about the outworking of this development for direct economic progress, the aim was for the creation of a racial leadership in Christ. Wilkie was quoted by Guggisberg because these ways of imagining development had emerged from their discussions, from Wilkie's sermons and from reading Wilkie's work.

Guggisberg had his own Christian agenda for human development with which he wanted to influence both mission and government schools, and perform to a wider English imperial audience. Guggisberg's vision for human development was not only Christian because of the political significance of his relationship with Wilkie, it also emerged from his own sense of identity. In the *Future of the Negro* he wrote that:

> Our task today is infinitely more difficult, including as it now does moral and intellectual as well as material, development. It is precisely because we have this dual task that we want more and more the best that England can give us; not only the best in science and professions, but men and women imbued with the real Christian spirit - the spirit of the life and teachings of Jesus, love of mankind and a desire for service…there is no greater work that an Englishman can do for mankind.[108]

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106 M. Jones, *Health Policy in Britain's Model Colony: Ceylon (1900-1948)* (Andhra Pradesh, India: Orient Longman, 2003).

107 G. Guggisberg and A. G. Fraser, *The Future of the Negro: Some Chapters in the Development of a Race* (London: Student Christian Movement, 1929) p.64.

108 G. Guggisberg and A. G. Fraser, *The Future of the Negro: Some Chapters in the Development of a Race* (London: Student Christian Movement, 1929) pp.99-100.

As Hodge describes of J. H. Oldham (who wrote extensively on Christianity, race and colonialism) in the *Triumph of the Expert* economic development and Christian human development were tied together in 1920s and 1930s British imperialism.[109] For Guggisberg there was similar coordination but he went further to foreground morality over technology. Material progress, technological advancement and professional aid was only a part of the role of English colonialism, in his vision. More than economic, technocratic or scientific expertise, colonialism required 'moral and intellectual' teaching. In this regard, such a human progress would be modelled by 'men and women imbued with the real Christian spirit' whose lives were embedded in Biblical teaching and in the outworking of the love found through a life in Christ. Guggisberg, himself a Canadian, saw it as a particularly English calling to do the works of the national faith for the sake of mankind. Guggisberg wanted a specific type of Christian developmentalist colonial state. These statements were directly disseminated to the wider imperial audience in order to bolster the moral image of his colony as well as to entice further colonisers with opportunities for performing certain muscular Christian identities in the Gold Coast. This dissemination can be registered in the book's positive contemporary reviews by writers in the International African Institute and the Journal of the African Society.[110] Moreover, it was given wide coverage amongst potential recruits to both medical missions and the Colonial Service by being published by the Student Christian Movement, which between 1890 and the 1960s was Britain's largest student religious body.[111]

This Christian vision for human development was bound up with the improvement of healthcare in the colony. In the *Future of the Negro* the authors wrote that the elusive power of Christian character might be imbibed by teaching sanitary hygiene and thus 'moral hygiene'. This had social power to change the character of the race, in Guggisberg's eyes, as well as the individual African believer or citizen. Importantly, the authors wrote that all this could be as much the hallmark of government schools and hospitals, as the mission ones. This was because often missions suffered by becoming the 'battle-ground of denominational enthusiasms'. Again, for Guggisberg, development was 'spiritual' and material growth, he wanted practicing and believing Christian staff to fill education and medicine in the Gold Coast:

> Some people would prefer to deal with character training and religious teaching separately; others to omit the latter entirely. Neither of these courses can be followed if successful results are to be achieved. The character of a child,

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[109] J. M. Hodge, *Triumph of the Expert: Agrarian Doctrines of Development and the Legacies of British Colonialism* (Ohio: Ohio University Press, 2007) pp.136-143.

[110] F. Shelford, 'Review: The Future of the Negro by Sir Gordon Guggisberg, K. C. M. G. and A. G. Fraser, M. A.' *African Affairs XXIX (CXIII)* (London, 1929) pp.104-105; H. S. Keigwin, 'Review: The Future of the Negro. By G. Guggisberg and A. G. Fraser' *Africa 4.3* (July 1931) pp.372-373.

[111] S. Constantine, *The Making of British Colonial Development Policy 1914-1940* (Frank Cass and Company Ltd., 1984) p.289; S. Brewitt-Taylor, 'From Religion to Revolution: Theologies of Secularisation in the British Student Christian Movement, 1963-1973' *The Journal of Ecclesiastical History 66.4* (October 2015) pp.797-811.

> in whatever degree it may be inherited, cannot be developed unless religion forms the basis of character training. By religion, I mean Christian habits of life and thought. However much some may hold the view that Christianity had failed to maintain peace and goodwill in the world, the fact remains that it is the highest practical system of life that the world has known…I wish to emphasize that character training, unlike the Scriptures, cannot be a subject of instruction; but, like real Christianity, it can unconsciously be imbibed by the pupil in every act of school life if opportunities are made.[112]

Both in clinics and in schools, the vision for human development was that it would be 'imbibed' in an unconscious way, by the 'real' Spirit of Christianity rather than by direct Gospel propagation. Here the move away from literal evangelism of the Word, to the evangelism of the Spirit, was certainly not a secularising shift. In this section of *Future of the Negro* the authors were laying out a way of developing the race through the development of 'habits of life and thought'. Godly character would emerge through the 'highest practical system of life' not simply the learning of scriptural truths. Importantly for healthcare, Guggisberg conceived of human development in terms of the non-material power of Christ on the unconscious mind. Thus, clinics with the atmosphere of the Holy Spirit could be as powerful in the human development of the race, as schools and direct 'religious teaching'. Moreover, Fraser made the connection even more explicit arguing that:

> Mission hospitals and welfare centres can be run at far less cost than Government institutions. But their greatest advantage is that in them the spirit of service is eager and constant…Mission control, too, generally allows much more adaptability to local circumstances and gives more time to the doctor to do his real job, and by long continuance in one place, to know and be known by the people. Thus he becomes a trusted friend.[113]

In this description of the advantage of medical missions over those of Government, Fraser depicts mission in the classic terms of long-term 'continuance', trust and relationship in one place. This would both allow the missionaries to be in control and adapt to local culture, but also to show through the spirit of 'eager and constant' service, the truth of the Gospel.

In high-level medical education, the government and mission worked closely with international partners in the Phelps Stokes Commission to advance the Christian vision for human development in the Gold Coast and more widely. As with Gold Coast developmentalism generally the network around the drive for elite medical education included Guggisberg, Presbyterian missionaries and Fraser. What was different about this area was that these key figures in Gold Coast development were brought together and promoted by an

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[112] G. Guggisberg and A. G. Fraser, *The Future of the Negro: Some Chapters in the Development of a Race* (London: Student Christian Movement, 1929) pp.91-92.

[113] G. Guggisberg and A. G. Fraser, *The Future of the Negro: Some Chapters in the Development of a Race* (London: Student Christian Movement, 1929) p.122.

international organisation, the Phelps Stokes Commission. The Phelps Stokes education survey in 1920-1921 provided a platform and funding in the Gold Coast for colonial government, mission-educated Africans, Protestant missions, American education philanthropy and African-Americans to work together on, amongst other things, high-level medical education. A central figure in this process was J. E. K. Aggrey, who had been funded by the A.M.E. Zion Church (the first American mission church in the Gold Coast) to return to the United States to study at their Livingstone College where he spent two decades as a student and teacher. Through this, Aggrey had been drawn into Phelps Stokes by its educational director Jesse Jones, whom Aggrey met when Jones was a preaching as a chaplain at Hampton Institute. Aggrey became one of Phelps Stokes key speakers around Africa because of his passion for racial harmony based on cooperation and the Tuskegee model of education led by Booker T. Washington - an educated black man who was notable for his 'accommodationist philosophy' of working closely with whites (in contrast to W. E. B. Du Bois's more radical challenges to the status quo).[114] Through the Phelps Stokes' first education survey in Africa (1920-1920) Aggrey developed a close relationship with Guggisberg and the Gold Coast mission leaders, who had their views on education promoted and shaped by the survey.[115] As Guggisberg wrote in the first commission report, the education survey and Aggrey's visit to the Gold Coast 'was productive of great good' and showed that 'Our educational progress is proceeding steadily in the right direction'. Wilkie was also quoted extensively. In spite of its challenges to imperial rule, the survey's conclusions became influential for the Colonial Office who suggested they produce a second Education survey of Africa, because the first in 1920-1921 was so successful.[116] They did so and the second in 1924 was partly funded by the Rockefeller Commission, another international organisation embedded in mission networks.[117] The Phelps Stokes Commission brought together diverse actors in the mid-1920s under similar ideas and aims to begin to build an elite college and medical school. In the Gold Coast, the suggestions became a new education ordinance in 1925, taking effect two years later.

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[114] S. M. Jacobs, 'James Emman Kwegyir Aggrey: An African Intellectual in the United States' *The Journal of Negro History* 81.1/4, (Winter - Autumn, 1996) pp.47-61.

[115] As James Campbell rightly emphasises, the Phelps Stokes survey was about promoting the Tuskegee philosophy in Africa, not creating new ideas altogether; J. T. Campbell, *Songs of Zion: The African Methodist Episcopal Church in the United States and South Africa* (Oxford: Oxford University Press, 1995) pp.311-312.

[116] J. Illife, *A Modern History of Tanganyika* (Cambridge: Cambridge University Press, 1979) p.338; Y. G-M. Lulat, *A History of African Education from Antiquity to the Present: A Critical Synthesis* (Westport, CT: Praeger Publishers) pp. 36, 214-215.

[117] The Rockefeller Foundation itself had strong links to Baptist mission and funded Christian medical education in China; E. H. Berman, *The Influence of the Carnegie, Ford and Rockefeller Foundations on American Foreign Policy: The Ideology of Philanthropy* (Albany: State University of New York Press, 1983) p.23; J. Farley, *To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation (1913-1951)* (Oxford: Oxford University Press, 2004) p.307; Q. Ma, 'The Peking Union Medical College and the Rockefeller Foundation's Medical Programs in China' in W. H. Schneider (ed.) *Rockefeller Philanthropy and Modern Biomedicine: International Initiatives from World War I to the Cold War* (Indiana: Indiana University Press, 2002) pp.159-184; J. R. Stanley, 'Professionalising the Rural Medical Mission in Weixan, 1890-1925' in D. Hardiman (ed.) *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam-New York, NY: Rodopi, 2006) pp.115-137.

In conceiving of elite medical education, African American accommodationist theory intersected with older colonial ideas of race and Christian character. For the Gold Coast the key effect of the Phelps Stokes Commission was to form a mission and government team which would build and staff the elite college of Achimota on the Christian accommodationist lines of Booker T. Washington and J. E. K. Aggrey, shaping for generations the nation's vision for developing healthcare.[118] The Gold Coast government aimed to ensure that medical students did not have to leave the Gold Coast because, as the legislative council put it in 1927:

> owing to the absence of suitable hostels in Great Britain, it was impossible for Africans there to develop character satisfactorily….(the conditions are) in the majority of cases injurious to his character. His previous education in the Gold Coast has not prepared him to meet them…the only remedy was for the Gold Coast to start a medical school of its own…it was probable that during the first few years of the school's existence it might be necessary for African students to complete their training in Great Britain; but that there would be less harmful result owing to the opportunities for developing character that would be given both at Achimota and in the Medical School.[119]

As already described in Guggisberg's development theorising, Christian 'character' was at the centre of these plans. Guggisberg had also wrote of his concerns about the dangerous influence of foreign travel on elite Africans in a 'Review of 1920' for the *Gold Coast Pioneer* in which he argued that:

> A few of our citizens, unfortunately only a few, have received a higher education. As this, however, has usually been received in Europe it by no means follows that it does not bring with it a certain danger, for it must be dangerous to send a youth away to a foreign country during the most impressionable time of his life when he incurs the risk of becoming so impressed with European institution as to run a grave change of losing touch with his people…a race must learn to think before it can cope with the great rush of a civilisation which is alien to it.[120]

Here Guggisberg and the Presbyterian missionaries' conception of the racial development directly impinged on the way in which development spending was focused. Given his elitist model, a higher education was vital to ensuring that Christian character drove the African leaders who were increasingly taking a key role

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[118] E. H. Berman, 'American Influence on African Education: The Role of the Phelps-Stokes Fund's Education Commissions' *Comparative Education Review* 15.2 (1971) pp.132-145, and 'Tuskegee-in-Africa' *Journal of Negro Education* 48.2 (1972) pp.99-112; S. Yamada, 'Educational borrowing as negotiation: re-examining the influence of the American black industrial education model on British colonial education in Africa' *Comparative Education* 44.1 (February 2008) pp.21-37; K. King, *Pan-Africanism and Education: A Study of Race, Philanthropy and Education in the southern states of America and East Africa* (Clarendon Press, 1971).

[119] 'General Conditions Governing Medical Training of Africans' *Gold Coast Colony Legislative Council Debates Session 1927-8,* pp.147-148, Balme Library, University of Ghana (Accra, Ghana).

[120] H.E. Governor Guggisberg, 'A Review of 1920: Speech in the Legislative Council' *Gold Coast Pioneer* 1.1 (Accra: February 1921) pp.10-11, NEWS8145, NP000449727, British Library (Boston Spa, UK).

within government. For example, in 1921-22 there were 57 'Special Native Appointments' to the government, compared with 26 in 1919. These were within technical departments, but the role of native authorities and chiefly power within the legislative assembly was also growing.[121] For Guggisberg, human development in the Gold Coast was also imagined in terms of the touch between leaders and the people; education had to ensure that there was not irreparable socio-political divisions.

Within their vision for human development Guggisberg and Aggrey were concerned about the pace of change within African men. Guggisberg was not alone being anxious about how progress might detach educated African men from their communities and traditions. This was not a new worry. The popular moralising tract *Marita or the Folly of Love* serialised in a newspaper in the Gold Coast in 1886 challenged colonial legal marriage as unsuited to the civilisational position of the African man. Crucially, the text navigated divisions in literacy and their dangers for unequal power within male-female relations. For example, there was particular concern that men who could read should not run bible study groups where they could control women. *Marita* provided a script for an African civilised masculinity which was not too detached from past norms.[122] These concerns had been shared by Fantes like Aggrey in 1902 who, through the Aborigines Rights Protection Society, argued that they wanted: 'Educated Fantis not Europeanised natives'. Guggisberg's concerns about racial development were related to these older models of careful pace of change aiming not to disrupt racial unity but also to map out a civilised African masculinity alongside ensuring traditional norms were included in development. His trade schools at Kyebi, Asante-Mampong, Asuantsi and Yendi in the 1920s aimed to ensure educated Africans also could still work with their hands, not thinking it to be a 'disgrace'.[123]

For Guggisberg, development funding in the interwar Gold Coast was also divided up based on a model of extraction of labour from the South, facilitating the transition to cash crops in Asante and civilisational human development (schools and universities) on the coast. Guggisberg's vision for human development in the capital was structured around a geography of exploitation and capitalist progress in Asante where cocoa and mineral exports such as gold were largely produced. In order to produce the labour needed for gaining tax revenues on income and on exports, the Northern Territories were viewed as a labour reservoir which should not be developed too much. As John Nott's path-breaking work on the spatial aspects of nutritional health has shown, education was actively held back in the north to all but the most exceptional boys.[124]

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[121] R. S. Gocking, *The History of Ghana* (Westport, CT.: Greenwood Press, 2005) p.61; H.E. Governor Guggisberg, 'A Review of 1920: Speech in the Legislative Council' *Gold Coast Pioneer* 1.1 (Accra: February 1921) pp.10-11, NEWS8145, NP000449727, British Library (Boston Spa, UK).

[122] S. Newell (ed.) *Marita: or the Folly of Love, A Novel by A. Native* (2002) pp.1-37, 42-49, 53-75, 93-99, 120-144.

[123] R. Addo-Fenning, 'Christian Missions and Nation-Building in Ghana: An Historical Evaluation' in J. L. Cox and G. ter Haar (eds.) *Uniquely African: African Christian Identity From Cultural and Historical Perspectives* (Africa World Press, 2003) pp.206-207.

[124] J. D. Nott, *Between Famine and Malnutrition: Spatial aspects of nutritional health during Ghana's long twentieth century, c.1896-2000* (Unpublished Doctoral thesis, University of Leeds, 2016) p.121.

Instead, any development such as with yaws and trypanosomiasis was focused on ensuring stability in the animal population and health amongst labouring men. By contrast, measles which probably was one of the biggest killers in the North even in this period was almost completely ignored. The Gold Coast report Ministry of Health report in 1953 noted that the disease had not been discussed in previous annual reports.[125] In Asante, much medical mission work was begun in the interwar years. Only with determination and some conflict could missionaries set up any health institutions in the North before the mid-1940s, the real expansion had to wait until the wider agenda of the first development plan in the 1950s. In the South, there were extensive discussions about the extent of development. However, the major concern for the South and Accra was to produce a cadre of Christian leadership which could manage the other regions. Guggisberg's human development relied on extraction and coercion in the North and high level leadership development in Accra, and the extent of his funding was shaped by geographies of neglect.

A final nuance was that for the Cape Coast Fante, Aggrey - Christianity, mission and the medical school figured in disputes over authority within colonial governance and how the sacral space of 1920s Accra was mapped. There were also divisions within regions and between ethnic groups, as well as across the colony. For Aggrey, the medical school work was linked to harmony between the races on the kinds of gradual training programmes at Tuskegee. It was also linked to the long-term attempts of the Cape Coast Fante elite (of which Aggrey was one, given his ethnicity and where he had studied, fought for and grown up) to push for political power and status within the capital since the early twentieth-century. For decades the Fante elite had despised the role of the Ga in Accra and challenged it with a modernising Christian discourse of access to education and rejection of traditional culture. Frustrated at being away from the centre of power, in 1903 the Cape Coast Fante elite through their paper the *Gold Coast Leader*, had fulminated at the 'fetish' dances that were allowed in Accra and argued that these should not be tolerated by any 'civilized and Christian government'. For Aggrey, the inequalities within power on the coast were being repeated in battles over elite medical education in the 1920s. In his arguments was the continued desire to ensure the Cape Coast elite a position within the increasing inclusion of Africans to the legislative assembly and technical advisory roles. It was not new for such arguments to utilise concepts of civilised Christianity in government to support these claims to ethnic power. Yet, this was not simply pragmatic. Ethnic disputes intersected with religious battles for Accra; a landscape considered sacral by the Ga-Adangme tribes whose ancestral and ritual topography continued to matter in the capital in the 1920s. As John Parker has shown there were a variety of competing visions of the city in 1920s Accra with Christianity 'gradually form(ing) a new moral community and offering an alternative vision of the future'.[126] At stake here was not simply financial and political power but also ritual power. Placing the medical school on this landscape, for Aggrey and Guggisberg was a part of the

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[125] *Report of the Ministry of Health 1953* (Accra: Government Printing Office, 1953) p.29, Korle Bu Teaching Hospital Library (Accra, Ghana).

[126] J. Parker, *Making the Town: Ga State and Society in Early Colonial Accra* (Oxford: James Currey Ltd., 2000) pp. 170, 184-6, 240-241.

ongoing conflict between civilising Christian mission, traditional religion and government over who had spiritual authority within the colonial capital.

In spite of colonial intentions, the medical school did not materialise in Accra until the 1960s; however, through the Phelps Stokes Commission, missionaries and the colonial government, Achimota College did embody ideals of elite Christian human development. Most of the Phelps Stokes suggestions were unable to be put into practice; their standards were simply too high and in the Gold Coast by 1930, 150 'bush schools' had to close, at a time when only 10 per cent of the children in the colony had any education.[127] The medical school also never appeared. However, in 1924 an elite school called Achimota was set up by Aggrey, Guggisberg and (the co-author of *The Future of the Negro*) Fraser, who had met Aggrey at J. H. Oldham's home in Surrey.[128] It was financed originally with £607,000 which was around 85 per cent of the entire 1920s development budget, and then in the 1940s it was given another £127,000 through the Colonial Welfare and Development Act.[129] Achimota became the school which produced the majority of the politicians, lawyers and doctors of independent Ghana who began their careers in the 1950s and 1960s. These figures imbued the school and its pupils with an international Christian vision of race, development and medicine.[130] After Aggrey's death in 1927, Guggisberg said of him at the memorial service that:

> he had two incalculably valuable assets - faith in God and faith in his people…Only the real faith that lifted him above himself could have sustained through the last three years and he had that faith - the real faith of a real Christian…Aggrey indeed was the finest interpreter which the present century has produced of the white man to the black.[131]

Fraser added: 'He was one of the purest men I have ever met…He it was who persuaded me to go out to Achimota'.[132] Alongside these articles were numerous tributes in the *Gold Coast Leader* by Africans. Aggrey disseminated and embodied a very specific kind of Christian development culture within Achimota which

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[127] F. M. Bourret, *The Road to Independence, 1919-1957* (Stanford: Stanford University Press, 1960) pp.26-35.

[128] Oldham was a missionary statesman who was critical in combining government and mission in the interwar years; W. E. F. Ward, *Fraser of Trinity and Achimota*, (Accra: Ghana Universities Press, 1965) p.169; K. Clements, *Faith on the Frontier: A Life of J. H. Oldham* (Edinburgh: T and T Clark, 1999).

[129] P. Foster, *Education and Social Change in Ghana* (London: Routledge & Kegan Paul, 1965) p.167; Havinden and Meredith, *Colonialism and Development*, p.219.

[130] This theme will be picked up in chapter 3 with Kwame Nkrumah, and chapter 5 with the Ghanaian Christian international health worker Francis Chapman Grant - both of whom were educated at Achimota.

[131] 'Tribute from Sir Gordon Guggisberg, 3rd August 1927' *The Gold Coast Leader* (September 17, 1927) p.8, MFM.MC.1788, British Library (Boston Spa, UK).

[132] 'Tribute from the Rev. A. G. Fraser. Principal of the Prince of Wales's College, Achimota Gold Coast 3rd August, 1927' *The Gold Coast Leader* (September 17, 1927) p.8, MFM.MC.1788, British Library (Boston Spa, UK).

had implications for healthcare even when the medical school was not set up. All this was in the context and network of wider mission-government development visions and partnerships.

ii. MEDICAL MISSIONARIES AND THE EXPANSION OF THE COLONIAL STATE: MATERNAL AND CHILD HEALTH, 1919-1942

Away from the elite visions in the centres of colonial power the Guggisberg-Presbyterian mission agenda had other effects for human development and healthcare for the rest of the colony. Particularly significant was the growth of maternal and child healthcare in the Gold Coast. As elsewhere in British colonial Africa, missions aimed to reformulate domestic structures and produce paragons of Christian motherhood through hygiene practices and the rituals of child and maternal health. The effects of these concerns were significant in the south of the colony and in Asante, and linked again to the geographic model of colonial extraction around which development in the Gold Coast was structured. As well as in the battle for central leadership and elite power, Christian missionary models of human development figured in the construction of African family healthcare; however, this was limited in effectiveness. As this section will also show, there was some resistance by Africans to the Presbyterians and by the late 1920s the Presbyterian dominance had ended in favour of wider denominational involvement, especially from Catholics, the Red Cross and the Basel mission.

In interwar Tanganyika and in interwar Buganda, historians have shown the strong relationship between maternal and child health, and medical mission. First, Michael Jennings has shown that in Tanganyika, missionary maternal and child health between 1919 and 1939 made a 'major contribution to colonial provision of western biomedicine' and that this extent of this work forced the colonial state to 're-evaluate its relationship with the mission sector and shift to the funding of such services'. By the early 1930s, missions had become the main provider of maternal and child health in Tanganyika; for example, the Africa Inland Mission work in Kola Ndoto attended to 5,830 confinements between 1930 and 1933, whereas three comparable government clinics only attended 1,287. Whilst Akerele et al. have noted that missions had a keen interest in maternal and child health for evangelism, Jennings has emphasised that missions were not an island unto themselves and that: 'The evolution of maternal and child welfare emerged from (a) blend of Christian rhetoric, colonial state pragmatism, and international trends in public health'.[133] Second, as Shane Doyle has shown for Buganda, a referral system of Church Missionary Society 'country centres' were 'so efficient at relaying problem maternity cases to Mengo hospital by the 1930s that their states of stillbirth, maternal mortality, and neonatal death match matched those of England and Wales'. Doyle shows that after 1919 the missionary doctor at Mengo, Albert Cook, contributed to the setting up of a network of maternity

[133] M. Jennings, '"A Matter of Vital Importance": The Place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-39' in D. Hardiman (ed.) *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam-New York, NY: Rodopi, 2006) pp.227-250.

clinics with government subsidies. This was linked to his success repackaging maternal and child health for both the Ganda chiefs and the colonial state in terms of ignorance and not immorality. By 1926 there were nineteen state and mission maternity centres in rural Buganda, twenty dispensaries, and government and mission hospitals at Kampala, Entebbe and Masaka. The Franscican Sisters also opened a midwifery to rival Cook, but this was small-scale before 1936 when the papal prohibition against nuns' direct maternity work was passed. There was also a steep increase in maternity cases at Mengo based on chiefly coercion and consistent missionary and government hygiene messages about the dangers of home birth.[134]

In the Gold Coast missionaries encouraged and shaped maternal and child health in their own terms and they were facilitated by the colonial government. Child welfare work was begun by the Scottish mission in January 1921 by Dr. Jessie Beveridge who, according to government reports, 'opened a clinic and dispensary for the treatment of minor ailments of school children and infants at Christiansborg, Accra'. It apparently was a roaring success and quickly led to the Government 'supplying drugs and paying the salary of an interpreter'. Amidst a death rate of 400 per 1000 births in some areas, the clinic was seen as an oasis by the government and between 1923 and 1924 the Government extended its own efforts by setting up temporary infant welfare centres in Christiansborg and James Town under Dr. Mary Magill and other Women Medical Officers. By 1926 the government built a hospital, the Princess Mary Louise, for children with a European Women Medical Officer, 'African subordinate staff' and two nurse midwives. In addition, a dispensary was set up to carry on Beveridge's work and a Government Woman Medical Officer was posted to Sekondi to begin a welfare centre and weekly clinic in Chama. In the first eight months of the 1926 financial year, the Princess Mary Louise Hospital had 8,444 attendances, the clinic at Christiansborg had 2,987, and the centre at Sekondi had 4,964.[135]

Missionaries were such a key feature of Gold Coast colonial health that to truly bind the colonial mission with that of the Christian mission, there were unsuccessful attempts by Guggisberg to hand over the entire maternal and child healthcare system to the Presbyterians. Simultaneously with large expansions in colonial infant welfare work, in April 1926, government officials met with a Presbyterian committee 'to consider the taking over by the Missions of the Welfare work in the large centres in the Gold Coast' and 'the transfer of all welfare work including the existing work in Accra and Sekondi' to the Missions. The conclusions were in favour of considerable cooperation:

> It was the opinion of the Director of Medical and Sanitary Services of that period that such work could only be successful if carried out by the Missionary Societies…the success and development of the work can only be guaranteed if the original suggestion is adopted of asking the Missions to become responsible for all welfare work

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[134] S. Doyle, *Before HIV: Sexuality, Fertility and Mortality in East Africa, 1900-1980* (Oxford: Oxford University Press, 2013) pp. 124-127, 260-264.

[135] Infant Welfare Centres, 1923-1926' *Gold Coast Colony Legislative Council Debates No. 1 Session 1927-8,* pp. 191-192, Balme Library, University of Ghana (Accra, Ghana).

> for women and children. The object of the Government is not primarily to secure economy but success…The recommendations were approved generally by the Governor who name the Scottish Mission as the Mission to be asked to initiate the scheme…A letter from the Colonial Secretary, of 14th April, was read conveying the thanks of the Governor to the members of the Committee and noting with pleasure the willingness of Mr Wilkie to refer the matter to headquarters; also asking, in the event of the Secretary of State approving the transfer, if the Scottish Mission is prepared to take over the present work at Sekondi , and to advise, in consultation with the Director of Medical and Sanitary Services, as to priority of further building at Sekondi or Akwapim…Council records its sense of the high honour conferred on the Mission by the request to undertake this responsible work for women and children.[136]

The evidence of what came of these committee meetings and experiments has not been recorded. However, the Presbyterian Mission did not gain the monopoly over maternal and child health that Guggisberg seems to have been planning for it in 1926. When Guggisberg handed over to Slater who became Governor in 1927, the stage was set for the expansion of maternal and child health in mission work - but from a wider set of practitioners. Not only did new Governors and the lifting of the papal ban in the following 5 to 10 years draw Roman Catholics in, they allowed back the Bremen and Basel missionaries, and facilitated the emergence of the International Committee of the Red Cross as one of the top three largest actors in Gold Coast infant welfare, alongside government and mission.

Missionaries in maternal and child health provided a vital source of information for planning development, connecting to African communities beyond colonial centres. Missionaries often had relations with locals that the state simply did not. For the AbaNyole in the 1920s, Osaak A. Olumwallah has shown that in health development, missionaries were critical intermediaries between the colonial state (who had a bad reputation for brutal tax collection) and the local community.[137] Near the centres of government power such as Accra, missions were not as critical. For example, in the case of the Accra epidemic of smallpox in 1919 and 1920, the medical officer in charge, Percy Selwyn-Clarke, emphasised the significance of chiefs in combatting the spread of disease, particularly by helping recruit local volunteers as hospital assistants.[138] However, when the health efforts extended more widely, particularly into rural areas, missionaries were

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[136] Gold Coast Mission Council (19th July, 1921-20th August 1927) pp.42-97, Gold Coast. Minutes of Mission Council 1918-27, D51, Acc.7548. Church of Scotland, National Library of Scotland (Edinburgh, UK).

[137]As Jones has shown with Ceylon, Olumwallah has also shown that in Kenya colonial medical coverage largely extended in reaction to outbreaks of disease and insanitary problems, drawing the state into intervening more broadly and intensely. Similar processes occurred in the Gold Coast, most notably with smallpox control. O. A. Olumwallah, *Dis-Ease in the Colonial State*, pp.162-185, 223; J. Lonsdale, 'European Attitudes and African Pressures: Missions and Government in Kenya between the Wars' *Race 10* 1(1968) pp.41-51; M. Jones, *Health Policy in Britain's Model Colony: Ceylon (1900-1948)* (Andhra Pradesh, India: Orient Longman, 2003) pp.42, 47, 52-60, 75-78, 152.

[138] P. S. Selwyn-Clarke, *A Monograph on Smallpox in the Negro and Negroid Tribes of British West Africa, with Special Reference to the Gold Coast Colony* (London: John Bale, Sons and Daniellson, Ltd., 1921) p.10; R. Gocking, *Facing Two Ways: Ghana's Coastal Communities Under Colonial Rule* (Lanham M.D., University Press of America, 1999) pp. 168-170 and 196.

crucial. This was the case in maternal and child health, and the dissemination of hygiene messages particularly. For example, in the eastern Gold Coast, the British Togoland Report of 1924 to the League of Nations wrote that:

> The presence of a qualified woman doctor on the staff of the mission, concentrating on Infant Welfare, has been a benefit to some outlying districts beyond the regular scope of Government Medical Officers. In her dispensary at Amedjope, and at many villages on tour she has, by individual treatment and general instruction, and by the circulation of appropriate literature among the more intelligent people, secured the confidence of the community, and she is now endeavouring to bring about a necessary improvement in the health conditions of mothers and children and to check the heavy infant mortality.[139]

Furthermore, mission contacts could also be vital in sanitation and vaccination campaigns. Markku Hokkanen has shown that between 1891 and 1940 in colonial Malawi missionaries were considerably involved in government vaccination campaigns and in treating government officials in rural areas.[140] In the Gold Coast, in A. W. Wilkie's diary he consistently notes his own inspection of sanitation and standards across the mission schools over the Gold Coast and details the outbreak of yellow fever in August 1926. Though, as Fraser wrote, the separation of the government medical and education department meant that schools were under-utilised in their capacity to help hookworm campaigns and ante-natal care, Wilkie shows how in the 1920s they were used as sites for vaccinations.[141] Where missionary education was more sporadic, for example in the Northern Territories, the colonial government had far less information or capacity to extend. Wilkie notes the significance of travelling medical missionaries such as Helen Russell, surveying a range of outposts and clinics.[142] Beyond maternal and child health work, missionary networks both medically trained or otherwise could be critical for the state to be able to extend their health work into areas that previously they had not navigated.

Driving this expansion was partly missionaries' interest in creating domestic norms and the role of mothers, but successes in hygiene work were limited in the longer term. As Jean Allman and Victoria

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[139] Togoland was a British protectorate but the Gold Coast government set up medical work (with missions) and economic development there in the 1920s and 1930s. In 1956 the Volta Region (part of Togoland) merged with Ghana. 'Public Health', *Report by His Britannic Majesty's Government on the Administration under Mandate of British Togoland for the Year 1924* (Submitted to the Council of the League of Nations, Geneva, 1925) p.35.; F. M. Bourret, *Ghana: The Road to Independence, 1919-1957* (Stanford: Stanford University Press, 1960) pp.106-111.

[140] M. Hokkanen, 'The government medical service and British missions in colonial Malawi, 1891-1940: crucial collaboration, hidden conflicts' in A. Greenwood (ed.) *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2015) pp.39-63.

[141] G. Guggisberg and A. G. Fraser, *The Future of the Negro: Some Chapters in the Development of a Race* (London: Student Christian Movement, 1929) pp.137-138.

[142] A. W. Wilkie, Gold Coast. Scottish Mission Record Book 1918-1938, D55, Acc. 7548, Church of Scotland, National Library of Scotland (Edinburgh, UK).

Tashijan have shown, 'making mothers' and 'dutiful wives' was not a part of the colonial project until the mid-1920s when there was expansion on the part of mission and government in all areas of female education and child welfare. These were combined mission-government efforts which are 'virtually impossible to disentangle'. In terms of the experience of women and children, they certainly would have been seen as coterminous. Through prizes at baby shows and competitions for registered babies, such as at the Kumasi Child Welfare Centre in 1928, Allman and Tashijan show how women were benefitted by entering the regulated world of colonial motherhood. This was not only in public settings but also in the private spaces of the home into which organisations such as The Gold Coast League for Maternity and Child Welfare entered to give demonstrations and critique hygiene practices. Allman and Tashijan argue that even with all these efforts and funding, Asante women were able to transform the agenda by the 1940s; their lack of interest ensured that the head of medical service in the Gold Coast, J. Balfour Kirk, called for reclaiming the fight to make mothers. Yet, it must be noted that this is overstated, as chapter 2 will further show, Balfour Kirk was unsuccessful in shifting the government focus back to preventative health and hygiene education. A mission-government concern hospital construction agenda was prioritised Alan Burns who ensured that Balfour Kirk was ousted from him position. The Asante women could resist and the choices were registered in colonial debates, but any direct effect on policy was limited and not 'fundamental' as Allman and Tashjian argue.[143]

[143] J. Allman and V. Tashjian, *"I Will Not Eat Stone": A Women's History of Colonial Asante* (Portsmouth, N.H.: Heinemann, 2000) pp.181-210.

Image I: Kumasi Health Week, 1929-1930. Babies in Judging Pens, Gold Coast Colony, Report on the Medical and Sanitary Department for the Year 1929-1930 (1930) Balme Library, University of Ghana (Accra, Ghana).

Image II: Kumasi Health Week, 1929-1930. Group of Prize Winning Babies, Gold Coast Colony, Report on the Medical and Sanitary Department for the Year 1929-1930 (1930) Balme Library, University of Ghana (Accra, Ghana).

Missions did not determine how child and maternal health was constructed but their political success ensured they were a critical actor in this contested terrain. Allman and Tashijan are certainly correct to show how 'impossible' it is to show missionary 'impact' given the range of factors at play. Missionary aims did not lead to clear outcomes and often could be lost amidst the social events they had created. Missions could not structure the encounter in 'incontestable ways', schemes such as bathing sessions had 'multiple and embattled' definitions for the women involved. Moreover, most women lived too far from these institutions ever to be effected. Yet, it is also important not to underdetermine the role of missions. Both locally through the daily routines of hygiene practices in their institutions and on a governmental level, missions were able to consolidate their place within the complex terrain of encounters with biomedicine and colonialism. In the 'gender chaos' of the interwar years in which women in Asante were moving into the cash economy, missions could not determine how domesticity was constructed - but they ensured they were a feature of the maternal and child landscape.[144] To paraphrase Allman, in hygiene classes and child health, they became the mediators of the mundane.[145] Yet, as Doyle argues for Buganda, in the Gold Coast too the general effect of mission medicine seems to have been to propagate the benefits of western healthcare not reformulate domestic structures.[146]

Missionaries often prioritised their own survival over reforming local communities. First, in some instances, the simplifying categories that missionaries used to classify the non-Christian world were put aside in the lived experience of intimacy and exchange in the cultural encounters of the mission field.[147] For example, in 1926 in the Scottish medical and educational mission at Abokabi on the Southern Gold Coast, Wilkie wrote in his diary of how the missionaries had to rely on help from the Chief to force local African Christians into being willing to provide labour for sanitary improvements to the school, otherwise it would be 'lost'. Negotiation with and reliance on traditional authority was sanitised in Guggisberg and Fraser's heroic development narratives, but adaptability and shrewdness were vital to the survival of a mission. However much missionaries like Fraser propagated heroic Christian 'development' narratives, Wilkie's diary shows that in practice missionaries prioritised their own long-term survival by negotiating with local traditional authorities, even if that meant using the power of the Chieftaincy to bully local African Christians.[148] Robert Rothberg has emphasised how Ugandan missions were reliant on Chiefs in their early

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[144] J. Allman and V. Tashjian, *"I Will Not Eat Stone": A Women's History of Colonial Asante* (Portsmouth, N.H.: Heinemann, 2000) pp.181-210.

[145] J. Allman, 'Making Mothers: Missionaries, Medical Officers and Women's Work in Colonial Asante, 1924-1945' *History Workshop Journal 38* (1994) pp.23-47.

[146] S. Doyle, *Before HIV: Sexuality, Fertility and Mortality in East Africa, 1900-1980* (Oxford: Oxford University Press, 2013) p.126.

[147] J. Cox, 'Master Narrative of Imperial Missions' in J. S. Scott and G. Griffiths (ed.s) *Mixed Messages: Materiality, Textuality, Missions* (New York: Palgrave Macmillan, 2005) pp.3-19.

[148] A. W. Wilkie, Gold Coast. Scottish Mission Record Book 1918-1938, D55, Acc. 7548, Church of Scotland, National Library of Scotland (Edinburgh, UK).

and fledgling stages in the nineteenth-century, but historians have noted this aspect far less for very long-term established ones like that at Abokabi, which had been running since the 1854 under the Basel Mission.[149]

In some cases, local communities themselves directly rejected missionary work. The upheaval of the government expulsion of the Basel Mission and its replacement with the Scottish caused considerable protest from African Christians in the colony, ensuring that the Scottish mission was unable to match up to its heroic development ideals at the outset. It seems likely that the reason for the insecurity of the Scottish mission among locals was that the Scottish mission did not have as strong relations with Abokabi locals as the departed Basel mission. The Scottish Presbyterians may have seamlessly replaced the Basel mission in the eyes of the colonial government, but indigenous Abokabi Christians were probably far less amenable to such sudden change enacted by the state, especially as it resulted from diplomatic issues external to the colony. Many towns and congregations of African Christians desperately wanted the Basel missionaries to return as can be seen in several articles and letters in the African-run newspaper *The Gold Coast Independent* in the early 1920s. As for the Scottish, they were regularly denounced. For example, in one article subtitled 'The Essence of the Basel Mission Spirit and the failure of the Scottish Mission Bluff' by Kwame Atoa Puma, the writer attacked the newcomers' superficiality:

> Whatever you do, you cannot vie with the Originators. In theirs, was no superficiality. And, most unfortunately, this keynote happens to underrun the whole system. Upwards of four years tutelage has failed to scottishfy our well seasoned mentality. If we keep intact our wind and limb, it is the Basel Mission Spirit that still sustains us; but what, when says its last as it surely must?[150]

Another article suggested that ten thousand full communicants had 'evinced great interest in the return of the Basel Missionaries'. Whilst a later piece denounced any statistical claims without evidence and a letter from the congregation in Akropong defended the 'rescue' of the mission by the Scottish, there was a considerable

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[149] R. Rothberg, 'Plymouth Bretheren and the Occupation of Katanga, 1886-1907', *Vol. 5 Issue 2, Journal of African History* (July 1964) pp.285-297; Missions- und Entwicklungsarbeit in Abokobi, (Südghana), 1854-1918 und 1975-2000, *Basel Mission Archives* (January 2001). When exchange and reliance were reduced, missionaries often more aggressively stuck to their original norms; M. Gullestad, *Picturing Pity: Pitfalls and Pleasures in Cross-Cultural Communication. Image and Word in a North Cameroon Mission* (Berghahn Books, 2007) pp.275-279.

[150] K. Atoa Puma, 'The Yearly Anniversary of the Scottish Mission: The Essence of the Basel Mission Spirit and the failure of the Scottish Mission Bluff' *The Gold Coast Independent* (16 February, 1921) p.127, MFM.MC1768, British Library (Boston Spa, UK); Similar comments and some reposts challenging the writers ability to speak for congregations without statistics are made in other articles such as, A. Full Communicant, 'Letter to the Editor' *The Gold Coast Independent* (2nd June, 1922) pp.393-394, MFM.MC1768, British Library (Boston Spa, UK).

amount of bitterness at the forced departure of the Basel missionaries. [151] For Scottish missionaries in the Gold Coast, amidst such dissent, the performance of the ideals of Christian development expressed in work such as Guggisberg and Fraser's had to be adapted in the face of hostility and political struggle locally. Janus-faced traditional authorities like Chiefs could be necessary allies for vulnerable missions.

After 1927, the close Presbyterian relations with the government declined. Following Guggisberg stepping down in 1927 there was a wider and larger proliferation of denominations and a shift in power away from the dominance of the Presbyterians. In the late 1920s and 1930s, the number of actors and groups in Gold Coast healthcare expanded and grew. Between 1932 and 1933, 74,317 children and 18,826 expectant mothers attending infant health clinics in the Gold Coast, in the following year the numbers were very similar, 74,160 children and 18,873. The Kumasi Welfare Centre expanded too with 589 admissions in 1931-2 and 655 in 1933-34, similarly the Princess Mary Louise Hospital in Accra had 668 admissions in 1931-2 and 515 in 1933-5. Given child welfare had only really begun ten years previously, these were large numbers and required a widening of the actors involved. The missions were a key player and so too, now, was the Gold Coast Branch of the British Red Cross Society (founded by Percy Selwyn-Clarke in 1929 as the League of Maternity and Child Welfare) which managed the Cape Coast and Sekondi welfare centres under the supervision of local medical officers.[152] Along with Government officers the Red Cross dealt with 22,789 attendances in Accra and 19,702 in Kumasi. Moreover, a Red Cross sister was in charge of the Kumasi weighing centre and domiciliary visiting from May of that year. Even at this point the government report stated that: 'A wide future would appear to lie before the (Red Cross) Society in the continuation and extension of this valuable side of their field activities'.[153] Added to this were the Bremen mission who returned to the Gold Coast and set up an infant welfare clinic at Amedzope which, in 1935, had 2,363 children attending.[154] With this work the Government approved a scheme for 28 midwives-in-training to have hostel.[155] In 1934, maternal mortality was estimated at 48 per 1000 births and infant mortality 115 per 1000 births. By 1949 infant mortality was at 1,954 which was a rate of 125 per 1000 live births, a slight rise

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[151] A. Communicant, 'Re the Basel Missionaries return' *The Gold Coast Independent* (24 February, 1923) p.129, MFM.MC1768, British Library (Boston Spa, UK); Samafu, 'Return of the Basel Missionaries' *The Gold Coast Independent* (21 April, 1923) p.265, MFM.MC1768, British Library (Boston Spa, UK); J. H. S. Parry and S. Donkor, Translated: 'Return of the Basel Missionaries' *The Gold Coast Independent* (22 June, 1922) p.4, MFM.MC1768, British Library (Boston Spa, UK).

[152] Ghana National Red Cross Society, *Early History and Report, September, 1956 to June,* 1965 (Accra: Lona Press, 1965) ACICR B AG 121 082-004, ICRC Archives (International Committee of the Red Cross, Geneva).

[153] The Gold Coast League of Maternity and Child Welfare also contributed to midwife care; 'Maternity and Child Welfare', *Report on the Medical Department for the Year 1933-4* (Accra: Government Printing Office, 1934) p.41, Balme Library, University of Ghana (Accra, Ghana).

[154] *Report on the Medical Department for the Year 1936* (Accra: Government Printing Office, 1937) p.36, Balme Library, University of Ghana (Accra, Ghana).

[155] *Gold Coast Colony Report on the Medical Department for the Year 1934* (Accra: Government Printing Department, 1935) p.28, Balme Library, University of Ghana (Accra, Ghana).

from 115 per 1000 but perhaps this was due to more births being attended to. More happily and successfully for medical work, in 1949 maternal mortality was at 310 and a rate of 18.3 per 1000 births which was a huge drop from 48 per 1000 in 1934. Both maternal and infant mortality then slightly reduced in the subsequent two years.[156]

By 1942, the Red Cross had become the dominant child and maternal healthcare provider in the Gold Coast. The Red Cross had grown its work massively by 1942 and had 38,402 children attending and 27,742 mothers, in the single year. Government centres had 39,990 children attending and 19,046 mothers, and missions (focusing mostly on children it seems) had 59,074 children and 2,929 mothers.[157] In addition, were the 97,174 attendances at the much larger Kumasi and Accra child welfare hospitals run by the government, this rose to 157,193 by 1944.[158] Missions in 1942 retained the largest role in child health with 64,601 child attendances, though only 2316 expectant mothers. By 1943 the Red Cross had gone from being a minor player in the early 1930s, to the largest actor in maternal and child health centres (excluding hospitals) by 1943, with 71,417 total attendances to the government's 71,017.[159]

A further major change in the 1930s was that Catholic medical mission was being widely financed by the government, laying the foundations for massive postwar Catholic growth. As well as the Red Cross, Catholic medical mission work increased, with Sisters empowered by the Papacy to acquire formal medical training. There was already a dispensary being set up at Kpandu in 1926 and extended to Djodje under the Sisters of Mercy.[160] By 1934 grants were being given to Catholic medical missions at Kpandu, Oeikwe, Akim Swedru, Asankrangwa and Djodji in the Central, Western and Eastern provinces of the colony.[161] These grants and missions laid the foundations for the massive postwar growth of Catholic medical mission analysed from chapter 4 onwards. These missions had a wide reach already, in 1934 the mission in Djodje saw 6,560 children attend, in Eikwe it was 22,143 and Kpandu, 20,710.[162]

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[156] *Gold Coast Colony Report on the Medical Department for the Year 1951* (Accra: Government Printing Office, 1952) p.3, Balme Library, University of Ghana (Accra, Ghana).

[157] *Gold Coast Colony Report on the Medical Department for the Year 1942* (Gold Coast: Government Printer, Accra, 1943) pp.4-7, LSTM (Liverpool, UK).

[158] *Gold Coast Colony Report on the Medical Department for the Year 1944* (Accra: Government Printing Department, 1945) p.7, LSTM (Liverpool, UK).

[159] *Gold Coast Colony Report on the Medical Department for the Year 1943* (Accra: Government Printing Office, 1944) p.7, LSTM (Liverpool, UK).

[160] The dispensary at Kpando was set up by the Little Servants of the Sacred Heart (Menton Sisters); http://hocatholicdiocese.org/about-us/about-diocese (Accessed: 27th October 2016).

[161] *Gold Coast Colony Report on the Medical Department for the Year 1933-34* (Government Printing Office, Accra, 1934) pp.39-45, LSTM (Liverpool, UK).

[162] *Gold Coast Colony Report on the Medical Department for the year 1935* (Government Printing Department, Accra) p.31, LSTM (Liverpool, UK).

By the end of the 1930s missions had only begun to form ecumenical links; divisions and tensions were the hallmarks of medical mission and the government was used still as a lever in inter and intra-denominational disputes. As Michael Jennings has demonstrated with Tanganyika, medical mission began being institutionalised through national ecumenical organisations from the 1930s. In the Gold Coast, the ecumenical organisation the Christian Council of the Gold Coast (CCGC) was formed in 1929 following the 1926 Le Zoute conference.[163] Though in the Gold Coast there was still denominational conflict and some unequal influence with government at this point (after all, the first joint secretary of the CCG from 1929-1931 was the Scottish Presbyterian mission leader A. W. W. Wilkie, showing their continued power). However, the general picture in this period remained the growing heterogeneity of missionary healthcare, with various Catholic organisations beginning their own maternal and child health work. Moreover, within outwardly cohesive denominations there was deep conflict. Catholic congregations, nationalities and missions had as many bitter conflicts as between them and Protestant groups. For example, there were fierce rivalries between the Franciscan Sister of Mary and the White Sisters over episcopate favour in the late 1930s. Amidst these tensions the colonial government was a key player; in this case nuns used government recognition to free themselves from the tutelage of the White Fathers and episcopate control.[164]

Government also were empowering Catholics in leprosy control and the change for leprosy control to create interdenominational cohesion was missed. As Kathleen Vongsathorn has argued, medical mission in Uganda ensured an over-emphasis on leprosy against that of other diseases because of its biblical links to the work of Jesus Christ healing lepers.[165] John Manton has argued that leprosy work was left to missions in Northern Nigeria until 1945 when this was institutionalised through a combination of the British Empire Leprosy Relief Association (BELRA) and the colonial government, which previously had focused on more prevalent diseases. In the Gold Coast, the government had been interested in leprosy work since the 1910s and in possibly working with Catholic missionaries in this regard.[166] In 1918 there was some consideration, by the Government's Principal Medical Officer, of training the White Fathers around Navrongo in professional medical work because of their utility in describing the incidence of leprosy cases in the Northern Territories. In 1930, this sort of state support was furthered with Dr. Seth-Smith who arrived from

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[163] M. Jennings, 'Cooperation and Competition: Missions, the Colonial State and Construction a Health System in Colonial Tanganyika' in A. Greenwood (ed.) *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2015) pp.153-173; A. W. Wilkie, Gold Coast. Scottish Mission Record Book 1918-1938, D55, Acc. 7548, Church of Scotland, National Library of Scotland (Edinburgh, UK).

[164] J-M. Bouron, 'Dominées ou dominantes? Les Soeurs Blanches dans L'Ambivalence des Logiques d'Autorité (Haute-Volta et Gold Coast, 1912-1960) *Histoire, Monde et Cultures Religieuses* 30.2 (2014) pp.51-73.

[165] K. Vongsathorn, '"First and foremost the evangelist"? Mission and government priorities for the treatment of leprosy in Uganda, 1927-1948'*Journal of East African Studies 6.3* (August, 2012) pp.544–560.

[166] J. Manton, 'Administering Leprosy Control in Ogoja Province, Nigeria, 1945-1967: A Case-Study in Government-Mission Relations' in D. Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam-New York: Rodopi, 2006) pp..307-332.

Lawra with medical supplies and trained the White Fathers in treating common illnesses.[167] Around the same time in 1929, Governor Slater, aimed to further leprosy work by forming a branch of BELRA which included many appointments and three regional committees. This could have been a key turning point in beginning the institutionalisation of missionary leprosy services in the Gold Coast as Scottish Presbyterian, Methodist, Catholic and Church of England delegates were amongst the 12 members of the central committee. However, there were setbacks; the government had expected BELRA to bear the cost of recurrent expenditures but BELRA had assumed the opposite. BELRA conducted several surveys of incidence throughout the 1930s, finding that there were 1.5 to 2 lepers per mile in the Gold Coast. What did occur was government funding of Catholics alongside this the older government leprosy settlements founded by Dr. Helen Hendrie amongst the Yendi, then in 1926 Dr. F. H. Cook began a small leper colony at Ho which had 82 patients by 1928.[168]

As with child and maternal health, by the mid-1930s, the government was considering giving missionaries control of all leprosy work and, in the early 1940s, the director of medical services proposed that it all could be 'safely entrusted to missionary societies' but this did not materialise. Some of the missionary societies would not consider the proposal until after the Second World War and those that would, wanted money that the Colonial Office would not provide. Though the Governor Alan Burns wanted to pay the missions, the Secretary of State for the Colonies rejected the suggestion, stating that overhaul of the Nigeria system was the priority. Thus, as Manton argues for Nigeria, Sylvester Gundona has shown that for the Gold Coast it was not until after the War that missionary leprosy work was properly institutionalised as part of a government and international organisational plan with Colonial Welfare and Development Funding.[169]

In the 1930s, it was not just Catholics but also the Basel mission that benefitted from the end of Presbyterian dominance. In 1931, the Basel Mission, restored to the Gold Coast from 1926, opened a hospital at Agogo near Kumasi. According to Pascal Schmid the Basel Mission had wanted to set up at Mampong and later Juaso but both attempts were blocked by the Scottish mission and the government - both of whom controlled much of the Basel missionaries' activities even after their restoration. This was much to the chagrin of Agogo's doctors, the second of whom disliked how remote the hospital was. There was also conflict between the Kumasi missionaries who emphasised evangelism and the central Basel Mission House which wanted the medical work to be so effective that it could fund other projects. In 1938 the superintendent was dismissed and there were even some issues with National Socialism in the staff. The

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[167] In the 1940s the White Fathers did build large facilities for their dispensary, adding casualty, children's and maternity wards. There was also a leper colony at Nandom and in 1955 Jirapa was turned into a hospital with government funding; R. F. McCoy, M.Afr., *Great Things Happen: A Personal Memoir of the first Christian missionary among the Dagaavas and Sissalas of northwest Ghana* (Canada: The Society of Missionaries of Africa, 1988) pp.243-261; I. Egala, 'Orders of the Day' *Gold Coast Legislative Debates, 1955-1956: Ministry of Health* (17 March, 1955) p.1146.

[168] S. Gundona, '"Coping with this scourge": The State, Leprosy and the Politics of Public Health in Colonial Ghana, 1900-mid 1950s' (Unpublished Doctoral Thesis, The University of Texas, 2015) pp.68-128.

[169] J. Manton, 'Global and local contexts: the Northern Ogoja Leprosy Scheme, Nigeria, 1945-1960' *Historia, Ciencias, Saude* 10.1 (2003) pp. 209-223.

colonial government, who had effectively competed with Agogo for well paying patients in the 1930s, closed the hospital anyway in 1940 and detained all the staff except one nurse.[170] Other than Agogo, this kind of general and large missionary hospital construction did not grow until after the Second World War. Nor did the full growth of Catholic medical work into more professional forms, given the previous restrictions on training. A symbolic turning-point was in 1948 when the Catholic Medical Mission Sisters built their hospital at Berekum.[171] As will be discussed in chapter 2 in this decade there was also a proliferation of types of denomination who were backed by government and majorly collaborating in medical work, such as the Seventh Day Adventists, the Methodists and the Salvation Army.[172] Institutionalisation, the widening and parity of denominations involved with government medical work and the expansion of a hospital system with government did not occur until after the Second World War and only on the eve of Ghanaian independence in 1957. This post-Second World War expansion was related to the huge increase in Colonial Office provision for development which, in the ten years following 1945, provided £120 million (which was then raised to £140 million by the 1950 Colonial Welfare and Development Act).[173]

Government power by the 1940s was more diffuse across the missions; as in Malawi, the close relationship of the Scottish Presbyterian mission and the colonial state had been completely disrupted and major rifts emerged in the 1950s. The Gold Coast colonial state's relationship with the Scottish Presbyterians had some similarities with contemporary relations in Malawi. In Malawi between the 1900s and the 1930s the Scottish Presbyterians and the state had been closely aligned. According to John McCracken, by the 1920s, with their networks of schools and hospitals, the missions at Blantyre and Livingstonia had been 'drawn into an intimate, though, at times, strained, relationship with the government'. Going further than this and building on the work of Karen Fields on the Watchtower movement, McCracken argues that in Central Africa the early colonial state 'had more than a passing resemblance to medieval European states, with the spiritual and material resources of the Church being used to bolster state authority'. However, by the 1940s and into the 1950s this had broken down and new rifts had emerged in response to a wider reappraisal of relations with the state by the church. In Blantyre the Scottish mission even became 'genuinely self-governing' by transferring financial responsibility to the synod and distancing themselves from the developmentalism of the colonial state. Instead, they focused on concerns about the spirituality of their

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[170] P. Schmid, 'Mission Medicine in a Decolonising Healthcare System: Agogo Hospital, Ghana, 1945-1980' *Ghana Studies* 15/16 (2012/2013) pp.287-329.

[171] B. Mann Wall, *Into Africa: A Transnational History of Catholic Medical Missions and Social Change* (New Brunswick, NJ: Rutgers University Press, 2015) p.33.

[172] G. Land, *The A-Z of the Seventh-Day Adventists* (Plymouth: The Scarecrow Press, 2009) p.115; *The Salvation Army Year Book 1960* (1960) pp.90-91; J. S. Pobee, *Kwame Nkrumah and the Church in Ghana, 1949-1966: A Study in the Relationship between the Socialist Government of Kwame Nkrumah and the Protestant Christian churches in Ghana* (Asempa, 1988) pp.49-53, 94-95.

[173] S. Constantine, *The Making of British Colonial Development Policy 1914-1940* (Frank Cass and Company Ltd., 1984) p.267.

parishioners which they feared had been abandoned for the sake of social improvement. Missions, though divided, generally went into open opposition regarding the creation of the Federation of Nyasaland and Rhodesia.[174] In the Gold Coast by the 1940s, the medieval style relationship of Guggisberg and the Scottish Presbyterians had been ended as well. In the 1950s in the Gold Coast too, the Scottish Presbyterians departed from their close role with state and set up independent, synod-run, missions. These were still medical but this was because of the necessity of intervention into the problems of ill health in areas where they had attempted to set up churches. It was also because of encouragement to medical work by a local Pentecostal missionary in charge of government community development in the Northern Territories and so was only loosely related to changes in national government interest.[175] The Scottish Presbyterians may not have warred in the same way as those in Malawi with developmentalism and state changes that occurred in the 1950s, but they too detached from the government.

iii. CONCLUSION

This chapter has shown how closely tied were the development practices and ideas in the Gold Coast colonial state to those of the Presbyterian missionaries. A Christian vision for human development was articulated in works written collaboratively between the Governor Gordon Guggisberg and the key missionary A. G. Fraser. Christian human development was directly influential in the creation of high-level medical education through collaboration between Aggrey, the Phelps-Stokes commission, Guggisberg and the Presbyterian missionaries. This chapter has also shown how human development was created within an extractive colonial geography. Medical education and choices over which diseases on which to focus depended on this model dividing up the coast from Asante and the Northern Territories. Moreover, into these contests were claims for sacral authority and political power within the capital between Cape Coast, Fantis and Ga. Whilst development in Accra focused on elite human and racial progress, in rural areas medical missions focused on reforming domestic relations through maternal and child health, though their success

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[174] J. McCracken, 'Church and State in Malawi: The Role of the Scottish Presbyterian Missions, 1875-1965' *Christian Missionaries and the State in the Third World* (eds.) H. B. Hansen and M. Twaddle (James Currey, 2002) pp.176-193 citing K. E. Fields, *Revival and Rebellion in Colonial Central Africa* (Princeton N.J.: Princeton University Press, 1985) p. 41.

[175] Correspondence and papers of the Church of Scotland Overseas Council relating to Africa (1965-75) Acc 9638 Church of Scotland, National Library of Scotland (Edinburgh, UK); Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner Scheme of the Reverend Colin Forrester-Paton, in the Gold Coast, later Ghana, 1954-71, Acc 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK); Further papers, mainly ca. 1970-1995, but many earlier, relating to Church of Scotland and other Scottish Presbyterian Missions, and Scottish Churches abroad, Acc 12398, Church of Scotland, National Library of Scotland (Edinburgh, UK) Colin Forrester-Paton Papers 1939-1994, GB 3189 CSCNWW37, New College Library, University of Edinburgh (Edinburgh, UK); Interview with Author, L. Duncan, UK (23 December 2014); A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997) esp. p.108.

was limited. These visions were outworked with the colonial government and Presbyterian missions - which at one point were so close as to merit the proposal of Presbyterians taking over the entire system of maternal and child health. However, they were limited in imposing their domestic norms and furthering their work by a lack of resources, hostility from Africans, the agency of local communities, issues with diseases and, ultimately, with the departure of Guggisberg. After Guggisberg, missionaries proliferated and had more equally spread relations with the colonial government. By the 1950s, the Scottish Presbyterian position of dominance and close relationship with colonial state development had ended.

The consequence of missions in this period was to widely introduce Africans to very specific forms of hygiene and biomedical teaching which were determined by evangelistic concerns. The result was the neglect of diseases such as measles which would become a long-term problem for health on the Gold Coast and the neglect of the Northern Territories which would only be partly challenged in the postwar period. By the 1930s missions had proliferated and become more heterogenous, with more denominations and organisations such as BELRA and the Red Cross becoming major actors. Some of the basis of later homogenisations through ecumenical groups had begun and maternal and child health was a common concern, but the overall picture of medical mission by the middle of the Second World War was of diversity and competition within shared health focuses.

The overall effect on maternal and child health of medical mission in the 1930s, the Red Cross and the government financing of many denominations was considerable but not long lasting. As shown in Table I, child mortality decreased throughout the first half of the 1930s, this in spite of increased surveillance through the medicalisation of childbirth. It seems clear that the focus on child and maternal health had a considerable effect on infant mortality itself, especially when missions were backed by government funding across the denominations. As will be shown in chapter 2 this trend did not continue beyond the 1940s. What did last and was built upon, was the widespread financing of medical missionary activities across many denominations. For Catholic medical mission this process laid the foundation of huge postwar funding, analysed from chapter 4 onwards.

Year	1930	1931	1932	1933	1934
Infant Mortality per 1000 related births	116	114	102	100	105

Table I 'Infant and Child Mortality' *Report of the Ministry of Health for the Year 1954* (Accra: The Government Printer, 1957) pp.21, 97, Wellcome Trust Library (London, UK).

Chapter 2

MEDICAL MISSIONS AND THE VOLUNTARY SECTOR IN THE LATE COLONIAL GOLD COAST, 1939-1957

The emergence of the postwar voluntary sector in colonial Africa comprised a revolution in statecraft that is still being worked out in many African national contexts. It was part of the first development plan in Ghana and it structured international and national healthcare, and the role of civil society, from the late 1940s onwards. The transformation ensured that medical mission's place in the landscape of African healthcare would continue to be significant many decades after the end of colonialism, and in many cases, still is so today. Yet, what the limits of the voluntary sector were and how medical missionaries related to this large scale shift in colonial statecraft have not been explored in-depth by historians. The original contribution of this chapter to the historical literature is to analyse medical missionaries and the voluntary sector: the boundaries they placed on its reach and their overall role in its construction in the Gold Coast up to independence in 1957.

This chapter will significantly extend John Stuart's analysis of 1950s missionary voluntarism and it builds on Michael Jennings' thesis that a formal voluntary sector emerged in Tanzania in the 1950s and 1960s by analysing similar patterns in the Gold Coast.[176] As a result of a combination of factors medical mission grew rapidly in the 1950s and ensured in this period that its institutions, beliefs and culture would remain long after the formal end of colonialism in 1957.

In order to argue this the chapter will be divided into two sections. The first section, from 1939 to 1951, will show how the Gold Coast Governor Alan Burns focused on hospital construction and medical missions' use of hospitals as a technique for gradual Christianisation. A medical mission voluntary sector emerged in public debates about colonialism and Christianity in the 1930s and was consolidated by British Colonial Office policymakers in the early 1950s.[177] A key turning point was in the late 1940s, when the voluntary sector was formalised by the Maude Commission under the direction of John Maude. Maude's vision was for voluntarist norms to support the emergence of the democratic welfare state.

The second section will explore how the changes worked in practice up to independence in 1957 and how Maude's promotion of a culture of voluntarism was largely detached from the realities of medical mission in the Gold Coast. This section will begin by analysing the final colonial Governor, Charles Arden-Clarke and

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[176] M. Jennings, 'Common Counsel, Common Policy: Healthcare, Missions and the Rise of the 'Voluntary Sector' in Colonial Tanzania' *Development and Change* 44.4 (2013) pp.939-963, esp. 960-961; M. Jennings, 'The precariousness of the franchise state: Voluntary sector health services and international NGOs in Tanzania, 1960s - mid-1980s' *Social Science and Medicine* 141 (2015) pp.1-8.

[177] Moreover, throughout this chapter, the concept of 'voluntary' and the volunteer will be complicated and nuanced. The term is ambiguous and this chapter will explore some of its competing theoretical usages, and different ways in which it was performed in practice.

his own pro-missionary agenda as he oversaw the embedding of a missionary voluntary sector. It will then emphasise the heterogeneity of medical missions. How medical missions negotiated the voluntary sector role is complicated and how individual denominations adapted differently to the process has not been examined by historians. This section will show how the Catholic medical mission at Berekum rejected government funding. This will be contrasted with the Seventh-Day Adventist mission hospital at Kwahu who accepted government money but who diverged from government norms, focusing on the supernatural. Finally, it will examine the Scottish Presbyterian mission clinic in the Northern Territories who had little access to state financing (a significant change from the dominance of Scottish Presbyterian in the interwar period), but who practiced older norms of Christian sacrifice and were themselves types of volunteers.

i. ALAN BURNS, JOHN MAUDE AND THE VOLUNTARY SECTOR: MEDICAL MISSION IN THE GOLD COAST, 1939-1951

The process that defined the formal character of the 1950s voluntary sector began under Alan Burns, the Governor of the Gold Coast in 1941 and then between 1942 and 1947, who was keen to promote gradual Christianisation through medical mission.[178] Burns wrote in his *History of Nigeria* (1929) that for a 'real Christianity' to be introduced into Africa, the work must be 'slow and patient'. Vital to this steady pace, he claimed, was medical mission:

> Much can be done in the meantime through the schools and by medical missions to gain the confidence of the people, without which nothing will be accomplished…There are also numerous European missionaries throughout Nigeria who are preaching the Gospel, educating the people, and alleviating their physical sufferings by medical work. There are men - and women - of high character, undoubted piety, and thorough devotion to their mission.

Burns suggested that unfortunately 'sectarian differences' weakened the 'force' of Christian evangelism because they 'puzzle the pagan mind'. He noted with wonder 'that so much has been done with such divided counsels' of denominational rivalry. Moreover, he argued that:

> The conservative African is not to be hurried, and it is only by slow and patient work that a real Christianity can be introduced. Much can be done in the meantime through the schools and by medical missions to gain the confidence of the people, without which nothing will be accomplished.[179]

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[178] M. Epstein (ed.) *The Statesman's Year-Book 1943: Statistical and Historical of the States of the World for the Year 1943* (London: Macmillan and Co., 1943) p.250.

[179] A. C. Burns, *History of Nigeria* (George Allen and Unwin Ltd., 1929/1955) pp.251-252.

In these sections, where he outlined his own vision for how Christianity could be promoted, Burns quoted two of the main architects of the formal government-mission alliance in the 1920s British Empire - the missionary statesman J. H. Oldham and Lord Frederick Lugard. From Oldham's notable publication *Christianity and the Race Problem*, Burns further bolstered his frustration about Christian division, citing Oldham's claim that:

> Unless the Christian Church can exhibit a brotherhood as real as that of Islam, we cannot be surprised if the latter is more successful in winning the allegiance of pagan people.[180]

Burns linked this to his disappointment about the 'friction that has existed in the past between the Government and the missionaries' because of their interference in political and judicial matters. He cited Lugard's issues with missions who were looking to the government for support when they were thrown out by a paramount chief. Burns' overall message was that, by focusing on building trust over the long-term especially through medical mission, with government assistance in 'pagan areas' and avoiding the tensions resulting from government challenging Islamic authority, Christianity could flourish. Burns' book linked to key debates around Oldham and mission-government cooperation, and it was successful, being republished in five editions, the last in 1955.[181] Through this academic work, several Gubernatorial roles and a stint as the Assistant Under-Secretary of State for the Colonies in the early 1940s, Burns had become a major contributor to the discussion of how mission would function until the end of colonialism.[182]

As a result of his gradualist understanding of Christianity and colonialism, Burns was especially keen on hospitals and blocked out the dominance of 'preventative health'. Given the missiological and imperial culture in which Burns debated and received his ideas, his main focus was on hospital building. These were bastions of modern medicine in which over a long, sustained and protected period of time, missionaries

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[180] J. H. Oldham, *Christianity and the Race Problem* (Student Christian Movement, 1924) p.263.

[181] A. Burns, *History of Nigeria* (George Allen and Unwin Ltd., first published in 1929, second edition 1936, third edition 1942, fourth edition 1948, fifth impression 1951, fifth edition/sixth impression 1955) pp.249-260.

[182] Sir Alan Burns Collection of Gold Coast [i.e. Ghana] photographs, 1940s, Ministry of Information, West African Photographic Service, Y30448D, Royal Commonwealth Society Library, University of Cambridge (Cambridge, UK); J. M. Hodge, *Triumph of the Expert: Agrarian Doctrines of Development and the Legacies of British Colonialism* (Ohio: Ohio University Press, 2007) pp.136-143; H. Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011) pp.106-107; S. Clarke, 'The Research Council System and the Politics of Medical and Agricultural Research for the British Colonial Empire, 1940–52' *Medical History* 57.3 (July 2013) pp.338–358; D. Maxwell, 'From Iconoclasm to Preservation: W. F. P. Burton, Missionary Ethnography and Belgian Colonial Science' in *The Spiritual in the Secular: Missionaries and Knowledge about Africa,* (eds.) P. Harries and D. Maxwell (Grand Rapids, Michigan: Wm. B. Eerdmans Publishing Co., 2012) p. 183, citing H. H. Oldham and H. Vischer, "Memorandum on the Place of the Vernacular in Africa Education and on the Establishment of a Bureau of African Languages,' Spring 1925, in SOAS, IMC/CBMS, Box 204, cited in W. Young, '"They had Laid Hold of Some Essential Truths": Edwin W. Smith (1876-1957), a Wise Listener to African Voices," in *European Traditions in the Study of Religion in Africa* (eds.) F. Ludwig and A. Adogame (Wiesbaden, 2004), p.172.

could build trust with local communities and display order, their expertise, cleanliness and bodily difference in biomedical clothing and equipment. As Fraser had put it in *Future of the Negro*: 'to know and be known by the people'.[183] Missions could also directly convert locals whilst they were ensconced in hospital beds, as Megan Vaughan argued: 'a lengthy stay…provided a medical and spiritual training', it was a kind of 'rite of passage'.[184] In consequence, Burns famously clashed with his head of medical services, James Balfour Kirk, leading to the early retirement of the latter in 1944. Balfour Kirk wanted to establish a 'Policy of Preventative Medicine' which would emphasise immunisation and sanitary improvement to lower the incidence of disease. Balfour Kirk wrote that the Gold Coast needed:

> a general clean up of the country by means of mass survey and treatment campaigns, combined with the provision of water supplies and other essential sanitary apparatus and improvements.[185]

As Deborah Neill has shown, tropical medicine specialists like Balfour Kirk, were equipped by their 'transnational epistemic communities' to 'influence policy making by collectively identifying problems and solutions…circumscribing the boundaries and delimiting the options'.[186] However, whilst Balfour Kirk might have been supported transnationally by imperial medical networks, nationally, Burns reigned. Burns' spread of options were rooted in the networks and organisations of knowledge production in British interwar mission which surrounded Oldham, not in those of imperial medicine. Just as medicine could shape missionary theology, here theological ideas were considerably shaping medicine. Burns also justified the focus on hospitals by arguing that:

> While there can be no doubt of the great importance of preventive medicine, public opinion will not be satisfied if those who are actually sick are neglected in keeping well those who have so far been fortunate in escaping illness.

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[183] G. Guggisberg and A. G. Fraser, *The Future of the Negro: Some Chapters in the Development of a Race* (London: Student Christian Movement, 1929) p.122.

[184] M. Vaughan, Curing their Ills: Colonial Power and African Illness (Stanford: Stanford University Press, 1991) pp. 61-62; D. Hardiman, 'Introduction' in D. Hardiman (ed.) *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam-New York: Rodopi, 2006) pp.16-20.

[185] P. Schmid, 'Mission Medicine in a Decolonising Healthcare System: Agogo Hospital, Ghana, 1945-1980', *Ghana Studies 15/16* (2014) pp.287-331 citing J. Balfour Kirk, "Memorandum on the Type of Department Which Will Be Necessary to Implement a Policy of Preventive Medicine of the Gold Coast," (5 July 1943) CSO11.1.646 PRAAD (Accra, Ghana).

[186] D. Neill, *Networks in Tropical Medicine: Internationalism, Colonial and the Rise of Medical Speciality, 1890-1930* (Stanford: Stanford University Press, 2012) pp.5-8.

This he noted especially with regard to 'primitive tribes' and people with family in hospital both who needed to be inspired with 'belief in the good intentions of the Government'.[187]

Burns was able to spend more on hospitals, and development generally, because of high cocoa prices and increased revenue from the landmark 1940 Colonial Welfare and Development Act. Based on high revenue of mineral exports such as gold, which in 1938 had fetched £484,200 and cocoa which had gained £9,990,000 in 1937 for 236000 tons, Burns initiated a policy throughout the 1940s of hospital building where possible.[188] He also collected around £800,000 annually in income tax, bringing total revenue to an average of £4,469,000 annually, as opposed to the £3,669,000 annual revenue before the war. In 1944 Burns proposed £924,000 to be spent on new district hospitals, £400,000 on a new central hospital in Kumasi and £250,000 on a mental hospital. This was out of a total of £3,789,000 spent on development including roads, housing, water and electric lighting as well as harbour and railway improvements, and agricultural credits which totalled £1,400,000. Hospitals therefore comprised 30.33 per cent of development expenditure. Burns also defrayed £1,000,000 from the Colonial Welfare and Development funds over five years to pay for this, which had risen significantly in 1940. The annual expenditure on development in 1935-1936 to 1939-1940 was around £2,690,000 annually, under Burns this rose to around £4,250,000 annually.[189] Burns set the terms of the huge medical mission expansion in the Gold Coast which started shortly after he left office in 1947. Burns ensured that for the next decade hospital construction was the priority.

Burns' lack of funding for rural health projects especially in the Northern Territories and high incidence of preventable disease, frustrated some rural health workers. The entomologist, Kenneth Stacey Morris, wrote in a letter to his Mother from the Northern Territories in 1939 explaining how little his tsetse control for the government cost:

> Our team working through a strip of Lawra district only, in six months covered 1,000 sq miles of country, visited 52 villages and towns, examined 15,000 people and found and treated over 500 cases of sleeping sickness…This is a team of semi or un-educated local native trained by Saunders and I, none of whom gets more than £3 per month, mostly getting £1 to 35/- - The whole team of about 15 people, for diagnosis and treatment, costs only £25 per month in salaries, and works perfectly without our supervision from one month to another.[190]

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[187] Governor's Despatch No. 222 of the 26th July 1944, to the Secretary of State for the Colonies (1944) pp.1-11, Private Archives of the Family of Alan Burns (UK).

[188] P. Schmid, 'Mission Medicine in a Decolonising Healthcare System: Agogo Hospital, Ghana, 1945-1980', *Ghana Studies 15/16* (2014), pp.287-331; S. Addae, *Medical Histories, Volume One: From Primitive to Modern Medicine [1850-2000]*, (Accra: Eureka Foundation, 2012), pp.76-90.

[189] Governor's Despatch No. 222 of the 26th July 1944, to the Secretary of State for the Colonies (1944) pp.1-11, Private Archives of the Family of Alan Burns (UK).

[190] K. S. Morris, 'Letter to Ma' (16th September 1939) Box 1 File 2, MSS Afr s 1824; t 34 (1901-65) *Kenneth Stacey Morris: Correspondence and Papers* NRA 26342 Morris, Bodleian Library, University of Oxford, (Oxford, UK).

Morris complained that the annual costs of his team were what 'some of the doctors will draw in allowances and perks, quite apart from salary, + quite certainly they don't do as effective work (sic)'. His three teams, he ranted to his Mother, would cost £900 with £500 in drugs and other expenses and 'shall save up to 3,000 lives per year…Cheap as life may be rated out here, or when enclose in a black skin. I don't think the authorities could boggle at that'. The government concern for hospital provision and Christianisation clashed with Morris' aims for the promotion of imperial masculinity and secular humanitarianism:

> here sit I, responsible for all this, and capable of its vast expansion had I but the chance, listening to the echoes of our wonderful 20th century civilisation blowing each other to bits to the tune of God knows how many hundreds of millions of pounds, and wondering, with very real doubts, if I shall be allowed, kindly graciously permitted by our wonderful humanitarian system, to spend 10/- a time saving the lives of these poor wretches who have a thing enough time of it anyway - + yet keep smiling - And above all - have given up killing each other for some time now ![191]

For Morris, rural health provision was not simply about altruism but about a lifestyle in which one personally performed strong masculine character in the wilderness. Nations and governments' capacity to develop Africa was judged by Morris according their ability to hunt, more than how civilised or Christian an institution appeared.[192] On the other hand, Morris' fury was clearly overstated. In December 1949 Morris was offered £100,000 a year for a national Tsetse control unit, a considerable amount given that overall medical expenditure for the colony was only £1,161,250 in 1950.[193] Though even upon this offer, Morris still felt the Gold Coast government's focus on such official institutions fell far short of the mark, describing the administration as content with him becoming one of the 'dull pompous cogs…(who) kid themselves that they are doing a man's job'.[194]

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[191] K. S. Morris, 'Letter to Ma' (16th September 1939) MSS Afr s 1824; t 34 (1901-65) *Kenneth Stacey Morris: Correspondence and Papers* NRA 26342 Morris, Bodleian Library, University of Oxford, (Oxford, UK).

[192] K. S. Morris, 'Letter to Ma' (12th February 1942) Box 1 File 2, MSS Afr s 1824; t 34 (1901-65) *Kenneth Stacey Morris: Correspondence and Papers* NRA 26342 Morris, Bodleian Library, Oxford University (Oxford, UK).

[193] 'Appendix II: Revenue and Expenditure: Expenditure by Heads' *Colonial Office: Annual Report on the Gold Coast for the Year 1950* (London: His Majesty's Stationery Office, 1950) p.99, British Library (Boston Spa, UK).

[194] K. S. Morris, 'Letter to Ma' (16th December 1949) Box 1, File 2, MSS Afr s 1824; t 34 (1901-65) *Kenneth Stacey Morris: Correspondence and Papers* NRA 26342 Morris, Bodleian Library, University of Oxford (Oxford, UK).

Image III: Kenneth Stacey Morris in the Northern Territories (early 1940s) Box 3 File 2, No. 43, MSS. Afr. s. 1824, Bodleian Library, University of Oxford (UK).

As well as rural health workers, African newspapers complained bitterly about poor sanitation. The *African Morning Post* provided space for 'Provincial Items' which community spokespersons mostly used to complain about insanitary conditions, changes in chieftaincy and church building work. Taking as a snapshot a few weeks in January 1939 it is clear how big an issue sanitation had become. On Thursday 12th, a news report for Cape Coast demanded that the 'attention of the local Medical Officer of Health' be 'called to the insanitary condition of the Castle Yard Latrine' which served officials and prominent people using the Post Office and the Court. This 'pity' the writer blamed on the latrine being used by the public and consequently it had become 'very filthy'.[195] The following Tuesday the correspondent for Dunkwa chastised the government for letting the female wards become 'unhealthy' and requested a European hospital be built.[196] In the same section, the writer for Nkawkaw described how the latrines had become full and 'Even when they were in use they were found to be insufficient for the inhabitants of the town'. For this, they chastised the 'indifference of the authorities concerned with the affairs of the town' who indulged in 'unnecessary litigation' and the columnist advised the Sanitary Inspector to ask for the Chief's co-operation in helping improve the area.[197] This was the same for Kokofu in which the author went into detail, explaining that:

> The sanitary conditions here leaves much to be desired. Goat and sheep's excrement abound in the streets, thus producing an unpleasant smell. This is detrimental to the health of the inhabitants. We strongly appeal to the Omanhene and M. O. H. in charge of the Bekwai district to solve the situation.[198]

There was more in the next day's newspaper. On Wednesday 18th the correspondent for Mepom also wrote that the 'sanitary conditions of this town leaves much to be desired' but this time the inhabitants themselves were blamed for ignoring the dictates of the Chiefs:

> Refuse is freely thrown on streets. The outskirts of the town are weedy, thereby mosquitoes are bred and poisonous reptiles sheltered. The inhabitants do not care to carry out the orders of the Odi. kro…This town needs special attention as there had once broken out yellow fever here.[199]

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[195] 'Provincial Items: Cape Coast: General News' *The African Morning Post* (Thursday 12 January, 1939) p.3, MFM.MC1788, British Library (Boston Spa, UK).

[196] 'Provincial Items: Dunkwa: General News' *The African Morning Post* (Tuesday 17 January, 1939) p.3, MFM.MC1788, British Library (Boston Spa, UK).

[197] 'Provincial Items: Nkawkaw: State of Affairs is Bad' *The African Morning Post* (Tuesday 17 January, 1939) p.3, MFM.MC1788, British Library (Boston Spa, UK).

[198] 'Provincial Items: Kokofu: General News' *The African Morning Post* (Tuesday 17 January, 1939) p.3, MFM.MC1788, British Library (Boston Spa, UK).

[199] 'Provincial Items: Mepom: Sanitation is Bad' *The African Morning Post* (Wednesday 18 January, 1939) p.3, MFM.MC1788, British Library (Boston Spa, UK).

Given the possibility of yellow fever, these were more than irritated busybodies. Across Gold Coast villages and market towns, the insanitary conditions were proclaimed in a variety of appalling, illustrative examples. The problem was also with foreign trade. In the next week the correspondent for Mpraeso complained that Nigerians were selling fish unfit for human consumption and that the Sanitary Inspector needed to conduct daily visits.[200]

There were some attempts to provide dispensaries and preventative healthcare but these struggled. In 1939, the Legislative Council decided that they wanted to copy the Rockefeller Foundation's work on yellow fever in Brazil in the Gold Coast. In 1938 seven new dispensaries were opened in Abomosu, Attabubu, Prang, Yeji, Grube Fian and Ketiu in order to reduce the incidence of disease such as yaws and malaria 'in the poor and more remote areas'. The predominant aim for the subsequent years was to improve 'conditions in the mining health areas…rural sanitation…congested slums…(and) the extension of health education'.[201] Village dispensaries were the focus because, as the Legislative Council stated 'we are fully aware that Government cannot build hospitals in every state'.[202] Moreover, as one of the African Chiefs, Nana Hima Dekyi XII, stated in the legislative debates in 1940 not only had the fees become too high for the poor to visit hospitals, the Council itself had 'no money' to help.[203] However, context for improvement was made impossible during the Second World War. As a result of staff shortages, whilst there was no 'diminution of Maternal and Child Welfare' other areas faltered.[204] The new hospital for the Takoradi-Sekondi became unavailable, the new Cape Coast hospital's maternity section could not be opened, there were 'severe' epidemics of cerebro-spinal meningitis and outbreaks of smallpox. Moreover, the training of dispensers and nurses planned became impossible.[205] Thus, the colonial government's attempts to initiate immunisation campaigns were stymied. Only Morris seemed to consistently continue his work and he found himself desperately frustrated whilst doing it. In 1941, R. S. Blay told the Council that more than 70 per cent (and in some areas more than 90 per cent) of applicants had been rejected from the army because of poor health, particularly yaws and guinea worm, because there were few dispensers and government doctors' fees were

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[200] 'Provincial Items: Mpraeso: Sanitary Inspector to Note' *The African Morning Post* (Thursday 19 January, 1939) MFM.MC1788, British Library (Boston Spa, UK).

[201] 'Health' *Legislative Council Debates Issue No. 1* (Session 1939-March 14 1939) p.11-13, Balme Library, University of Ghana (Accra, Ghana).

[202] *Legislative Council Debates Issue No. 1* (Session 1939-March 23 1939) p.158, Balme Library, University of Ghana (Accra, Ghana).

[203] Nana Hima Dekyi XII, *Legislative Council Debates* (Session, 1940-March 20 1940) p.131, Balme Library, University of Ghana (Accra, Ghana).

[204] *Legislative Council Debates* (Session 1941-February 18, 1941) pp.10-11, C.S.C 450, British Library (Boston Spa, UK).

[205] *Legislative Council Debates* (Session 1941-February 18, 1941) pp.10-11, C.S.C 450, British Library (Boston Spa, UK).

too high.[206] By 1943, Nana Nyarko VII, the representative of the Ewe-speaking people, was complaining that:

> The poorer parts of the country have little or no medical service…instead of having a few well-equipped hospitals at a few centres there should be many dispensaries all over the country, so that it should not be difficult for any one in need of medical aid to obtain same at the time he needs it…Too much is spent at great centres, and too little is spent in vast areas.[207]

From 1946 onwards there was a concerted government response to the vicious epidemics particularly with smallpox and yaws. In 1946 the government returned to large-scale vaccination campaigns of smallpox as they had done in Accra in the 1920s and more generally in the 1930s. In March 1947 it was reported that 512,939 vaccinations had been performed in 1946, in comparison to 113,361 during the previous year. As a result, in 1947 173 people died from 838 cases (mostly confined to the Navrongo-Nangodi area), as opposed to 1,646 cases with 330 deaths in 1946. By 1948 this had dropped further to 651 cases and 120 deaths, 61 of these in one epidemic in Winneba-Swedru. In 1948, out of a population of 3,962,692 there were 1,377,827 smallpox vaccinations.[208] This scale corroborates William Schneider's thesis that 'in the aftermath of each new outbreak there was more sensitivity, vigilance and attention paid to smallpox' in colonial Africa, that it was not technical or organisational innovation that paved the way for global eradication in the 1960s and 1970s, and crucially that:

> efforts at smallpox control and prevention from the 1920s to the end of colonial rule in West, Central and East Africa…were by far the earliest and for a long time the largest efforts at introducing Western medicine to Africa.[209]

As across Africa, so too in the Gold Coast, these campaigns were: 'a model for further public health efforts, including the WHO eradication campaign'.[210] Mass treatment of yaws also increased in the Dagomba region

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[206] Blay's claim was based on evidence in a newspaper rather than a government enquiry; R. S. Blay, *Legislative Council Debates* (Session 1941-February 26, 1941) p.73, C.S.C. 450, British Library (Boston Spa, UK).

[207] Nana Nyarko VII, *Legislative Council Debates* (Session 1943-March 3, 1943) pp.112-115, C.S.C. 450, British Library (Boston Spa, UK).

[208] 'Chapter VII: Social Services: 1. Health' *Colonial Office: Annual Report on the Gold Coast for the Year 1948* (London: His Majesty's Stationery Office, 1950) pp.43-45.

[209] W. H. Schneider, 'Smallpox in Africa during Colonial Rule' *Medical History* 53 (2009) pp.193–227.

[210] W. H. Schneider, 'Smallpox in Africa during Colonial Rule' *Medical History* 53 (2009) pp.193–227.

of the Northern Territories in which twelve teams were able to treat 20,609 cases.[211] This work continued into the next year under the direction of trypanosomiasis staff and with the help of the French authorities which bordered the North.[212] This benefitted from Colonial Welfare and Development fund money, yaws treatment gained £8,000 between 1948-1949 to which the colonial government added £2,240.[213] It must be noted that the focus of the colonial government on yaws, smallpox and sleeping sickness may have been to do with the relative ease of tackle these diseases. In the case of yaws it may also have been related to its similarities to syphilis which was a major concern for many British colonial officers and missionaries in interwar colonial Africa.[214] In spite of these renewed efforts, communicable diseases remained huge killers with little investment to stop them; cerebrospinal meningitis recorded 11,002 cases and 868 deaths in 1948 alone.[215]

However from 1944 onwards, hospital building had become the colony's main aim, though it was not until 1950 that this became rapid, the pathway had been chosen. In 1944, £83,000 was provided by the Legislative Council for building two new hospitals, out of a total Council expenditure of £5,055,764.[216] In 1946 a nurses training school and hospital were constructed for £46,000 using funds from the £3,500,000 allocated to the Gold Coast through the Colonial Welfare and Development Act. The only issue holding back more hospital development was staff shortages and nurses colleges like these aimed at filling the gaps. In March 1945, there was a further large outbreak of smallpox and epidemic of cerebrospinal meningitis which recorded 1,052 deaths and had to be contained by the army. Nevertheless, the Takoradi-Sekondi hospital was renovated and in the following year a ten-year plan was laid out for 'building new hospitals and for major works in connection with existing ones'.[217] Moreover, £31,000 for a leprosy survey and £94,650 for constructing and initially staffing three leper colonies was allocated from the Colonial Welfare and Development Fund. As Katherine Vorgsathorn has shown for Uganda that such leprosy efforts also

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[211] 'Medical and Health', *Legislative Council Debates* (Session, 1947-March 1947) pp.28-29, Balme Library, University of Ghana (Accra, Ghana)

[212] 'Medical and Health', *Legislative Council Debates* (Session, 1948-April 27 1948) pp.26-27, Balme Library, University of Ghana (Accra, Ghana).

[213] 'Appendix X: Development and Welfare Schemes Initiated or in Progress in 1949' *Colonial Office: Annual Report on the Gold Coast for the Year 1949* (London: His Majesty's Stationery Office, 1950) British Library (Boston Spa, UK).

[214] On syphilis and yaws in early colonial Uganda see S. Doyle, *Before HIV: Sexuality, Fertility and Mortality in East Africa, 1900-1980* (Oxford: Oxford University Press, 2013) esp. pp.123-138.

[215] 'Medical and Health', *Legislative Council Debates* (Session, 1949-March 15 1949) pp.34-35, C.S.C. 450, British Library (Boston Spa, UK).

[216] *Legislative Council Debates* (Session 1944-March 13, 1944) p.8, Balme Library, University of Ghana (Accra, Ghana).

[217] *Legislative Council Debates* (Session 1946-March 12, 1946) pp.6-7, 24-26, Balme Library, University of Ghana (Accra, Ghana).

constituted: ‘a system of isolated, in-patient…care that was limited in scope and reflective not of a goal for the public health…but rather a vision for the future of Uganda as a "civilised" and Christian country’.[218]

Crucially, fitting within Oldham’s vision for development, as the colonial government increased spending on medicine after 1947 largely it was funnelled into previous state and mission infrastructure channels formalising and institutionalising them. Of a total £10,964,604 spending in 1947-1948, 599,597 was spent by the medical heads. In the following year, 1948-1949, there was a further increase to £11,487,703 in total and £814,616 by the medical heads.[219] By 1950, medical heads expenditure had grown to £932,831, which amounted to an overall medical service expenditure of £1,161,250 with an extra £45,210 for tsetse control and £172,333 for rural water development.[220] By 1948 plans had been passed for extensions to the hospitals at Oda, Winneba, Ho and Keta, as well as new dispensary on the hospital grounds at Axim.[221] By 1950, 28 private and mission hospitals with 878 beds, there were 33 government hospitals (27 of which had medical officers) with 1,572 beds. A further mission hospital was planned for Worawora in Southern Togoland. This was in addition to widespread clinic work by the missions and international organisations. In 1949 the International Red Cross Society had five weekly mobile clinic serving over forty towns and villages and in 1950 they treated 60,000 patients in mobile and static clinics (suggesting some decline in the heights of their provision in the early 1940s discussed in chapter 1, perhaps because of increased strains on resources during the Second World War). In 1949, in the Northern Territories two mission dispensaries were opened by Europeans and Americans.[222] In 1950, at Jirapa the French-Canadian Catholics began the first maternity and child welfare clinic in the area, a leprosy clinic was opened at Banda in the Gonja district and a missionary maternity clinic was being built at Nakpanduri in the Mamprusi district.[223]

There was some innovation in healthcare but generally the trend was towards continuation of the mission-state development consensus. In addition to the clinics, the Medical Field Units - which formalised and

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[218] Given the obvious links to Christ’s ministry of healing outcast lepers, Vongsathorn has noted how ‘missionaries wrote often that in healing they were following in the footsteps of Christ, and this was truer of leprosy than other ailments’; See, K. Vongsathorn, ‘Gnawing Pains, Festering Ulcers, and Nightmare Suffering: Selling Leprosy as a Humanitarian Cause in the British Empire, c. 1890-1960’ *The Journal of Imperial and Commonwealth History* 40.5 (December 2012) pp. 863–878; K. Vongsathorn, “‘First and foremost the evangelist’”? Mission and government priorities for the treatment of leprosy in Uganda, 1927-48’ *Journal of Eastern African Studies* 6.3 (August 2012) pp. 544-560.

[219] ‘Appendix II: Revenue and Expenditure: Expenditure by Heads’ *Colonial Office: Annual Report on the Gold Coast for the Year 1949* (London: His Majesty's Stationery Office, 1950) p.91.

[220] ‘Appendix II: Revenue and Expenditure: Expenditure by Heads’ *Colonial Office: Annual Report on the Gold Coast for the Year 1950* (London: His Majesty's Stationery Office, 1950) p.99, British Library (Boston Spa, UK).

[221] ‘Medical and Health’, *Legislative Council Debates* (Session, 1949-March 15 1949) pp.34-35, C.S.C. 450, British Library (Boston Spa, UK).

[222] ‘Social Services: The Medical Service and the Native Authorities’ *Colonial Office: Annual Report on the Gold Coast for the Year 1949* (London: His Majesty's Stationery Office, 1950) p.34, British Library (Boston Spa, UK).

[223] ‘Social Services’ *Colonial Report on the Gold Coast for the Year 1950* (London: Her Majesty’s Stationery Office, 1952) pp.5 and 36-39, British Library (Boston Spa, UK).

unified government immunisation efforts particularly regarding Yaws in the Northern Territories - had £56,190 set aside for them and were in operation by the end of the decade.[224] Much was now being spent on medical services, made possible through loans, rises in export taxes, London stocks, the Colonial Welfare and Development Fund and the global post-1948 boom in cocoa prices.[225] Increased funding also resulted from Colonial Office change; as Joseph Hodge shows, quoting Michael Cowen and Robert Shenton, between 1947 and 1951 there was the one and only 'full blown Chamberlainite "colonial development offensive"…to serve the direct interests of the British national economy'.[226] However, in the Gold Coast these changes served to formally consolidate earlier patterns of health service, not innovate fundamentally.

The culmination of the tying together of medical mission and government in the Gold Coast was in the Government report in 1951 and the Maude Commission in 1952 which together ensured that 'voluntary agencies' became institutionalised. The *Report of the Commission of Enquiry into the Health Needs of the Gold Coast* was a landmark document in colonial and mission health which produced a detailed survey of the colony's medical provision. It followed on the heels of the Government's publication of a 'Statement of Principles regulating financial assistance to voluntary agencies undertaking medical work' in 1951. The Statement of Principles formally declared the desire to obtain 'assistance of non-Government agencies, particularly the missionary organisations, in the expansion of health service, especially in the field of maternity and child welfare work'. Following this the statement offered capital grants and contributions toward recurrent expenditure for hospitals under the administration of combined mission-government committees. The Maude Commission supported the statement wholeheartedly:

> We are strongly in favour of a policy designed to elicit a fuller contribution from the missionary societies and other voluntary agencies…if the maximum advantage is to be taken of these agencies whose objects are charitable and not profit-making, it is worth while having, if necessary, a careful negotiation with each without attempting to force the arrangements into a single mould.[227]

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[224] 'Social Services' *Colonial Report on the Gold Coast for the Year 1950* (London: Her Majesty's Stationery Office, 1952) pp.5 and 36-39, British Library (Boston Spa, UK).

[225] 'Between 1948 and 1952, the price of cocoa rose from £139 per ton to £300 per ton. The Colony's other exports also enjoyed boom prices, and government revenue, which was predominantly based on export taxes, increased over fourfold, from over £11 million to over £42 million' R. S. Gocking, *The History of Ghana* (Westport, Ct.: Greenwood Press, 2005) p.99

[226] J. M. Hodge, *Triumph of the Expert: Agrarian Doctrines of Development and the Legacies of British Colonialism* (Ohio: Ohio University Press, 2007) p.208; citing M. P. Cowen and R. W. Shenton, 'The Origin and Course of Fabian Colonialism in Africa,' *Journal of Historical Sociology* 4.2 (1991) pp.143-174; M. P. Cowen and R. W. Shenton, *Doctrines of Development* (New York: Routledge, 1996) pp.278-279 and 296-297.

[227] *Report of the Commission of Enquiry into the Health Needs of the Gold Coast: Vol 5, 1952* (Accra, Gold Coast, 1952) pp.45-47.

The latter comment challenging the uniformity of a formal 'non profit-making' sector is noted to have emerged from 'experience' with such relations within the UK. Maude himself was one of the major proponents of voluntary-state partnership in the NHS, he was concerned about the effect of government power on voluntarism and had gained significant control during his time as the Permanent Secretary of the Ministry of Health in the War.[228] In his concluding Gold Coast Development Estimates, Maude made provision for £140,000 of grants to medical missions to be expended by the end of the year.[229] This would be a formal sector, the sort which Jennings suggests emerged in Tanzania. However, Maude was also arguing here that such a voluntary sector should not be in a 'single mould'. Instead he wanted to empower the diversity and independent energy of mission *through* formalising their role within increasingly nationalised health systems. In the responding statement by the government on the Report, they fully backed Maude's recommendations.[230] In doing so they proclaimed the start of a decade of very high government spending on missions in which twenty-four medical mission hospitals would be built.[231]

In contrast to Burns, for Maude the defence of medical missionary agency was not only to bolster government efforts or missionary work, but also to ensure the survival of democracy in British societies and liberalism everywhere through a vibrant culture of voluntarism. Maude's hope was to ensure a culture of liberal voluntarism, around the missions in the Gold Coast, that would provide the lifeblood of a national healthcare system which otherwise could be turned into an instrument of coercion by the government. Voluntary associational life was conceived by Maude, through the liberal tradition of Alexis de Toqueville and Edmund Burke, as critical to ensuring the flourishing of modern society.[232] In his address in 1948 on 'The Place of Voluntary Effort in the National Health Service' to the British Hospitals Contributory Scheme Association, Maude argued that:

> voluntary effort (has) the enormous advantage of elasticity and freedom of action. In pioneering and experimental work there are risks which it is right and proper for voluntary agencies disbursing voluntary funds

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[228] Andrew Seaton has noted Maude's significance in the National Health Service in: A. Seaton, 'Against the "Sacred Cow": NHS Opposition and the Fellowship for Freedom in Medicine, 1948–72' *Twentieth Century British History* 26.3 (1 September 2015) pp.424–449.

[229] *Report of the Commission of Enquiry into the Health Needs of the Gold Coast: Vol 5, 1952* (Accra, Gold Coast, 1952) pp.45-47.

[230] *Statement by the Gold Coast Government on the Report of the Commission of Enquiry into the Health Needs of the Gold Coast* (Accra, Gold Coast: Government Printing Department, 1952) p.5.

[231] S. Addae, *Medical Histories Volume 1: From Primitive to Modern Medicine (1850-2000)* (Accra: Eureka Foundation, 2012), pp.87-91.

[232] A. de Toqueville, *Democracy in America* (Trans., Eds..) H. C. Mansfield and D. Winthrop (Chicago: University of Chicago Press, 2000/1835-1840) pp.491-493.

> to take, but which a Minister and public Department as trustees of public fund would be perfectly justifiable in refusing.[233]

Moreover, Maude argued that it was not only this pioneering spirit that could prevail in voluntary associations, this would also challenge the overbearing power of the state:

> It is almost a truism to say in these days that modern inventions - the development of instruments of physical coercion and perhaps even more instruments such as a government-controlled press…have vastly increased the scope and powers of the state…"You will always have a totalitarian State unless you do a great many energetic things to prevent it…"…any useful public activity carried on by voluntary workers (as Mr T. S. Eliot has recently put it, the fulfilment of a public need by a private enterprise) has a value as a counterpoise to these ever increasing activities of the State.[234]

In the context of Europe shortly after war with the Nazis, Maude set his argument for the flourishing of the voluntarist spirit amidst the threat of totalitarianism and the 'physical coercion' which seemed abundantly possible for a state to use against its citizens. Nevertheless, as Toqueville argued that the promotion of equality need to continue, so too did Maude argue that it was in combination with the equalising powers of an interventionist state that the 'fulfilment of public need' was possible.[235] Thus, his work emphasised their combination - a formal voluntary sector which operated in the loose reigns of a nationalised system. According to Maude the kind of organisations that this liberal, elastic and private culture to take root were 'the Churches, the Universities, professional bodies, Trade Unions, Friendly Societies and many others'. These Maude argued had:

> a part to play in providing this counterpoise not less but rather more valuable because the nature of their work brings them into close contact and collaboration with the public services.[236]

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[233] Sir J. Maude, *The Place of Voluntary Effort in the National Health Service: Address to the Conference of the British Hospitals Contributory Schemes Association* (Bristol: British Hospitals Contributory Schemes Association, 1948) pp. 5-11.

[234] Sir J. Maude, *The Place of Voluntary Effort in the National Health Service: Address to the Conference of the British Hospitals Contributory Schemes Association* (Bristol: British Hospitals Contributory Schemes Association, 1948) pp. 5-11.

[235] A. de Toqueville, *Democracy in America* (Trans., Eds..) H. C. Mansfield and D. Winthrop (Chicago: University of Chicago Press, 2000/1835-1840) pp.491-493.

[236] Sir J. Maude, *The Place of Voluntary Effort in the National Health Service: Address to the Conference of the British Hospitals Contributory Schemes Association* (Bristol: British Hospitals Contributory Schemes Association, 1948) pp. 5-11.

As the Gold Coast colonial government stretched out health services beyond the South, it was this vision for a progressive and lively voluntarist liberal culture, with voluntary agencies like medical missions taking risks in coordination with more restricted public services and pioneering the frontiers of the state, these trends informed their decisions. In their statement on Maude's recommendations, the Gold Coast government welcomed the endorsement of their policy and emphasised that 'greater flexibility' would be introduced into their financial arrangements with missionary societies and voluntary agencies.[237] This dovetailed well with the kind of voluntarism that John Stuart had argued that missionaries were trying to promote in late colonial Africa and it built well into the developmentalist visions already prominent within the Gold Coast from Guggisberg and Fraser through to Burns.[238] The result was that Maude had been successful not only in encouraging the application of public funds to voluntary agencies, but also in convincing the colonial government that the national health system be tailored to enable such a liberal voluntarist society.

More widely, the emergence of the formal voluntary sector in Africa was linked to the visions for the success of postwar state welfarism. Given their lack of democratic accountability and their linkages with the 'structural adjustment' reforms of the 1980s, NGOs and FBOs have been viewed as aberrations of state health systems; however, they were actually a fixed part of the system from the 1940s onwards. Michael Jennings has shown in his work on postwar Tanganyika that a public-private, state and non-state contract was produced through Grants-in-Aid provision. Nationalisation of the healthcare system in the 1970s served to reinforce this formal position of voluntary agencies by 'preventing "non-authorised" alternative actors from operating in the country'. The 'NGOisation' of African healthcare was, therefore, not a later product of neoliberalism but a long-term legacy reflecting 'fragility, fragmentation and structural weakness'. NGOs did not create the problem, they exacerbated the issues attendant on a 'franchise state' that had so few resources that it needed to outsource much of its healthcare to non-profit actors in order to prove that it could provide for the welfare of Africans.[239] As Jose Harris has argued, by 1950 there had been a general shift to seeing the voluntary sector as a means to the end of 'controlling…the sphere of public provision'. William Beveridge in his 1948 report was concerned that the Labour government was rejecting voluntary sector provision, but really they saw it as a component in achieving state welfarism. As Emma Hunter has shown the visions of the Beveridge Report were repeated in the Colonial Office Social Welfare Advisory Committee and shaped the emergence of state welfarism in East Africa. Within this were concepts of duty carried over into

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[237] *Statement by the Gold Coast Government on the Report of the Commission of Enquiry into the Health Needs of the Gold Coast* (Accra, Gold Coast: Government Printing Department, 1952) p.5.

[238] J. Stuart, *British Missionaries and the End of Empire: East, Central, and Southern Africa, 1939–64. Studies in the History of Christian Missions* (Grand Rapids, MI: Eerdmans, 2011) pp.6-25, 170-191 and 192-199.

[239] M. Jennings, 'Common Counsel, Common Policy: Healthcare, Missions and the Rise of the 'Voluntary Sector' in Colonial Tanzania' *Development and Change* 44.4 (2013) pp.939-963, esp. 960-961; M. Jennings, 'The precariousness of the franchise state: Voluntary sector health services and international NGOs in Tanzania, 1960s - mid-1980s' *Social Science and Medicine* 141 (2015) pp.1-8.

postcolonial Tanzania state-building.[240] Voluntarist ideas as well as formal structures were a part of the shift in state healthcare provision to formally incorporate medical missions.

The growth of a contracted and formal voluntary sector was happening across a variety of contexts in postwar sub-Saharan Africa. In Francophone as well as Anglophone Africa, the formal voluntary sector was produced on a large-scale, with Colonial Offices funding medical missions extensively through grants-in-aid in the late 1940s and 1950s. Part of the shift to formalise the relationship with missions that had been growing for decades was caused by the creation of massive development funds from Colonial Offices. In Cameroon in the 1950s, medical missions were funded extensively by subventions (grants) from the FIDES (Fonds d'Investissement et de Développement Economique et Social) a central French imperial fund created in 1946.[241] Much of this was Baptist medical missionary work from America, alongside older Catholic work.[242] Certainly, the drive for development can be seen in earlier pre-war initiatives and this was often with voluntary agencies' support. However, these earlier versions were directed by Governors like Guggisberg using their own strategies for raising money on the London stock market and building individual relationships with particular missions. In the postwar era, development planning as a systematic, internationally centralised programme effected African healthcare differently. As with FIDES, from Britain, the Colonial Welfare and Development Act (CWDA) in 1940 also ensured far greater provision than earlier grants. In both French and British development, the process was less piecemeal, less ad hoc and was more widely distributed to national infrastructure. Postwar funding also increasingly focused on large buildings, partly because it was too difficult to commit to recurrent expenditure. In Kenya, there were Grants-in-Aid to medical missions for maternity services in 1925 but generally funding for hospitals were not systematically given across East Africa until the 1950s.[243] In 1954, Zambia missions were receiving 50 per cent of their recurrent expenditure.[244] From 1940, the Zimbabwean colonial government was funding many mission hospitals and by 1977 still 63 of Zimbabwe's mission hospitals were funded by government grants-in-aid.[245]

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[240] E. Hunter, 'Voluntarism, virtuous citizenship and nation-building in late colonial and early post-colonial Tanzania' *African Studies Review* 58.2 (2015) pp. 43-61.

[241] G. Lachenal and B. Taithe, 'Une généalogie missionnaire et coloniale de l'humanitaire : le cas Aujoulat au Cameroun, 1935-1973' 227.2 Le Mouvement Social (2009) pp.45-63.

[242] E. K. Bongmba, 'From Medical Missions to Church Health Services' in E. K. Bongmba (ed.) *The Routledge Companion to Christianity in Africa* (Routledge, 2016) p.511.

[243] L. M. Thomas, *Politics of the Womb: Women, Reproduction and the State in Kenya* (California: University of California, 2003) pp.201-202

[244] Zambia, British Information Services, Centre Office of Information, Reference Division (1964) pp.23 and 43.

[245] C. J. Zvobgo, 'Medical Missions: A Neglected Theme in Zimbabwe's History, 1893-1957' XIII (ii) *Zambezia* (1986) pp.109-118; 'Zimbabwe' in J. Paxton (ed.) *The Statesman's Year-Book: Statistical and Historical Annual of the States of the World For The Year 1981-82* (The Macmillan Press Ltd., 1981) p.1637.

Similarly there were huge amounts of subventions given from FIDES to many missions in 1950s Senegal.[246] This was the case in a variety of other sub-Saharan African contexts too (with the exception of Northern Nigeria), though this thesis cannot describe their full extent.

Crucially, whilst there was more formalised and systematic provision postwar, still a variety of local actors had significant power in the timing and type of voluntary sector that emerged - particularly medical missionaries. A key aim of the FIDES and CWDA programmes were to ensure closely matched funding within colonial governments.[247] The postwar imperial welfarism was not defined simply by top-down control of central colonial offices but as with the 1920s and 1930s, by local administrations and local political conflicts. Moreover, whilst there was connection with 1940s British welfarism, the African context was very different. In colonial Africa there was an assumed lack of government capacity to stretch beyond the centres of power and a long-term expectation that the vital place of missionaries in colonial project would continue, especially in rural areas. By contrast, 1950s British national healthcare increasingly detached from church-support and the state was expected to fulfil wide responsibilities. In colonial Africa missions had a far greater say in how the voluntary sector emerged. In the colonial government in Tanganyika, missions felt threatened in the 1950s by new colonial objectives and whilst the government could never have radically reformed health services missions defended their corner. By 1952 links with missions were increasingly formalised.[248]

The more missions became a cohesive sector the more they could lobby with one voice. In the late 1960s the creation of ecumenical organisations, the Christian Health Associations, also further facilitated a unified political role. In Tanganyika an ambiguous voluntary sector-state relationship remained, with both reliant on the other and both jostling for independent control.[249] Furthermore, as John Stuart has shown, international pressures on missions such as the growth of the communism, anti-European sentiment, political violence, ecclesiastical devolution, African nationalism and the international community, encouraged them to be more concerted about their particular version of voluntarism.[250] In Britain, central training programmes were

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[246] M. M. Lefebvre, 'Histoire de L'Église Catholique au Sénégal' in J. Roger de Benoist (ed.) *Histoire de l'Église Catholique au Sénégal: Du Milieu du XVe siècle à l'aube du troisème millénaire* (Karthala, 2007) p.371.

[247] J. M. Hodge and G. Hödl, 'Introduction' in J. M. Hodge, G. Hödl and Martina Kopf, *Developing Africa: Concepts and Practices in Twentieth-Century Colonialism* (Manchester and N.Y, Manchester University Press, 2014) pp.1-34.

[248] M. Jennings, 'Common Counsel, Common Policy: Healthcare, Missions and the Rise of the 'Voluntary Sector' in Colonial Tanzania' *Development and Change* 44.4 (2013) pp.939-963, esp. 960-961; M. Jennings, 'The precariousness of the franchise state: Voluntary sector health services and international NGOs in Tanzania, 1960s - mid-1980s' *Social Science and Medicine* 141 (2015) pp.1-8.

[249] M. Jennings, 'Common Counsel, Common Policy: Healthcare, Missions and the Rise of the 'Voluntary Sector' in Colonial Tanzania' *Development and Change* 44.4 (2013) pp.939-963, esp. 960-961; M. Jennings, 'The precariousness of the franchise state: Voluntary sector health services and international NGOs in Tanzania, 1960s - mid-1980s' *Social Science and Medicine* 141 (2015) pp.1-8.

[250] J. Stuart, *British Missionaries and the End of Empire: East, Central, and Southern Africa, 1939–64. Studies in the History of Christian Missions* (Grand Rapids, MI: Eerdmans, 2011) pp.6-25, 170-191 and 192-199.

developed. Mission voluntarist ideas and well as voluntary sector structures shaped the emergence of national and international healthcare in sub-Saharan Africa.

ii. SEVENTH-DAY ADVENTISTS AND SCOTTISH PRESBYTERIANS: MEDICAL MISSION WITHIN THE VOLUNTARY SECTOR IN THE GOLD COAST, c.1952-1957

In spite of large-scale funding, there was a large division between the voluntarist hopes of John Maude, the gradualist Christianisation of Burns, and the actual experiences and perspectives of medical missionaries on the ground in the Gold Coast**.** The medical mission boom in the 1950s Gold Coast was caused by specific theological ideas, political support, economic empowerment and cultural change. Yet, medical missionaries' lived experiences were detached from these grand ideals of voluntarism and associational life. This section will conclude with analysis of the Seventh-Day Adventists (SDAs) Mission Hospital at Kwahu and the Scottish Presbyterian mission clinic at Sandema. The comparison here will examine how the formal voluntary sector and experiences of voluntarism did not match up evenly with medical mission identities and practices. Moreover, it will argue that even the focus on hospital provision did not encourage evangelism or gradual Christianisation in the terms that the government would have hoped for their hospitals. The SDAs were far more interested in the supernatural and in outdoor evangelistic theatre.

Charles Arden-Clarke, the Governor of the Gold Coast from 1949 to 1957, was pro-medical mission and consciously aimed to create a voluntarist culture more widely. In the early 1950s, as a result of the many pressures including changing international politics, the emergence of NGOs, ecclesiastical devolution and concerns about communism, missionaries and pro-mission colonial officials actively tried to cultivate a culture of Christian voluntarism through centralised Colonial Service organisations. John Stuart has shown how the first attempt at this was the Oversea Service which aimed to 'foster a sense of Christian fellowship' amongst new colonial service recruits. Notably, at the opening conference for the Oversea Service in 1953, the Gold Coast Governor Arden-Clarke contributed as a speaker. The Oversea Service was dropped for more broadly defined and less evangelical initiatives like the Voluntary Service Overseas (VSO) and eventually, in America, John F. Kennedy's Peace Corps.[251] However, in the Gold Coast, partly through Arden-Clarke, a Christian voluntarist culture was encouraged. The aims of the Oversea Service could be elaborated in a colonial government in which local personal power was still very effective and Arden-Clarke was the ideal promoter. His Father was a Church Missionary Society (CMS) minister in India into the 1920s and Arden-Clarke himself had originally considering going into Church ministry. He wrote to his parents in 1922 about his younger brother becoming a missionary, which he wrote would: 'buck you up no end, because I'm sure

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[251] J. Stuart, *British Missionaries and the End of Empire: East, Central, and Southern Africa, 1939–64. Studies in the History of Christian Missions* (Grand Rapids, MI: Eerdmans, 2011) pp.6-25, 170-191 and 192-199.

you were very disappointed in me'.[252] Moreover, Arden-Clarke had strong views on the benefits of medical mission that were not dissimilar to those espoused by Burns. In a letter to his Father in 1922, Arden-Clarke argued that twelve male missionaries trained in simple medicine would be far better than twenty erecting a stall in the village market and becoming a 'general nuisance' trying to preach monogamy and the Passion of Christ. That way 'Christianity will be knocked out by Mahommedanism' he wrote.[253]

Under Arden-Clarke, medical missions were hugely financed and well staffed, at the high point of world mission Gold Coast mission hospitals and clinics spread rapidly across the colony.[254] Government actual expenditure on medical services increased year on year in the early 1950s, it was £965,020 in 1950, £1,037,795 in 1951, and £1,607,545 in 1952. Missions were building hospitals and dispensaries abundantly. By 1958 the Minister of Health stated that the government paid the recurrent costs for the Catholic hospitals at Jirapa, Damongo and Navrongo, the Basel Mission hospital at Bawku, the English Church mission at Mampong and the Seventh-Day Adventist Church at Kwahu. The independent Ghanaian Government also provided annual grants to the Worldwide Evangelization Crusade's Leper Settlement at Kpandai, the Basel Mission Hospital at Agogo and the Methodist Hospital at Wenchi. They also provided annual grants to the Salvation Army clinics at Begoro and Boso, and the Catholic clinics at Akim Swedru, Eikwe, Dzodze and Nandom (see Image IV).[255]

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[252] D. Rooney, *Sir Charles Arden-Clarke* (London: Rex Collins Ltd., 1982) p.15.

[253] D. Rooney, *Sir Charles Arden-Clarke* (London: Rex Collins Ltd., 1982) pp.3, 15-19, 100-101.

[254] A. Hastings, *A History of African Christianity 1950-1975* (Cambridge University Press, 1979) pp.35-67, 159-175 and 224-288.

[255] It must be noted that given the Colonial Office previously staffed hospitals, whereas the colonies paid recurrent costs as well as grants, the form of the provision medical mission received may have been a result wider imperial policy; J. Arjarquah, E. A. Mahama, Mumuni Bawumia and J. D. Wireko, 'Oral Answers to Questions: Ministry of Health: Missionary Hospitals/Dispensaries at the National Assembly' *National Assembly Debates 1958 Vol. 10* (20 June 1958) pp.117-118, Balme Library, University of Ghana (Accra, Ghana).

Image IV - ‘The dispensary at Nandom gives an average of 37,000 consultations each year. Here a White Sister Chats with a mother who is waiting her turn in the queue with her baby (R/613/26) (c.1950s). K16447, National Archives at Kew (London, UK)

On the eve of decolonisation, missions were opening a plethora of medical institutions with government support and government itself was admitting its inability to set up sustained preventive healthcare. In 1955, the government stated that as mission medical work continued to expand this was 'encouraged as a policy of Government…in so far as the funds available for financial assistance permit'. In the same report, government contributions were extensively listed: in 1954 the new Presbyterian Hospital at Bawku had been completed, the Roman Catholic mission hospital at Navrongo was completed and progress was being made on their at Jirapa - both 'with funds provided by Government'. In addition, the 'Maternity Hospital and Midwifery Training Centre at Mampong was opened in May and was being run by the English Church Mission. There were also grants to the Methodist Mission at Wenchi in Ashanti, the Basel Mission staff training at Agogo, the Salvation Army at Begoro and several Roman Catholic Missions in the Western and Eastern regions alongside Jirapa in the North.[256] Finally, further plans were made for a hospital at Worawora run by the Evangelical Presbyterian Church. Extra funds were also given for pupil nurses hostels at the mission hospitals in Navrongo, Jirapa and Mpraeso (Kwahu).[257] At the same time, the government was building their own hospitals, such as at Koforidua for which £25,000 was earmarked.[258] Alongside these ventures there was the admission that systematic preventative healthcare across the colony was now extremely difficult and had largely been dismissed:

> during 1953, it was appreciated that the basic necessity of improved environment hygiene and the responsibilities of local authorities in this regard were inadequately recognised…It has to be recognised, however, that many local authorities set up under the recent re-organisations of local government are not yet in a sufficiently strong position to permit the establishment of appropriate health services within a co-ordinated framework of supervision by the Central Government.[259]

Given the long-term sustained focus on large-scale institutional medical provision, the new local authority structure could not make up the shortfall easily. Whilst campaigns in preventative healthcare were beneficial, they were not in a position to radically alter the infrastructure and administration already in place. Mission hospital and clinic growth continued. In 1956, £475,075 was granted by government for hospitals, clinics and

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[256] The Methodists themselves were given grants from the government totalling £104245 in 1951 alone, this was the second largest government contribution from all their overseas income. The largest was Ceylon at £172,632. Of course, these were not for healthcare alone and probably prioritised education; 'New Occasions: The Report of 1951 and the 166th Year of Methodist Missions, arranged for use with the Prayer Manual' *Methodist Missionary Society* (May 1952) p.52, Archives and Special Collections, SOAS Library and Archives (London, UK).

[257] T. Hutton-Mills, 'Committee of Supply: Ministry of Health: Expenditure' *Gold Coast Legislative Assembly 1954* (1 March, 1954) pp.1097-1098, Balme Library, University of Ghana (Accra, Ghana).

[258] 'Written Answers to Questions Rev. S. G. Nimako to I. Egala, 'Koforidua Hospital (Expenditure)' *Gold Coast Legislative Assembly Debates 1954* (13th August 1954) p.22, Balme Library, University of Ghana (Accra, Ghana).

[259] 'General Summary of Administration and Development: Staff and Services II' *Ghana Government Report of the Ministry of Health 1954* (Accra: Government Printing Department, 1957) pp.1-8.

dispensaries alone. This was spread across a variety of government and mission projects, for example, £2000 was given to support the Salvation Army's construction of a clinic at Boso.[260]

New mission actors in the 1950s capitalised on government funding to set up flagship institutions and working in places beyond where state medical services could not readily staff. The Seventh Day Adventists set up a hospital for the first time in the Gold Coast at Kwahu in 1955 (and officially opened in 1957).[261] Moreover, the British Salvation Army formed their first clinic at Begoro in 1952 leading later to seven others by 1982 and the Worldwide Evangelization Crusade built a Leper Colony at Kpandai in Northern Togoland in 1952.[262] Old mission actors, by contrast, took the opportunity to expand. For example, in 1953 the Presbyterians at Dunkwa Hospital built a new site with £49,000 of government development funds, with an extra £26,000 earmarked for 1955-1956.[263] Unlike the Government who struggled to staff large institutions in the far flung reaches of the colony, missionary bodies were at a zenith of recruitment from Europe and America.[264] However, there also many that chose not to capitalise on the money and those who were unable to gain any funding. Medical missions in this period were formalising but they remained complex, independent in many regards and varied.

Given issues with independence and wanting to bypass government interests, many missions also set up their own institutions without consulting government. The Roman Catholic Medical Mission Sisters Hospital at Berekum declined government financial aid of around £21,800, which the government could not 'force' them to accept. At the same time, in the same Legislative Assembly debate, the government declined to help Catholics at Foso set up a clinic and were not setting up their own health centre in the area.[265] In some cases, missions did not even inform government as to their aims; for example, in 1955 the Minister of Health declined to give a government subsidy to the Catholic hospital plan for Akrokerri because there was 'No information…received of any intention on the part of the Catholic Mission to build a hospital at Akrokerri' and that 'If the Mission has this intention it is hoped that it will first seek Government approval to implement

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[260] J. Ajarquah to I. Egala, 'Written Answers to Questions: Ministry of Health: Mid-Volta Health Services (Grants)' *Gold Coast Legislative Assembly Debates 1956-57 Vol. 1* (22 May 1956) p.60.

[261] L. Acton-Hubbard, 'Graduation at Kwahu Hospital' *British Advent Messenger* 67.12 (8th June 1962) pp.1-3; G. Land, *Historical Dictionary of the Seventh-Day Adventists* (Maryland: The Scarecrow Press Ltd., 2005) p.115

[262] 'Medical Work', *60th Anniversary: The Salvation Army: Ghana Territory, 1922-1982* (1982) p.7, Salvation Army International Heritage Centre Archive (London, UK).

[263] 'Oral Answers to Questions: Ministry of Health: New Dunkwa Hospital' *Gold Coast Legislative Assembly Debates 1953* (5 November 1953) pp.81-82, Balme Library, University of Ghana (Accra, Ghana).

[264] The struggle to staff hospitals was noted in the 1952 colonial medical department report; *Gold Coast Government Report on the Medical Department For the Year 1952* (Accra: Government Printing Department, 1952) pp.1-25, Korle Bu Teaching Hospital (Accra, Ghana).

[265] J. G. Awuah to F. K. D. Goka, 'Oral Answers to Questions: Berekum Holy Family Hospital (Government Subsidy)' *Gold Coast Legislative Assembly 1956-57 Vol. 1* (27th August, 1956) p.295, Balme Library, University of Ghana (Accra, Ghana); D. Buadi to F. K. D. Goka, 'Oral Answers to Questions: Foso Clinic (Government Grant)' *Gold Coast Legislative Assembly 1956-57 Vol. 1* (27th August, 1956) p.296, Balme Library, University of Ghana (Accra, Ghana).

it…(and state) at the same time what financial assistance, if any, would be required from Government'.[266] A similar issue occurred with regards to Roman Catholic aims to build a maternity hospital at Takyiman for which no application for funds was received.[267] In the same year, the Catholic White Fathers had the Gonja Development Company Hospital at Damongo purchased for them by the Government.[268] The Government then debated whether to buy them an ambulance.[269] This was not simply a denominational issue, but a question of particular congregations or groups who had specific aims and agendas at specific times. Moreover, some missions changed their minds when circumstances changed, the Catholic hospital at Berekum originally had been allocated £21,000 (part of which also was sequestered for the Anglican hospital at Mampong) but when funds were insufficient they were diverted and reconsidered.[270] At the end of the process, Berekum turned down the money offered - choosing to promote their own independence over gaining further financial or national political power.

A new mission, the Seventh-Day Adventist (SDA) medical mission at Kwahu in the mid-1950s provides an example of the complexities of mission involvement in a formalising voluntary sector. As already noted, the SDAs were successful at gaining funding from the colonial government to build their first hospital in the Gold Coast in 1955. This was part of a general expansion of SDA medicine across the world: in 1940 their healthcare assets amounted to $9,687,457.49 with 6,184 employees, by 1956 they totalled $53,841,675.96 with 10,292 employees. In the Gold Coast the government built the hospital and the SDAs staffed it and, as planned under the Maude Commission suggestions, it was established by a combined committee.[271] Along with money from offerings for foreign mission from Northern European Division (for Ghana in 1957 alone this totalled $30,802.33), the SDAs also had doctors from their Skodsborg Sanitarium in Copenhagen who

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[266] R. O. Amuaka-Atta to F. K. D. Goka, 'Oral Answers to Questions: Akrokerri Hospital (Government Subsidy)' *Gold Coast Legislative Assembly 1955* (14th November, 1955) p.408, Balme Library, University of Ghana (Accra, Ghana).

[267] C. S. Takyi to F. K. D. Goka, 'Oral Answers to Questions: Takyiman Maternity Hospital (Government Subsidy) *Gold Coast Legislative Assembly 1955* (8th November, 1955) pp.224-225, Balme Library, University of Ghana (Accra, Ghana).

[268] I. Egala, 'Orders of the Day: Committee of Supply: Ministry of Health' *Gold Coast Legislative Assembly 1955* (17 March 1955) p.1142, Balme Library, University of Ghana (Accra, Ghana).

[269] E. A. Mahama to , 'Oral Answers to Questions: Damongo Hospital (Ambulance Provision) *Gold Coast Legislative Assembly Debates 1955* (22nd March 1955) p.1325, Balme Library, University of Ghana (Accra, Ghana).

[270] Yeboah-Afari to T. Hutton-Mills, 'Committee of Supply: Ministry of Health: Expenditure' *Gold Coast Legislative Assembly 1954* (1 March 1954) pp.1133-1134, Balme Library, University of Ghana (Accra, Ghana).

[271] Editor, 'Evangelism' *Northern Light* 5.7 (July 1955) p.7.

could train staff in specific skills such as physiotherapy.[272] In the first few years the SDAs sent two European doctors and three European nurses, as well as employing many 'national' nurses and assistants.[273]

The initial doctors were presented in SDA newspapers as fired up by evangelistic zeal and a pioneering spirit. According to the *British Advent Messenger*, the second SDA doctor at Kwahu had 'cherished the ambition' of becoming a medical missionary since being a 'schoolboy'. He had committed to two and half years at Kwahu with his wife, and the paper called on all to pray for them to prosper in this difficult task far from their home in Derby, England.[274] Little was said about the people Peter was going to help, the focus was on where he had come from and how big a leap it was to uproot to Kwahu. The first SDA doctor at Kwahu, Dr J. A. Hyde, lauded the medical work there in terms of both modernity and effective Christian care. For example, in the SDA newspaper *Northern Light* in 1956, in an article entitled 'Progress in the Our Mission Fields', the columnist wrote that:

> Dr. J. A. Hyde reported on one of West Africa's newest institutions, the Kwahu Hospital, erected for us by the Gold Coast Government. In its first year it treated 28,844 out-patients and 557 in-patients. Every available space of the hospital has had to be used to try to house these. An indication of the regard in which the hospital is held was given by a recent visitor. On inquiring whether the institution was a mission hospital, and being told that it was, the visitor continued: "I knew it must be; I could tell it by the way you cared for your patients".[275]

In this description, alongside statistics of patient treatment and struggles at housing them all, is an anecdote meant to encapsulate the effect of Christian care. According to the comment, the hospital both helped those inside the institution and proclaimed in an incredibly obvious way the meaning of that care to surrounding people.[276]

However, the SDA's interpretation and reception of their role in the formal voluntary sector was little effected by the terms in which colonial government or Arden-Clarke imagined 'voluntarism'. According to the same Dr J. A. Hyde in 1958, the Governor-General (who by that point was the Earl of Listowel) and the WHO Advisor to Ghana both commented that the Kwahu hospital was the 'best equipped and run hospital they had seen in Ghana'. The latter said this within the Ministry of Health in Ghana, apparently much to the

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[272] 'News Notes' *West African Advent Messenger: Voice of the West African Union Mission of Seventh-Day Adventists* 11.7 (July 1957) p.3.

[273] 'Statistical Report of Seventh-Day Adventist Conferences, Missions and Institutions in the World Field For the Year Ending December 31, 1957' *Ninety-Fifth Annual Statistical Report of Seventh-Day Adventists 1957* (General Conference of Seventh-Day Adventists, Washington D.C., 1957) pp.2 and 14.

[274] 'Adventist Doctor For West Africa' *British Advent Messenger: Organ of the British Union Conference of Seventh-Day Adventists* (9 December, 1955) p.7.

[275] A. F. Tarr, 'Progress in Our Mission Fields' *Northern Light* 6.6 (June 1956) p.2.

[276] A. F. Tarr, 'Progress in Our Mission Fields' *Northern Light* 6.6 (June 1956) p.2.

chagrin of another representative. At this news Hyde declared that the Lord had 'caused His name to be glorified in the councils of men'.[277] This suggests much about how the SDAs had imagined the process of formal collaboration with government since 1955. For SDAs like Hyde, their success was imagined by them in terms of God's name being lifted high in government. This was a specific theology, taken from across the Bible, particularly in Old Testament passages such as Psalm 22, in which God collaborates with His people to proclaim His power in the assemblies of men.[278] The SDAs may have been able to navigate through changes in political context, but this did not mean that they simply received 'voluntarism' unquestioningly. Their successes were stitched into much larger narratives about creation and their own corporate relationship with God which would be increasingly revealed. In these aims they were not particularly subtle. At both the opening of the hospital in 1957, and at the graduation and expansion in 1962 the SDA presented copies of *The Ministry of Healing* (1905) to the Ministers of Health in which the motives of their medical mission are detailed.[279] The hope was that it would shape the government's work and 'bear testimony to the healing work of the Seventh-Day Adventists'.[280]

The SDAs used their role in the Gold Coast formal voluntary sector to conduct intense evangelism and supernatural ministry within a government-built hospital. Any voluntarist images that the SDAs promoted did not determine the internal culture of the mission hospital. In this they prioritised evangelism and spiritual warfare. The real passion of the medical work at Kwahu was certainly not in secular biomedical terms and the idea that as missions increased formal relations with government they secularised, was not the case in this mission. In several SDA newspaper articles this is well illustrated. For example, in the N*orthern Light* in 1957 an article was written emerging from a mission service in London in which testimonies of God's ministry were shared between Northern European Leaders and guests. The writer J. M. Bucy, an America SDA and wife of an SDA Pastor, describes how:

> During the model Sabbath school and mission service conducted by M. E. Lind, the Division Sabbath school secretary everyone actively participated in the review and the lesson study. Then came the gripping story of the deliverance from fetish worship. Miss Amy Horder, a nurse from our Kwahu Hospital in Ghana, told of a woman delivered from heathen worship and a serious physical condition through prayer and loving medical ministry. Truly a remarkable mission story with a happy ending![281]

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[277] A. F. Tarr, 'Heartening Progress in West Africa' *Northern Light* 9.5 (May 1959) pp.4-5.

[278] Psalm 22, King James Version.

[279] L. Acton-Hubbard, 'Kwahu Hospital Officially Opened' *Northern Light* 7.12 (December 1957) p.6; L. Acton-Hubbard, 'Graduation and Expansion at Kwahu Hospital' *West African Advent Messenger* 16.6-7 (June-July 1962) p.3.

[280] L. Acton-Hubbard, 'Graduation and Expansion at Kwahu Hospital' *Northern Light* 12.7 (July 1962) p.4.

[281] J. M. Bucy, 'Division Committee Highlights, November 6 to 13, 1957: New Gallery Fellowship day' *Northern Lights: Organ of the Northern European Division* 8.1 (January 1958) p.1.

This picture of simultaneous spiritual and physical conversion epitomised the effect at which the hospital aimed. Moreover, this was no minor service, Miss Horder was presenting to the heads of SDA mission. 'Fetish' and 'heathen' worship, which were reported to be healed through prayer, were as much a hallmarks of the hospital agenda as much as biomedical illnesses. Furthermore, in an article in the same year in *Messenger*, initially quoting Acts, Lionel Acton-Hubbard the Director of Nursing at Kwahu, wrote that the Hospital's mission was:

> "to labour both for the health of the body and for the saving of the soul…healing all who are oppressed by Satan"…"the medical missionary work is to bear the same relation to the work of the third Angel's message that the arm and the hand bear to the body. Under the direction of the divine head they are to work unitedly in preparing the war for the coming of Christ." The gospel ministry is needed to give permanence and stability to the medical missionary work; and the ministry needs the medical missionary work to demonstrate the practical working of the gospel - neither part of the work is complete without the other.[282]

These impressions from Revelations about the Second Coming of Christ, regarding the 'third angel' especially, are common to SDA theology and here were intermixed with historic church medical missionary traditions about the care of the body and soul, and the practice of gospel being expressed through healthcare. The article sets the Hospital's ministry in the spiritual battle which 'prepared' the coming of Christ, giving their medical mission eschatological significance. Whilst this was not completely different to other missions formulating roles within the colonial state, the emphasis on the supernatural within government-funded healthcare is striking.

The media produced from Kwahu Hospital was about building personal and social identities, as well as beneficial political ones alone. Isabel Hofmeyr has argued that missions created an international '"archive" of strategies for reading and interpretation' across the world, allowing them to imagine themselves *as if* addressing a 'vast international Protestant public', whatever the reality.[283] Hofmeyr's thesis rings true for the SDA authors. With a limited readership in reality and an isolated existence in rural Gold Coast, Acton-Hubbard was constructing a sense of self on an imagined larger spatial and temporal plain, through narrating his place in the Hospital in his articles. These writings provided a platform for individuation and distinction for his role, and a way of trying to shape his identities for himself and for others in dialogue with all the competing demands that the mission field placed on him. As Guido Ruggiero puts it with regards to Italian Renaissance self-fashioning:

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[282] L. Acton-Hubbard, 'An Interesting Experiment at Kwahu' *Messenger: Voice of the West African Union Mission of Seventh-Day Adventists* 11.8 (August 1957) pp.1-2.

[283] I. Hofmeyr, 'Inventing the World: Transnationalism, Transmission, and Christian Textualities' in J. S. Scott and G. Griffiths (eds.) *Mixed Messages: Materiality, Textuality, Missions* (New York: Palgrave Macmillan, 2005) pp.19-36.

> family, friends, neighbours, fellow-citizens, and other social solidarities…each constructed in dialogue with a person a socially recognized personal identity for that individual. Identities based upon 'consensus realities' could be quite different for the same person depending on the group that shared them.

The personal narratives that Acton-Hubbard was creating here give perspectives on how he related to colonial discourses, theology, the supernatural, other people, objects and institutions, and his alien position in the Gold Coast. They do not provide an authentic picture of what was really happening in the hospital, but for how subjectivities were fostered within the context of missionary medicine.[284]

An SDA article from 1956 on electricity, prayer and preaching at Kwahu Hospital shows more detailed aspects of how medical missionaries imagined their roles and experiences. Acton-Hubbard writes in his article entitled 'The Light Shines at Kwahu' of how one night imagining how impressive the Hospital must look to the outside because of illuminated by electricity and how much the locals must desire the 'light' of Jesus Christ. In consequence he gathered the 'young people' around the Hospital, largely a group of male students, and set out to organise an event in the town in which they could proclaim the 'Story of Redemption'. Having gained the Chief's permission (navigating these local politics was vital to the survival of a medical mission) Acton-Hubbard and his group prayed together and began 8 weeks of preaching to assemblies of 'The chief, the Queen mother…the elders…(and) about 80 nonbelievers'. The male students sang anthems and people came to hear before sometimes going to the Hospital's Sabbath service afterwards. Acton-Hubbard and his disciples were replaying the Acts of the Apostles in the wilderness with even a make-shift Pharisee from a local mission to battle:

> Yes, Friends, the young people of the hospital are sharing the light that has been given to them and the Lord is adding His blessing. The students are holding several before and after meetings and are gaining interests. In the course of one meeting a catechist from another mission in another town intruded and asked awkward questions at the end of the meeting. He was given a hearing and his questions were answered to the obvious satisfaction of the chief, his elders, and the assembled company. Yes, a new day is dawning in Atibie, Kwahu. The Holy Spirit is in this work and I feel we are right as we reiterate the words of our Lord "Say not ye, there are yet four months and the cometh the Harvest? Behold I say unto you, lift up your eyes, and look on the fields: for they are white already to harvest." John 4.35.

Having seen off the challenge of local politics in competing missions and powerful chiefs, Acton-Hubbard declared that the evangelism was charging forward with success. Not one mention of any actual medicine in the Hospital can be found in his account - the point of the institution was a base for mission and the shining of literal and spiritual light. His declaration that the 'Holy Spirit is in this work' combined with quoting

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[284] M. Fulbrook and U. Rublack, 'In Relation: The "Social Self" and Ego-Documents' *German History*, 28.3 (1 September 2010) pp.263–272; citing G. Ruggiero, *Machiavelli in Love* (Baltimore, 2007) p. 21.

Christ, is classic trope of Protestant testimony in which the feelings and experiences of the believer's relationship with God are set within the limits of scriptural authority.[285] For his own sense of destiny and with an audience of potential supporters in prayer and money, Acton-Hubbard was constructing a 'socially recognized personal identity' of the evangelist, out on the frontiers of the faith, in dialogue with the movement of the Holy Spirit and the local culture. This was an alternate 'consensus reality' to the sanitised medical director which Acton-Hubbard performed at Hospital openings and graduations for government officials. The role within the formal voluntary sector was an identity largely separate from Acton-Hubbard's spiritual and evangelistic life.

Yet, the contrast of the SDA spiritual agenda and that of its biomedical and colonial political function were not entirely distinct. Pamela Klassen has argued that for many early-twentieth century Canadian doctors technology was imagined as a way of communicating divine love, power and prestige. Liberal protestants were prominent on Hospitals boards and teams of determining clinical practice and they perceived the point of the needle as the channel of the Holy Spirit. Whilst sacral texts disseminated ideas, new materials such as electricity, radio and x-rays were seen 'as both metaphorical and physical channels for healing'.[286] Moreover, as with Acton-Hubbard's epiphany when realising the powerful effect of the light from the Hospital, Klassen argues that many Protestants blended 'scientific and romantic discourses of experience…proclaim(ing) the salvific and therapeutic benefits of technological and medical progress as tools for staying alert to the workings of the spirit'. In the Hospital itself Acton-Hubbard was training what he referred to as 'Lightbearers' that is students who were charged with 'going out Sabbath by Sabbath, distributing literature and tracts, holding compound meetings and of course giving Bible studies'. They were trained with 'visual aids, special tracts, source material, marked Bibles…(and with) the coloured sign "Lightbearer", suitably set off on each side with a flaming torch'. Yet, as well as being a team of roving preachers, the photo with the article shows that these were also nurses and medical auxiliaries, half of them dressed in white medical uniforms and hats (Image V).[287] As Acton-Hubbard wrote on regarding a group of visiting 'evangelistic students studying health and First Aid at Kwahu' were 'absorbed into the working of the hospital'. The students attended lectures on helping on the wards, outpatient departments and even attended major operations. On Sabbath morning they prayed, praised and sang, they also had Bible Studies prepared by Dr. Hyde:

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[285] L. Acton-Hubbard, 'The Light Shines in Kwahu' *The West African Advent Messenger* 10.8 (1 August, 1956) p.5.

[286] P. Klassen, *Spirits of Protestantism: Medicine, Healing and Liberal Christianity* (University of California Press, 2011) pp.18, 102-103.

[287] L. Acton Hubbard, 'Kwahu Hospital Light Bearers' *The West African Advent Messenger* 12.5 (1 May, 1958) p.7

> with the thought of the completeness of the work in God's remnant people…(and) pointed out most vividly the tragic results of over specialisation and counselled us to look to the Master for our guide in living and working…A medical evangelist work has always been near to the hearts of Seventh Day Adventists.[288]

Thus, not only was evangelism an outworking of the hospital ministry, hospital ministry was also used to train evangelists in the meaning of body and soul healing. Giving them physically demanding tasks within the Hospital was not to teach them how to be doctors alone but also to show them how to discipline their work as local evangelists. For example, using the problems with 'over specialisation' in restricting a doctors capacity to help lots of people, Dr Hyde instructed the evangelists on how exactly they should live - looking to Christ and not to narrow intellectual tracks. In drawing everyone into medical aid, Hyde was suggesting that general medicine itself expressed the complete work of Christ's ministry in which all become one in Him. In some sense was no real split here between physical and metaphorical healing, the healing of the body and soul were joined.

[288] Acton-Hubbard, 'An Interesting Experiment at Kwahu', pp.1-2.

Image V: L. Acton Hubbard, 'Kwahu Hospital Light Bearers' *The West African Advent Messenger* 12.5 (1 May, 1958) p.7.

A contrasting mission who began their medical missionary work in the 1950s were the Pentecostals and Scottish Presbyterians at Sandema in the Northern Territories. In 1951 Reverend William Lloyd Shirer, who had been at odds with the Gold Coast colonial government for twenty years, took a job with them as a community development officer. Shirer and his wife Margaret had toured the hinterlands since 1930 and built an Assemblies of God station among the Dagomba. In 1950, British colonial policy shifted direction and the Northern Territories was included partially in the expansion of mass literacy and healthcare, reshaping missionary roles within the neglected region. With fluency in two African languages and a wide network of local contacts, Shirer became a prime target for government recruitment. Shrewdly he accepted the new offer to the Department of Social Welfare and Community Development, and Margaret was given a role as director of the Vernacular Literature Bureau.[289] With little evidence of why they made the switch from strictly 'religious literacy' to government education work, it has been suggested that debates over 'social mission' encouraged their move.[290] Perhaps as well the Shirers exemplify the pure opportunism mission sometimes required. Abruptly, the Shirers had gone from religious mavericks to hot property in the eyes of the state and it seems likely that the couple simply used this to the advantage of Protestant mission. As shown in their work with the Scottish Presbyterians, on the side of the Shirers' new employment they continued to scout out opportunities for missions, using their knowledge and political clout to open the doors wide to incoming teams.[291]

Through their government position, the Shirers facilitated the Scottish Presbyterian medical mission among the Builsa in the Northern Territories which ran from 1955 to 1972. As it was originally designed as a church planting mission and then adapted to suit the large medical needs of the local population, the project was desperately underfunded. It was mostly staffed by volunteers and unpaid Scottish nurses married to clergy. Nevertheless, with the Shirers' advice and contacts the mission drew in crowds of local people for the church and medicine, it forged long-term relations with communities, built several buildings, became a focus for vaccination programmes and set up an ad-hoc but vital ambulance service to the local Catholic hospital. With only an empty government clinic arriving in the 1960s and a couple of Catholic priests in the adjacent

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[289] In this work, Margaret Shirer became known nationally for producing the first written text of vernacular languages in the North, see 'Life in the Northern Territories: Pressing Problems of Roads, Water', *Daily Graphic* (February 7, 1953) p.7.

[290] K. Skinner, 'From Pentecostalism to politics: mass literacy and community development in late colonial Northern Ghana' *Paedagogica Historica*, 46.3 (June 2010) pp.307–323, esp. 311-315.

[291] Correspondence and papers of the Church of Scotland Overseas Council relating to Africa (1965-75) Acc 9638 Church of Scotland, National Library of Scotland (Edinburgh, UK); Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner Scheme of the Reverend Colin Forrester-Paton, in the Gold Coast, later Ghana, 1954-71, Acc 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK); Further papers, mainly ca. 1970-1995, but many earlier, relating to Church of Scotland and other Scottish Presbyterian Missions, and Scottish Churches abroad, Acc 12398, Church of Scotland, National Library of Scotland (Edinburgh, UK) Colin Forrester-Paton Papers 1939-1994, GB 3189 CSCNWW37, New College Library, University of Edinburgh (Edinburgh, UK); Interview with Author, L. Duncan, UK (23 December 2014); A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997) esp. p.108.

area, for almost twenty years the Presbyterian group provided the sole biomedical care to a region of around 70,000 people.[292] As a result of the Shirers and alongside evangelism, ministry and sustained church growth, the Presbyterians created the first elements of biomedical health infrastructure in the area.

The mix of government administration and church-funded mission work between these adroit Pentecostal ministers and Presbyterian medical workers typifies how fluid the boundaries continued to be between the sacred and the secular in healthcare on the eve of the Gold Coast's decolonisation. Healthcare in Sandema was part of a large scale increase in medical mission in the 1950s which spanned across the Gold Coast, including the North, and was backed by a great deal of government funding. There was a plethora of different forms of medical mission involved in this process but which together had transitioned into a formal voluntary sector by the end of the 1940s. As a result of a blend of colonial policymaking, government decisions and missionaries' aims, the expansion was defined by contractual relations to the state. At the same time, informal collaborations remained essential to the sustainability and effectiveness of the missions, especially in local relations with communities, government, chiefs and other missions. There were limits to formal government control and informal relations remained significant to the growth of mission.

By contrast with the SDA mission, the Scottish Presbyterian Medical Mission in Sandema in the Northern Territories had a stronger sense of themselves as volunteers but could not benefit financially from the formalisation of the voluntary agency sector. In terms of their own self-identity, a form of voluntarism mattered far more to the Scottish medical mission at Sandema than it did in general with the SDAs. All of the health workers and nurses at Sandema were literally unpaid until 1966 when they employed their first professional member of staff. Before that the medical mission was informal and unsystematic; it was funded by the Scottish Foreign Mission board but only for the church ministry that it was setting up. It must be noted here that whilst the Northern Territories were included in the 1950s development agenda, this certainly was not such a radical alteration, it still remained the neglected region of the colonial state. The medical work, which comprised a huge amount of the mission's actual efforts, did not earn anything. It was supplied by individual nurses and Minister's wives filling their suitcases with medical equipment and drugs on the way to the Gold Coast. They also personally fundraised on furloughs by travelling around Scotland in all weathers, including thick snow, to churches' 'bandage Sundays', Women's Guilds and Sunday Schools. In a Letter to the Partners of the mission, its leader Colin Forrester-Paton wrote that:

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[292] Correspondence and papers of the Church of Scotland Overseas Council relating to Africa (1965-75) Acc 9638 Church of Scotland, National Library of Scotland (Edinburgh, UK); Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner Scheme of the Reverend Colin Forrester-Paton, in the Gold Coast, later Ghana, 1954-71, Acc 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK); Further papers, mainly ca. 1970-1995, but many earlier, relating to Church of Scotland and other Scottish Presbyterian Missions, and Scottish Churches abroad, Acc 12398, Church of Scotland, National Library of Scotland (Edinburgh, UK) Colin Forrester-Paton Papers 1939-1994, GB 3189 CSCNWW37, New College Library, University of Edinburgh (Edinburgh, UK); Interview with Author, L. Duncan, UK (23 December 2014); A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997) esp. p.108.

> 30 or 40…(come) ever morning for treatment…government had to withdraw the African nurse from the existing Sandema Dispensary…Mrs Duncan originally planned to do something for mothers and their children but as soon as it became known that she was a nurse, people began flocking to her.[293]

Mrs Louise Duncan was the wife of Robert Duncan, the Minister attached to the mission, and had almost no knowledge of the Gold Coast or Africa at all when she arrived in 1956. Unlike the Forrester-Patons who had Oxford degrees, the Duncans were working-class Glaswegians with Robert being the first to attain higher education in his family. Using local networks and connections Colin Forrester-Paton attempted to get funding from the government under their expansion of medicine in the Northern Territories but was never successful. He wrote in 1957 that the Government offered 'to provide a building, medical supplies and a junior assistant for any missionary nursing sister', but nothing arrived, except an assistant in 1959.[294] Instead, the medical mission was set up on a shoestring to cater for biomedicine for around 70,000 Builsa in the region. The waiting room was simply under a tree, the clinic just a large table and the 'Good Luck' cards sent to the Duncans when they were leaving Scotland were turned into patient records. Finally, in desperation, they conducted an emergency ambulance service with their jeep, shuttling extreme cases and problematic births to the Catholic Hospital at Navrongo 18 miles from Sandema.[295]

The Sandema missionaries struggled with disgust, contracting diseases and treacherous journeys and retold these experiences in terms of a volunteer's sacrifice and overcoming. Unlike the settled hospital at Kwahu, the work at Sandema far more obviously exemplified the kind of adventurous 'voluntarism' that was being promoted in the OS, the VSO and the Peace Corps in the 1950s. Some of those that staffed the medical mission were not even trained and had to battle disgust at the sores and wounds to which they suddenly were forced to attend. For example, Jean Paton, the wife of Colin Forrester-Paton, writes in her memoirs that when she had to bandage a septic leg in the dry heat of rural Sandema she wished she had had medical training. This visceral experience in a make-shift clinic without any real support or financial help pushed these missionaries to the edge. Similarly to how Julie Livingston has described negotiating disgust in Botswana, such experiences also were used in memory to construct a life-narrative of over-coming difficulty with self-

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[293] C. Forrester-Paton, 'Letter to Partners' (23.9.1957), Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner Scheme of the Reverend Colin Forrester-Paton, in the Gold Coast, later Ghana, 1954-71, Acc. 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK).

[294] J. Paton, 'Random Personal Memories of Sandema' in A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997) pp.126-131; C. Forrester-Paton, 'Letter to Partners' (8.08.1959) Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner Scheme of the Reverend Colin Forrester-Paton, in the Gold Coast, later Ghana, 1954-71, Acc. 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK). National Library of Scotland (Edinburgh, UK).

[295] Interview with Author, L, Duncan, UK (26 March 2015); Interview with Author, L. Duncan, UK (23 December 2014).

sacrifice and learning more dependence on the love of Christ.[296] Like many Peace Corps volunteers who reported not knowing what to do or how to help the places to which they had been sent, the Sandema missionaries were throwing their work together as it came to them.[297] Sometimes this was narrated in terms of impossible struggle and other times in terms of achievement against the odds. Instead of working solely in the clinic, Jean Paton attempted to produce community health education and teach basic hygiene in order to best use her skills.[298] For Louise Duncan, the struggle to maintain the clinic at one point became almost unbearable, her husband writing to the mission board that:

> We are faced with the possibility of closing the clinic if we do not find someone. The great physical strain was seen in the contemplated outstation work, which has never been developed for obvious reasons. If a women's worker were appointed of whom you had doubts about her ability to tackle the trekking, then there is no need for her do it (sic). The clinic, the women's class and the Sunday school in Sandema would offer her enough work without that strain.[299]

Yet, in her life narrative, retold in interview, the story was of overcoming the difficulty of disease and burden. Even the story of her contraction of typhoid was retold in terms of the miraculous journey Robert took to get to the hospital, managing to drive across thin concrete tracks totally submerged under a flooded river.[300] Given the much later re-telling this cannot be assumed to given a pure picture of the past, present concerns in conversation with the interviewer shaped exactly the kind of stories that Louise would and could tell. However, given the similarity of the narratives of experiences with Peace Corps volunteers in the 1950s and 1960s, a sense of a volunteer culture with specific struggles can, tentatively, be suggested.

Given their exclusion for the formalisation of the voluntary sector in the Gold Coast, local politics were a much more significant concern for the medical mission at Sandema. At the outset of the mission it was building relations with local chieftaincy, using interpreters, that ensured they were able to settle in the area. Across the life of the mission these negotiations continued to be vital. For chiefs the mission was useful, by

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[296] J. Livingston, 'Disgust, Bodily Aesthetics and the Ethic of Being Human in Botswana' *Africa: The Journal of the International Africa Institute* 78.2 (May 2008) pp.288-307.

[297] L. L. Lombas, *Individualism in Action: an Investigation into the Lived Experiences of Peace Corps Volunteers* (Unpublished Doctoral Thesis, University of Colorado, 2011) esp. p.61; M. E. Latham, *Modernization as Ideology: American Social Science and Nation-Building in the Kennedy Era* (Chapel Hill: University of North Carolina Press, 2000).

[298] J. Paton, 'Random Personal Memories of Sandema' in A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997) pp.126-131

[299] R. Duncan, 'Letter to Rev Neil Bernard, Africa Secretary. F. M. C. (6 June 1960) Correspondence and papers of the Church of Scotland Overseas Council relating to Africa (1965-75), Acc. 9638, Church of Scotland, National Library of Scotland (Edinburgh, UK).

[300] Interview with Author, L. Duncan, UK (26 March 2015); Interview with Author, L. Duncan, UK (23 December 2014).

acting as 'gatekeepers' between the medicine, land and community, bolstered their legitimacy as spiritual and political leaders. In order to continually empower themselves, as Justin Willis has shown, chiefs constructed 'elaborate political structures' using different forms of knowledge.[301] Before colonialism most chiefs in the Northern Territories were not custodians of the land but in the 1920s creating such administrative roles from them allowed 'indirect rule' to function.[302] Navigating these power dynamics was crucial, as Robert Duncan writes, the chief in Doninga was pro-Roman Catholic so they could not go there. However, when a fight occurred between the Chuchiliga and Sandema Nabs the missionaries capitalised by joining in the peace process and making new contacts without having to travel. The result was they ensured their welcome in Chuchiliga, and the 'Kasem towns of Gbenia, Chiana and Ketiu'. As with much earlier pioneering missions, such as those described in nineteenth-century Uganda by Robert Rothberg in 1964, the Sandema missionaries were dependent on chiefs to make their ambitions to grow a reality.[303] This was significant in an everyday sense, for example, Forrester-Paton describes how 'by coming to our service in the Local Council Hall from time to time, with a group of elders and once at least with a large retinue of drummers' the Chief pronounced his authority as a Builsa and surveillance of who was doing what.[304] Forrester-Paton noted that this could be 'awkward for the preacher who might find halfway through his sermon that he was speaking to a very different congregation'. The priority he notes was not in 'converting the Chief' but in 'managing him'.The Chief was the central authority in an area sidelined by the colonial state, he would invite an Imam, he would attend the White Fathers events and aid the Presbyterians because, as he once commented to Forrester-Paton 'when a girl has several suitors, she gets more gifts'.[305]

As a result of the mission's reliance on the local politics, the Presbyterians fostered close relations of exchange with the community. In Marianne Gullestad's *Picturing Pity* on a North Cameroon mission she argues that missionaries fostered one-way relations with local communities because they only gave out aid instead of entering in meaningful, interdependent processes of exchange in which they received gifts too.[306] This has much merit, missions which had stronger and more formal relations with the voluntary sector in the Gold Coast need to not ask communities for as much; therefore, they did not need to spend as much time

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[301] J. Willis, 'Chieftaincy' in J. Parker and R,. Reid (eds.) *The Oxford Handbook of Modern African History* (Oxford: Oxford University Press, 2013) pp.208-223.

[302] C. Lund, *Local Politics and the Dynamics of Property in Africa* (Cambridge University Press, 2008) pp.1-67.

[303] R. I. Rothberg, 'Plymouth Bretheren and the Occupation of Katanga, 1886-1907', *Vol. 5 Issue 2, Journal of African History* (July 1964) pp.285-297; R. Duncan and L. Duncan, 'Sandema District (II)' in A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997 pp.135-141.

[304] Interview with Author, L. Duncan, UK (26 March 2015).

[305] C. Forrester-Paton, 'Sandema (1)' in A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997) pp.108-125.

[306] M. Gullestad, *Picturing Pity: Pitfalls and Pleasures in Cross-Cultural Communication. Image and Word in a North Cameroon Mission* (Berghahn Books, 2007) pp.275-279.

considering the community's way of seeing the world.[307] By contrast, situations of interpretation and exchange in which intermediaries such as translators were critical power brokers, were not as common once missions had bureaucratised and formalised.[308] However, the missions Gullestad describes were still shaped by the cultural encounters into which they entered. As Jamie Scott has noted, even in contexts in which there was a significant imbalance of power, there was still a 'constant commerce' in which missions were changed by context in which they found themselves.[309] What was different about missions like that in Sandema was that over a long period of living in the area, negotiating with political leaders, conducting clinic work and healthcare in homes, and eating in locals markets, the missionaries became a part of the community. Louise Duncan described in interview her enjoyment of being invited to join in festivals where the elders drank and people danced. She developed close personal bonds with the Builsa neighbours who made dresses with her and, when she first arrived, came to see if the white rubbed off when she washed. She also recalled the many children that would follow her around wanting to learn English as she travelled around for house visits and putting on lamp-lit film slide shows for them. Robert Duncan particularly emphasised an extraordinary moment when he prayed with the community over their crops during droughts and rain suddenly began to fall.[310] Louise recalled how the mission finally did formalise in the mid-1960s with a professional nurse, contracts and financial obligations and that, by contrast to their work in the 1950s, no mission had since 'been as free as we were free'.[311]

However, not all the community were enthralled by the Sandema mission, only illiterates, children and the Sandema Chief. From the local Catholic perspective, the Sandema and Assemblies of God missions were battling for influence amongst the population by negotiating with the Chief and giving handouts to the poorest elements of the community (including soap and sweets), but not always successfully. In the White Father's annual mission report for 1958 and 1959, the author wrote that the Sandema mission was brokering deals with the Sandema chief to its advantage. The author wrote the Presbyterians were 'working against the will of the Chief of Chuchiliga', whereas in Sandema the Chief seemed to be using 'his influence and authority to more or less force some people to follow their catechism-classes'. The Chief was also covering their move to empty a Presbyterian teacher in their Middle School by getting him to write to the Education Department at Tamale saying there was no Builsa teacher capable of the post. The White Father noted that the Presbyterian Pastor was giving milk to women and selling pieces of soap 'at a greatly reduced price'

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[307] M. Laven, *Mission to China: Matteo Ricci and the Jesuit encounter with the East* (London: Faber and Faber, 2011).

[308] B. N. Lawrance, E. L. Osborn and R. L. Roberts, *Intermediaries, Interpreters and Clerks: African Employees in the Making of Colonial Africa* (University of Wisconsin Press, 2008).

[309] J. S. Scott, 'Penitential and Penitentiary: Native Canadians and Colonial Mission Education' in J. S. Scott and G. Griffiths (eds.) *Mixed Messages: Materiality, Textuality, Missions* (New York: Palgrave Macmillan, 2005) pp.111-134.

[310] R. Duncan and L. Duncan, 'Sandema District (II)' in A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997) pp.135-141.

[311] Interview with Author, L. Duncan (26 March 2015); Interview with Author, L. Duncan, (23 December 2014).

which was enabling them to enrol a 'moderate group of illiterates'. By contrast, the literate classes had abandoned the Protestants and according to the White Father, joined the Catholics. The Head Teachers in the District attempted to force the Chief to retract his letter regarding the lack of capacity. 'Needless to say,' the White Father concluded, 'the Presbyterians are looked upon with more and more suspicion by all the teachers and literate people'. Finally, the report explained that another ploy of local Protestants, this time the Assemblies of God mission, had been to literally hand out 'candies' to children to attract them. This was followed by, the report fumed, by a 'violent outburst of shocking insults towards the Catholic Church'.[312] Though it claimed, with some satisfaction, that there those who chose the Catholic church over 'candies'.

[312] Box 484, 'Report 1958-1959, Navrongo RS1, Rapports and Statistics' White Fathers Archive (Rome, Italy).

Image VI - ‘White Fathers in the Northern Territories of the Gold Coast’

‘The White Fathers - are responsible for a great deal of welfare work among the people of the Norther Territories of the Gold Coast…The motor cycle - which can get through narrow tracks which no four-wheeled vehicle could tackle - is the favourite means of transport among White Fathers in the North. A large number of remote villages are regularly visited’. (R/613/13) K16447, National Archives at Kew (London, UK)

Finally, in contrast, to the Sandema mission's maternal and child healthcare, the general government focus remained on hospital provision and maternity and child welfare clinic work was declining. In 1945 mission centres had 97,126 children (double that of the Red Cross and Government Centres combined, at 52,738 for government and 42,819 for the Red Cross) and 6,238 expectant mothers compared with 30,990 at government centres and 36,893 at Red Cross.[313] By 1950 mission centres had already begun to reduce to 93,856, with Government picking up the shortfall with 84,520, numbers for expectant mothers were about level with 1945. However, by 1952 missions had dropped to 67,664 children attending and government to 59,725. Expectant mothers were seen around twice as much with 11,337 for missions but government saw very few - 15,145 compared with 33,037. New government funding was clearly not going into the same types of medicine that it was in the 1920s and 1930s when missions led the way in provision for child and maternal health.

With the switch to a focus on hospital provision in Burn's agenda, maternal and child health suffered in the 1950s compared with the 1930s. In 1952 the Ministry of Health had complained that it was struggling to find a sufficient number of trained Health Visitors.[314] The infant morality rate rose from 119 in 1945 to 125 in 1949.[315] In 1953 the death of rate of women at child birth increased from 18.4 per 1000 total births to 19.0 per 1000 in 1953, by 1954 it was at 21 per 1000 total births.[316] In 1954 the medical report declared that: 'there appears to have been no real improvement in the Infantile Mortality Rate during the past 20 years'. Whilst they could not provide an accurate survey of the whole colony given the difficulty to gain full government registration (for maternal morality, the figures were based on 36 registration areas from 1950 to 1954), the estimates were as follows:

Year	1950	1951	1952	1953	1954
Infant Mortality per 1000 related births	122	117	125	113	119

Table II: 'Infant and Child Mortality' *Report of the Ministry of Health for the Year 1954* (Accra: The Government Printer, 1959) pp.21, 97, Wellcome Trust Library (London, UK).

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313 Again, a considerable change from the dominance of the Red Cross in the earlier 1940s; *Gold Coast Colony Report on the Medical Department for the Year 1945* (Accra: Government Printing Department, 1946) p.13, LSTM (Liverpool, UK).

314 'Maternity and Child Welfare', *Report on the Medical Department for the Year 1951* (Accra: Government Printing Department, 1952) p.11, Korle Bu Teaching Hospital (Accra, Ghana).

315 'Infantile Mortality Rate' *Report on the Medical Department for the year 1950* (Accra: Government Printing Department, 1952) p.8.

316 'Table X: Birth, Still-Birth, Death, Neonatal, Infantile and Maternal Morality Rates - 1950-1954' *Report of the Medical Department for the Year 1954* (Accra: The Government Printer, 1957) pp.21, 97, Wellcome Trust Library (London, UK).

This was consistently higher than the figures for the 1930s shown in the conclusion of chapter 1, in which infant mortality was reduced to 100 per thousand related births. Obviously the incorporation of greater amounts of people, from population rises and the extension of state surveillance, will effect these statistics but the general impression is of mixed success in the 1930s and serious issues in the 1950s. This infant mortality problem particularly was hotly debated in the Legislative Assembly in which the Ministerial Secretary for the Ministry of Health, J. K. Donkoh, blamed pregnant women for failing to attend hospitals regularly. At this some honourable members replied 'Oh no! No!' and Dr Ansah Koi argued that it was the lack of sufficient oxygen in hospitals. Another minister, Mr Boakye blamed the problem on the lack of maternity clinics across the country.[317] Given how difficult a long journey for a pregnant woman might be to a hospital, and the general reduction in clinics and lack of local care, in a sense all these arguments had merit. As the American political scientist and sociologist, David Apter, wrote in 1955 from a field study with Gold Coast University on Akuse dispensary, in the colony:

> The death rate is high, how high no one knows in precise terms. Dispensaries are few and far between. Health facilities are overcrowded. In some areas people are afraid to go to a hospital because so many people die there after having traveled many miles on foot, by canoe, or by lorry, arriving too late for effective treatment.[318]

Hospitals might provide a high level of care but to even access one also required a high level of risk for most people. On the other hand, it must be also noted that when an ante-natal care mobile clinic was run in HuHunya it was 'very poorly attended'.[319] As the ante-natal care at Sandema Presbyterian missions shows, some women were discouraged by husbands from leaving the house to visit clinics. Therefore, house visits were required which needed relationships of trust to be fostered over a long time for decent care to be possible.[320] Skimming the surface of the problem could be just as ineffective as sporadically setting up white elephants. Though, not everything had changed, in 1947 rising child and maternal health attendances had been assessed by the medical department as caused by them becoming a 'pleasant social event' similarly to

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[317] J. K. Donkoh, J. G. Awuah, Dr. Ansah-Koi and Mr Boakye, 'Oral Answers to Questions: Ministry of Health: Maternity Death Rate and Infant Mortality Rate' *Gold Coast Legislative Assembly 1954* (1 March 1954) pp.1088-1090, Balme Library, University of Ghana (Accra, Ghana).

[318] D. E. Apter, *Ghana in Transition* (Princeton: Princeton University Press, 1955/Second Revised Edition 1963) p.40.

[319] 'Red Cross Clinics' *Report on the Medical Department for the Year 1955* (Accra: Government Printing Department, 1959) p.48, LSTM (Liverpool, UK).

[320] Interview with Author, L. Duncan, UK (22 December 2014); Interview with Author, M. Byers, UK (29 December 2014). Interview with Author, D. Hodds (07 April 2015); A. A. Berinyuu (ed.) History of the Presbyterian Church in Northern Ghana (Accra: Asempa Publishers, 1997) esp. p.108.

the Kumasi health weeks in the 1930s.[321] Overall, in spite of the issues and in contrast to mission like that at Sandema, hospital construction such as that of the SDAs at Kwahu, continued apace.

iii. CONCLUSION

This chapter has shown how trends similar to those found by Michael Jennings for Tanzania, were also taking place in Ghana at the same time. It has significantly extended John Stuart's analysis of 1950s missionary voluntarism and has, for the Gold Coast, supported Jennings' thesis that a formal voluntary sector emerged in Tanzania in the 1950s and 1960s. In the late colonial Gold Coast there was a huge expansion of medical mission based on the terms set by Governor Alan Burns during the Second World War. The aim was to create a large hospital network paid for by government and staffed by Christian missions within a formal voluntary sector. The result for missions of these various trajectories was complex and not uniform or unilinear. Mission culture was not simply determined by voluntarist political agendas, financial aid or softly shaped voluntarist norms within the colonial state. Missionary responses and culture were determined by denomination, specific congregation, theology, location, timing and generation - as much as by other forces.

Burns and Maude's visions were unevenly matched up with the realities of medical mission in 1950s Ghana. In the Seventh-Day Adventist medical mission Hospital at Kwahu they were successful at benefiting from the emergence of the formal voluntary sector. However, their interpretation and reception of these processes did not stay in the terms colonial government may have imagined. Alongside political identities were SDA missionary self-fashioning of social and cultural identities. These were informed by supernatural narratives and materials, and joined together biomedicine and spiritual culture. Rather than gradually Christianising through medical work, they went out into the streets with theatre.

By contrast, the Scottish Presbyterian medical mission at Sandema was very unsuccessful at gaining anything from the emerging voluntary sector. This was partly because though the Northern Territories did gain more hospitals and government funding in the 1950s, large swathes remained neglected. Instead, more like a nineteenth-century mission, the Sandema clinic relied on deft negotiation with local politics and the community. The concept of 'voluntary' was ambiguous and was deployed in contested ways across this period. The mission clinic at Sandema much more clearly shows the relevance of volunteering and the voluntarist lifestyle; however, they could not gain anything other than a single assistant or find their place within the formal voluntary sector. This was partly a consequence of the state focus on creating a voluntary sector of hospital provision which trumped the promotion of Maude's voluntarist norms.

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[321] 'Maternal and Child Welfare', *Gold Coast Colony Report on the Medical Department for the Year 1947* (Accra: Government Printing Department, 1948) p.4, Korle Bu Teaching Hospital (Accra, Ghana); 'Kumasi Health Week, 1929-1930: Group of Prize-Winning Babies', *Gold Coast Colony Report on the Medical and Sanitary Department for the Year 1929-1930* (1930) pp.13-57, Balme Library, University of Ghana (Accra, Ghana).

Finally, building on the previous chapter, this piece has also shown how opinions on Christianisation, and ambitious aims for Christian mission and development were not confined to medical missions alone. Colonial Governors and officials had their own perspectives on proselytism, evangelism and development, which could be separate, complementary or even directly antagonistic to the views of medical missionaries themselves. As will be shown in the next chapter, battles over claims to true Christian faith, to modernity and development, to the meaning of medical mission, and to the support of Ghanaian Christians, could be fought between the churches and state, and within them. These postcolonial conflicts and debates were understood in relation to the colonial past, and in relation to the experiences and identities of medical missions and development within colonialism.

Chapter 3

MEDICAL MISSIONS IN NKRUMAH'S GHANA, c.1957-1983

In 1962 David Murray returned to his home at Achimota School to find it burned down. He had worked there since 1956 as a doctor for the school and unofficial medical officer for the Scottish Presbyterian Church before taking a long furlough of three years back in Scotland in 1959. When they first arrived, on the eve of independence in 1957, the family had been warmly welcomed into the Ghana of the first postcolonial President - Kwame Nkrumah. The Murrays' first years mostly went without a hitch and were given a grand house on Achimota land. However, when they returned, Nkrumah's regime had hardened its attitude towards specific groups. Seated at Achimota, Nkrumah's alma mater and a beacon of Ghanaian development, Murray was a prime target for a symbolic attack on the aspects of Africa yet to be decolonised. Burning down the Murrays' house was only the beginning. In public, locals turned on the family, the press denounced them and the chemist hindered their access to pharmaceuticals. Around them expatriates were being expelled. On one occasion, the brother of Achimota Hospital's Sister, Vicky Teye, returned after visiting and demanded that they remove and burn his name out of their visitor's book.[322] The Murrays managed to leave Achimota and David took a job at the nearby 37 Military Hospital, but there too he was resented by other staff and bullied out as imperial remnant. In 1968, the Murrays left Ghana for Uganda where they set up a private practice.[323]

This snapshot of the Murrays' fluctuating fortunes captures an important aspect of missionary lives in postcolonial Africa, but it is certainly not the whole picture. Whilst this account might be evocative of the sort of challenges missions could face, under Nkrumah such conflict was largely confined to the centres of state power. In Nkrumah's socialist development of Ghana between 1957 and 1966, medical missionaries could be cast as necessary experts and healthcare workers because of the consolidation of their power in late colonialism. At the same time, because of their role in colonialism and their long-term linkages to its structures, they also could be attacked as vestiges of imperial rule. Missions thus could be seen both as representatives of scientific modernity or stooges of colonial anti-modernity. Ultimately, how this contested role played out in the development narrative depended on the political utility for Ghanaian nationalist of identifying themselves with either missionary modernity or their colonial roots. Simultaneously missions could be identified as important supporters of technocratic development or detractors from postcolonial independence, when it suited Ghanaian political actors. Yet, throughout these battles, missions continued to expand their coverage and funding from government. By 1967 there were 34 mission hospitals in Ghana

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[322] D. Murray, *Bits and Pieces: The Undistinguished Career of David Murray* (Unpublished Memoir, 2011) courtesy of David Murray's daughter Naomi Forbes.

[323] Murray, *Bits and Pieces: The Undistinguished Career of David Murray* (2011); B. Baddoo, *To Ghana with Love* (lulu.com, 2012).

staffed by a wide variety of congregations and denominations, only a handful fewer than the 39 Government hospitals.[324]

This chapter will explore Nkrumah's relationship with medical missionaries and the need and desire to fund them. Second, it will explore the other voices within the Ghanaian government supporting medical missions and Christianity more widely. It will examine a moment in 1958 when a high-ranking politician, Mumuni Bawumia, argued in the Parliamentary Assembly to give all Ghanaian healthcare over to missions. It will contrast this with the invocations on behalf of missions of J. E. Appiah. Appiah wished to be seen empowering high-level technical medical missions such as the Basel mission at Agogo, in order to dissociate with his former 'tribalism' in the early 1950s. Not all political actors in Nkrumah's Ghana knew how to navigate the tensions between missions and development to their advantage. This chapter will also show how, on their own initiative, 'leftists' in the Northern Territories took control of all the Catholic hospitals in Navrongo. This was shortly followed by Nkrumah returning all the hospitals to the missionaries and funding them even more extensively. Nkrumah's developmentalism could seem inconsistent, changed across his tenure and, as will be shown, could be confusing even for his adherents.

This chapter will conclude by examining how medical missions were changing in response to decolonisation, taking the narrative beyond Nkrumah's downfall in 1966.[325] Crucially, this section will emphasise the detachment between high level concerns for modernity and sovereignty in the Ghanaian Parliament, and medical missions' own experiences and perspectives on decolonisation. Rather than imagining changes in terms of modernisation or separation from colonialism, medical missions imagined it in terms of 'Africanisation'. This section will compare the differences in Catholic and Protestant responses to 'Africanisation', analysing how local, regional and transnational politics could shape this process as much as national political change.[326] It will argue that Catholic medical mission 'Africanised' in the sense of training many Ghanaians as nurses. However, because expatriate missionaries kept control of many of the higher positions in healthcare, 'Africanisation' in terms of responding to ideas, structures or perceptions of 'African-ness' was more limited. In order to show this, the chapter will utilise longer-term data on the Africanisation of medical missions in Ghana up to 1983.

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[324] 'Table 8: Distribution of Hospitals, Health Centres and Other Fixed Clinics by the Type of Institution and Region' *Republic of Ghana: Annual Report of the Medical Services of Ghana 1967* p.64, ACS0.1.48 (Liverpool School of Hygiene and Tropical Medicine).

[325] A. Hastings, *A History of African Christianity 1950-1975* (Cambridge: Cambridge University Press, 1979) p.224.

[326] D. Maxwell, 'Decolonisation' in N. Etherington (ed.) *Mission and Empire* (Oxford: Oxford University Press, 2005) pp.290-291.

i. NKRUMAH, CHRISTIANITY AND MEDICAL MISSION IN GHANA, 1957-1966

Nkrumah set the context in which Ghanaian politicians and medical missions imagined the process of development and independency in the 1950s and 1960s. He dominated political structures and political culture but in complex and contested ways. In order to show how medical missions in Ghana responded to decolonisation, understanding the nuanced ways in which Nkrumah imagined Christianity and missionaries is important background. Nkrumah was concerned to re-sacralise the Ghanaian state when he took over as President in 1957. Nkrumah began a process of re-defining Christianity in his own terms, in relation to pre-colonial pasts and traditional African religion. Amidst his challenges to missionary tradition, he promoted Christian beliefs. Moreover, alongside his attacks on medical missionaries such as David Murray, Nkrumah needed the formal voluntary sector and historic forms of mission medicine to run healthcare. Given the consolidation of medical mission across the colony in the 1950s, Nkrumah focused on symbolic and culture wars in visible places in the capital with wider significance for African achievement - such as at Achimota. Concurrently, mission healthcare in Ghana grew across the country. David Murray's tale of expulsion was an actually an anomaly. Nkrumah constructed the kind of narrative of modernity he wanted for Ghanaian freedom from imperial and religious bonds by focusing on key points of significance that would be seen by specific audiences, not wholesale or systematic change. Nkrumah did not wholly reject the religious past but modified older economies of the sacred. Sacraments were reconceptualised, traditional rituals were retained and developed in new ways, and in cultural exchanges and negotiations old and new beliefs were mixed.[327]

Nkrumah's relationship with religion was complicated to say the least. He had trained as a Presbyterian minister in the United States and yet had also (at the very least) allowed a cult around him as a Messiah to form whilst he was President. He advocated a type of civil religion and noted that because religion was an 'instrument of bourgeois social reaction…the state must be secular', and yet ejected clergy he did not like, planted Party officials in churches and carried a walking stick and white handkerchief like a 'priest of African religion'.[328] This was a state that wished to influence religion, whilst not wanting the church to influence it. Notoriously Nkrumah infuriated the church and missions when he put up a statue of himself outside Parliament House with a sign saying 'Seek ye first the political kingdom' (an authoritarian twist of Christ's invocation to 'Seek ye first the kingdom of God'), and still Nkrumah drew on all forms of spiritual

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[327] For similar processes in a different time period and culture see A. Walsham, 'Historiographical Reviews: The Reformation and the "Disenchantment of the World" Reassessed' 51.2 *The Historical Journal* (2008), pp. 497–528 citing Robert W. Scribner, 'The impact of the Reformation on everyday life', in Mensch und objekt im mittelalter und in der fru¨hen neuzeit (Osterrichische Akademie der Wissenshaften, Philosphisch-Historische Klasse Sitzungsberichte, vol. 568, Vienna, 1990), pp. 315–43.

[328] R. Yaw Owusu, *Kwame Nkrumah's Liberation Thought: A Paradigm for Religious Advcoacy in Contemporary Ghana* (Eritrea: African World Press Inc., 2006) p.137; C. Forrester-Paton, 'Letter to E. C. Bernard (African and America Secretary) copy to WFM and T. S. Colvin' (1.12.61) Ghana Treasury and Secretary 1955-1961, Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner, Acc. 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK).

authority from animism to the freemasons.[329] What can be said is that Nkrumah shifted from a relationship with God, which he described as 'very personal…(and) direct', to a focus on the aggressive pursuit of pan-African cultural and political independence as his primary concern when he assumed power.[330] As much as was practically feasible, secularisation and attacking missionaries were important tools in his Nkrumah's arsenal but as rhetorical and symbolic strategies rather than literal policy. In spite of his image as an ideologue, Nkrumah did not let any animosity toward the colonial government-mission nexus interfere with his paramount aim of African independence, and for the moment that meant the success of his brand of Ghanaian nationalism at all costs.[331]

In general, Christianity was also incredibly useful to Nkrumah because, as John Pobee puts it, the Nkrumah's Part the CPP (Convention People's Party) realised that 'homo ghanaiensisis is homo radicaliter religiosus and could, therefore, be reached through religion'. As Rupe Simms has shown, the Party newspapers used Biblical language, relating taking up CPP principles to being filled with 'new wine'. Moreover, several times in the early 1960s the *Evening News* described Nkrumah as the Second Coming of the transfigured Messiah. From 1963 the Newspaper Licensing Act had meant that only Party newspapers could exist and the *Evening News* had become one of the foremost mediums of state propaganda. Yet, as early as 1950, the same newspaper had re-written the beatitudes in Matthew in terms of self-government and activism: 'Blessed are ye, when men shall vilify you and persecute you, and say all kinds of things against you for Convention People's Party's Sake'. In another instance the Party changed the Lord's Prayer to read: 'Give us this day our full self-government/And forget about the infringement of charges'. Moses' exodus from Egypt, Ethiopianism and the challenge of the early Christians to Rome were all recast in terms of the fight for freedom from Empire. Christianity was also useful because it acted as a unifying system, language and set of practices for a nation riven by ethnic and political differences. Nkrumah cast himself not only as a Messiah but also as a 'non-denominational Christian'.[332] In this period, the heterogeneity of missions and Christianity was constructed according to its significance in building the nation. Resacralising the state was part of reconstructing the Ghanaian citizenship and consolidating political power. This was particularly important given that Nkrumah's main supporters were school leavers, who had low level literacy mostly from mission schools and therefore would have known many of the most common phrases of the Bible.[333]

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[329] A. A. Rahman, *The Regime Change of Kwame Nkrumah: Epic Heroism in Africa and the Diaspora* (N.Y.: Palgrave Macmillan, 2007) p.102.

[330] E. Obiri Addo, *Kwame Nkrumah: A Case Study of Religion and Politics in Ghana* (Maryland.: University Press of America, Inc., 1997/1999) pp.65-68.

[331] R. Simms, '"I am a Non-Denominational Christian and a Marxist Socialist": A Gramscian Analysis of the Convention People's Party and Kwame Nkrumah's Use of Religion' *Sociology of Religion* 64.4 (2003) pp.463-477.

[332] R. Simms, '"I am a Non-Denominational Christian and a Marxist Socialist": A Gramscian Analysis of the Convention People's Party and Kwame Nkrumah's Use of Religion' *Sociology of Religion* 64.4 (2003) pp.463-477.

[333] F. M. Bourret, *The Road to Independence, 1919-1957* (Stanford: Stanford University Press, 1960) p.150.

Nkrumah's relationships with missions were also complicated. In 1951 Nkrumah was given the title 'leader of government business' winning a democratic election which was a colonial concession to trade unions and nationalist organisations demanding 'self-governance'. Shortly after, in 1952, Nkrumah was given the title of 'Prime Minister'.[334] At this point, when Nkrumah was first successful in national politics and no longer in a prison cell, he denounced general poor healthcare and missionary education for their places in colonial injustices :

> There were slums and squalor in our towns…All over the country great tracts of open land lay untilled and uninhabited, while nutritional diseases were rife among our people….our existing schools were fed on imperialistic pap, completely unrelated to our background and needs.[335]

By 1957, after violence, constitutional impasse and political turmoil Nkrumah had capitalised on the economic success of the Gold Coast and on his status amongst school-leavers to win victory for the CPP and establish himself as President without a formal opposition.[336] This laid the groundwork for his dictatorship. Across this period Nkrumah developed one of his conceptions of missionaries, in tandem with his changing ideologies, as harbingers of colonial oppression and roadblocks to socialist modernity. In 1963, Nkrumah wrote that missionaries had participated in the colonial theft and slavery:

> While missionaries implored the colonial subject to lay up his treasure in Heaven, where neither moth nor rust doth corrupt, the traders and administrators acquired his minerals and land…Assuming the Christian responsibility of redeeming Africa from the benightedness of barbarism the ravages of the European slave trade were forgotten; the enormities of the European conquest ignored.[337]

In the same year, Nkrumah's Minister for Foreign Affairs and President of the UN General Assembly agreed in his own book that:

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[334] This election was based on around 30 per cent of the adult population and is covered extensively in other histories; R. Gocking, *The History of Ghana* (Westport, Ct.: Greenwood Press, 2005) pp.99-104.

[335] H. W. Mobley, *The Ghanaian's Image of the Missionary: An Analysis of the Published Critiques of Christian Missionaries by Ghanaians 1897-1965* (Leiden: E. J. Brill, 1970)

[336] On the 1950s elections, the role of the school-leavers and the CPP, see F. M. Bourret, *The Road to Independence, 1919-1957* (Stanford: Stanford University Press, 1960).

[337] H. W. Mobley, *The Ghanaian's Image of the Missionary: An Analysis of the Published Critiques of Christian Missionaries by Ghanaians 1897-1965* (Leiden: E. J. Brill, 1970) p.150 citing K. Nkrumah, *Africa Must Unite* (1963) pp.xiii, 5 and 22.

> In short, the personality of the African individual was systematically being debased and eventually denied, if not obliterated, by the support missionary activity gave to colonial rule.[338]

Another of Nkrumah's foreign ministers and one of Ghana's 'founding fathers' Emmanuel Ako-Adjei described mission as 'spiritual aggression' and 'spiritual imperialism' in spite of being a devout Christian himself who was educated in a Basel mission school.[339] Yet, Nkrumah still funded missionary medical work extensively because they were necessary experts and staff to ensure a stable healthcare system across the emergent Ghanaian state. As with his notions of religion and desacralisation more widely, missions were seen as a relative problem compared to his absolute focus on the success of Ghanian nationalism and pan-African independence. Where and when he drew the line on his ideological commitments was not simple.

In terms of ideology, Nkrumah's form of socialist transformation was not focused on changing property relations, eradicating religion, poverty or economic slavery, or really on 'class' at all, but on economic productivity and modernisation. In his long-term version was socialist mass welfare, but a mixed economy was its short-term, evolutionary means.[340] Nkrumah had argued in his earliest speeches that he wanted to mix East-West to cut a diplomatic path in terms of the non-aligned movement and to continue the technocratic developmentalism of his colonial predecessors and the wider world. This would make sense of his funding of European and America missions at the same time as supporting the Eastern Bloc. Yet, by 1960, perhaps even by 1958, his concerns for his grip on power, an attempt on his life and fears that he was being spied on by American intelligence forced him into choosing a single course publicly.[341] Once President, Nkrumah was quick about ensuring his hold on power and his silencing dissent; the Preventative Detention Act in 1958 consolidated his grip on the state, by 1959 regional and sectional politics was stopped and in 1964 the One-Party Act finalised this process.[342] At the same time, as Jean Allman has shown, Nkrumah's socialism meant mobilising youth for self-discipline and self-reliance, in ways that were tied to aviation and modernity.[343]

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[338] H. W. Mobley, *The Ghanaian's Image of the Missionary: An Analysis of the Published Critiques of Christian Missionaries by Ghanaians 1897-1965* (Leiden: E. J. Brill, 1970) p.150 citing A. Quaison-Sackey, *Africa Unbound* (1963) p.53; The title of Quaison-Sackey's book *Africa Unbound* was in direct support of J. Casely Hayford's attack on imperialism his work *Ethiopia Unbound* (1911) which extensively explored the relationship between mission and colonialism in the Gold Coast.

[339] J. Miller, *Missionary Zeal and Institutional Control: Organizational Contradictions in the Basel Mission on the Gold Coast, 1828-1917* (New York, NY: Wm. B. Eerdmans Press, 2003) p.29.

[340] J. D. Grischow, 'Kwame Nkrumah, Disability and Rehabilitation in Ghana, 1957-66' *52.2 The Journal of African History* (July 2011) pp.179-199.

[341] Nkrumah's tensions with the U.S. and how missions figured within these will be further elaborated in chapter 5.

[342] L. Mawuko-Yevugah, *Reinventing Development: Aid Reform and Technologies of Governance in Ghana* (Ashgate Publishing, 2014/Routledge, 2016) p.62.

[343] J. Allman, 'Phantoms of the Archive: Kwame Nkrumah, a Nazi Pilot Named Hanna and the Contingencies of Postcolonial History Writing' *The American Historical Review* 118.1 (February 2018) pp.104-129.

Nkrumah's visions of modernity were widely disseminated, but he could not control its interpretation or actual effect. Nkrumah claimed that the Ghanaian state needed to go through a process of re-sacralisation because historic colonial-mission relations had harmed society. Nkrumah argued that he did not want to create a 'political war on religion' when insisting on the 'secular nature of the state', but he did have very strong ideas about the African course toward modernity and this cast 'colonial' religion as backward.[344] However, Nkrumah's attempts at encouraging resacralisation faltered outside of state newspapers and state monuments. During his time studying for the ministry in the US, Nkrumah had attempted to remake the identity of J. E. K. Aggrey by performing Aggrey's funeral with libations and traditional ritual. The aim was to recast Aggrey as a bridge between African ancestry and African modernity. Yet, this did not automatically mean that Ghanaians re-imagined who Aggrey had been. Aggrey's legacy was seen by many as bound up with the historic mission church, with Cape Coast elitism, with the Fantes and with the Guggisberg vision for Christian human development.[345] He continually preached in these terms, in relation to his Christian faith and to the inspiration to reach the heights of development, without rejecting foreigners. Aggrey's most famous invocation for the 'black and white keys' to work together was not immediately thrown asunder when Nkrumah mourned him in a different way.[346]

Nkrumah's attacks on the historical role of mission also did not discourage their medical work in Ghana or stop him funding them. In some decolonising areas, such as Sudan and Indonesia, state unification problems were blamed on missionaries; they were held responsible for disruptions because their faith was contrary to the process of promoting national Islam. In others, authoritarianism and civil war led to missionaries fleeing to adjacent countries.[347] In Ghana, most missions were not only allowed to go unharmed, many medical missions continued to receive government funding. The first 10 year development plan set out from the recommendations of the Maude Commission did not stop in 1957 but continued until at least 1960.[348] In 1957 the Ministerial Secretary to the Ministry of Health F. K. D. Goka responded to a question as to whether the recommendations of the Maude Commission would be dropped that there would be 'no deviation from the programme' to which the Assembly responded with cheers of 'Hear, hear'.[349]

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[344] E. Obiri Addo, *Kwame Nkrumah: A Case Study of Religion and Politics in Ghana* (Maryland.: University Press of America, Inc., 1997/1999) pp.67-68, citing K. Nkrumah, *Consciencism* (New York: Monthly Press Review, 964) p.13.

[345] C. G. Baeta, 'Address for the Service Commemorating the Centenary of Aggrey's Birth' Achimota School (19th October 1975) Personal Archives of the Family of F. C. Grant (Accra, Ghana).

[346] A. A. Rahman, *The Regime Change of Kwame Nkrumah: Epic Heroism in Africa and the Diaspora* (N.Y.: Palgrave Macmillan, 2007) p.80.

[347] A. C. Wheeler, 'From Mission to Church in an Islamizing State: The Case of Sudan, 1946-64' in *Christian Missionaries and the State in the Third World* (eds.) H. B. Hansen and M. Twaddle (James Currey, 2002) pp.284-299.

[348] S. Addae, *Medical Histories, Volume One: From Primitive to Modern Medicine [1850-2000]*, (Accra: Eureka Foundation, 2012), pp.76-90.

[349] F. K. D. Goka to J. Kaleo, 'Oral Answers to Questions: Ministry of Health: Health Centres' *National Assembly Debates 1957* (3 December 1957) p.233, C.S.C. 450, British Library (Boston Spa, UK).

Many hospitals run by missions, which were constructed and equipped by government in the 1940s and early 1950s, still had their recurrent costs paid by government after independence.

Image VII. Captain Jeffrey Roberts received new Ministry of Health ambulance for Salvation Army clinic (c.1960s)
Image courtesy of The Salvation Army International Heritage Centre (London, UK)

The effect of the Burns Hospital agenda, the Maude Commission and Arden-Clarke's missionary zeal all long outlasted their tenure, and were added to with Nkrumah's development plans. As B. A. Konu put to the F. K. D. Goka in May 1957 in a debate over whether Ada would get a hospital:

> Does the Minister not appreciate the fact that it is more in the interest of the country as a whole to build at last one health centre in each of the 104 constituencies than to build central hospital in two or three towns where patients wait for hours on end to be attended?[350]

The Minister prevaricated and was a little riled when another question asked: 'Is it not a fact that the Government care very little for the health of the people in the rural areas?'. Goka responded: 'That is not a fact, Sir'.[351] The predominance of mission hospitals continued well beyond Nkrumah's rise to power and actually increased. Though there was certainly some opposition to the lack of Government interest in Hospitals it did not steer them from the course set out by the mission-government relations which began in the 1940s - any of Nkrumah's hostile public rhetoric was not even registered in the assembly. Nkrumah's 5 and 7 development plans included significant provision for healthcare and medical education. In the second development plan commencing in 1959, of the total £350 million requirement presented to the National Assembly, £200,000 was proposed for endemic diseases and health education, £1,130,000 was made for the new regional hospital at Tamale and new hospitals at Walewale, Wiawso and the first phase at Tarkwa. It also included mission hospitals at Mampong and Nsawam. £705,000 was provided for extension of existing hospitals and £800,000 for health centres in non-cocoa producing areas.[352]

In spite of Nkrumah's support, some Protestant missions struggled with funding and staffing from the later 1950s. In June 1957 there was a debate in the National Assembly over the Presbyterian Hospital at Worawora which was having difficulty getting nurses for its Hospital, running an ambulance service and housing its staff.[353] F. K. D. Goka, at the time the Parliamentary Secretary to the Ministry of Health declined to add to the funds for the Hospital:

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[350] B. A. Konu to F. K. D. Goka, 'Oral Answers to Questions: Ministry of Health' *National Assembly Debates 1957* (30 May 1957) pp.333-335, C.S.C. 450, British Library (Boston Spa, UK).

[351] F. K. D. Goka to B. A. Konu, 'Oral Answers to Questions: Ministry of Health' *National Assembly Debates 1957* (30 May 1957) pp.333-335, C.S.C. 450, British Library (Boston Spa, UK).

[352] 'A Time for Ambition' 3.2 *Ghana Today* (London: Published by the information section of the Ghana Office, March 18th 1959) Accessed at the University of Ghana, Accra, Ghana; 'Health: A Field of Vast Problems', 3.2 *Ghana Today* (London: Published by the information section of the Ghana Office, March 18th 1959) Balme Library, University of Ghana (Accra, Ghana).

[353] This was the historic Presbyterian Church that set up a Hospital at Adidome and had its roots in the Bremen and Scottish Presbyterian missions.

> The Voluntary Agency which manages this hospital was given a capital grant for £80,000 for the buildings. When this arrangement was made it was clearly understood that the Voluntary Agency would be responsible for equipping the hospital and for paying all recurrent costs other than those involved in training nurses…The management of the hospital is in the hands of the voluntary agency and it is its obligation and not that of my Ministry to take any steps that are necessary to provide an ambulance and staff quarters.[354]

Unlike Goka, the challengers Mr. Kodzo and Mr. Kusi were demanding more money from the government; because 'the hospital is now in dire need of nurses', 'the buildings in the hospital were put up by the Government without the quarters', and £80,000 grant was not sufficient 'to buy an ambulance besides meeting other expenses'.[355] Goka replied that 'nurses are in short supply all over the world' and that 'it was clearly stipulated that the Agency will provide quarters for the nurses'.[356] He added that '£80,000 was used in building the hospital' which has been running for some time (it had been built in 1952).[357] Nowhere during this debate was the question of the validity of funding missions raised, the problem was that Goka did not want to extend the original 1952 contract. That both Kodzo and Kusi were repeatedly challenging him shows how much the mission hospital mattered to the region; in spite of the failure of the mission to honour their agreement to provide nurses' quarters, two Ghanaian representatives were promoting them in a nationalist assembly. The mission's problem was not with government but with their financial circumstances. This was not an anomaly. As David Hardiman has shown six out of eleven Protestant mission hospitals were shut down between 1956 and 1965 in Gujarat by Indian churches because of a lack of finances.[358] It is possible that the Presbyterians efforts to staff another hospital at Adidome was over-stretching their healthcare resources, given their reduced power over education. The 1950s were the high-point of world mission and many missions expected to keep growing whatever happened with decolonisation and the Cold War. According to Adrian Hastings the amount of expatriate missionaries in Africa increased until 1966 and

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[354] F. K. D. Goka, Mr. Kodzo and Mr Kusi, 'Oral Answers to Questions: Ministry of Health: Worawora Hospital' *National Assembly Debates 1957* (28 June 1957) pp.1472-1473, C.S.C. 450, British Library (Boston Spa, UK).

[355] F. K. D. Goka, Mr. Kodzo and Mr Kusi, 'Oral Answers to Questions: Ministry of Health: Worawora Hospital' *National Assembly Debates 1957* (28 June 1957) pp.1472-1473, C.S.C. 450, British Library (Boston Spa, UK);

[356] F. K. D. Goka, Mr. Kodzo and Mr Kusi, 'Oral Answers to Questions: Ministry of Health: Worawora Hospital' *National Assembly Debates 1957* (28 June 1957) pp.1472-1473, C.S.C. 450, British Library (Boston Spa, UK);

[357] F. K. D. Goka, Mr. Kodzo and Mr Kusi, 'Oral Answers to Questions: Ministry of Health: Worawora Hospital' *National Assembly Debates 1957* (28 June 1957) pp.1472-1473, C.S.C. 450, British Library (Boston Spa, UK); J. S. Pobee, *Kwame Nkrumah and the Church in Ghana 1949-1966 : a study in the relationship between the Socialist Government of Kwame Nkrumah, the first Prime Minister and first President of Ghana, and the Protestant Christian Churches in Ghana* (Accra: Asempa Publishers, 1988) pp.94-95.

[358] D. Hardiman, 'Introduction' in D. Hardiman (ed.) *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Rodopi B.V., 2006) p.21.

subsequently declined.[359] As David Maxwell has shown, because of their loss of education to postcolonial states many mission churches started working more in healthcare, female self-sufficiency, and environment and sanitation.[360] However, for some missions this may have been logistically too difficult, whatever the political context.

ii. BAWUMIA'S OPENING GAMBIT: MEDICAL MISSIONARIES, GHANAIAN POLITICIANS AND SENIOR OFFICIALS, 1957-1966

Within the political culture of development and Christianity that Nkrumah was trying to construct, Ghanaian politicians used different strategies to gain power for themselves. One of the tactics was to identify with certain aspects of medical mission and not others. At the various levels of Ghanaian politics, creating links with and defending aspects of medical mission could be vital to retaining a foothold in the government of the postcolonial nation state.

It was not only because of old commitments to colonial recommendations that the independent government funded medical mission, some Ghanaian Ministers wanted to spread medical mission right across the new nation. David Maxwell has emphasised that the 'mission-educated leadership of nationalist movements was distinctively lukewarm towards the Church'.[361] Whilst this argument holds true for most at the very top of nationalist movements, many of those one-rung down from the Presidencies, without such a great public-facing role, were proud of their mission roots and keen to see mission control extended into other services. This fits more in line with revisionist historiography that has delineated views of the rank and file from the leadership within African nationalist Parties; but here it is extended to more subtle levels within government leadership itself.[362] Crucially, it was not only Ministers that liked mission itself that advocated for medical missionaries, it was also politicians who knew that supporting it could be used to their own political advantage.

One of the most striking examples of a senior Government socialist supporting medical missions was that of Alhaji Mumuni Bawumia. Around the same time as Nkrumah was consolidating his grip on power by ending sectional and regional politics, and in same week that Bawumia 'crossed the carpet to join with CPP' to a chorus of cheers from CPP members, Bawumia advocated for the all of healthcare to be transferred to

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[359] A. Hastings, *A History of African Christianity 1950-1975* (Cambridge University Press, 1979) pp.35-67, 159-175 and 224-288.

[360] D. Maxwell, 'Post-Colonial Christianity in Africa' in H. McLeod (ed.) *The Cambridge History of Christianity: Vol. 9, World Christianities c.1914-c.2000* (Cambridge University Press, 2006) pp.410-411.

[361] D. Maxwell, 'Decolonization' in N. Etherington (ed.) *Mission and Empire* (Oxford: Oxford University Press, 2005) p.296.

[362] D. Maxwell, 'Decolonization' in N. Etherington (ed.) *Mission and Empire* (Oxford: Oxford University Press, 2005) pp.285-306.

missionaries. All of it, except the central hospitals. He argued on June 20th 1958 in the National Assembly that:

> In view of the shortage of doctors and the difficulty experience by the Government in recruiting doctors, will the Government consider handing over all hospitals, with the exception of central hospitals to the Missionaries?[363]

This statement was made only three days after Bawumia had joined the CPP. At the most pivotal and controversial moment of Bawumia's career, he claimed that missions should take over the entire of Ghanaian healthcare. Two months later Nkrumah attempted to give Bawumia a Ministerial post but was persuaded against it because of internal issues in the CPP. Bawumia statements had clearly not antagonised Nkrumah. If anything, it may have been that, given Nkrumah's own private attitude to missions, that Nkrumah had considered Bawumia's comments as a serious potential policy direction. In 1962 Bawumia was made Minister of State and Northern Regional Commissioner and was given by 'Chiefs, old and new CPP members all..the support and cooperation' he needed. This was all in spite of the later souring of relations including Nkrumah accusing Bawumia of attempting to assassinate him in September 1962.[364]

For Bawumia, supporting medical missions was a ploy for other political means and one he was experienced in making. In 1955 Bawumia had used the building of a Baptist Mission Hospital to consolidate regional political power for Mamprugu. Bawumia helped to ensure the building of the Nalerigu Baptist Mission Hospital when he worked for the Mamprusi Native Authority. In his memoirs Bawumia explains that the District Commissioner had been hoping in January 1955 that a US Baptist mission tour might settle in Mamprugu. The aim was, according to Bawumia, 'to ensure the development and expansion of Nalerigu to befit its state as capital and seat of the King of Mamprugu'. This was not about Christian evangelism but about regional geographies of power. Moreover, Bawumia knew that the Government was not going to support the area and had not included Nalerigu 'in its development programme for either a health centre or hospital'. Thus, the plan was actually to oppose the CPP to which at this point Bawumia said he would go to 'any length to get the hospital established'.[365]

In order to make this support of the Baptist hospital possible Bawumia then worked with the local chief, Na Sheriga (the Paramount Chief), to purchase 'a big ram, eggs and yams to welcome them' and then when they arrived 'assembled all sick people in and around Nalerigu…includ(ing) the blind, lepers and chronic chest pains…and pregnant women'. He mobilised the Elders to show support and marshal the sick to show

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[363] J. Arjarquah, E. A. Mahama, Mumuni Bawumia and J. D. Wireko, 'Oral Answers to Questions: Ministry of Health: Missionary Hospitals/Dispensaries at the National Assembly' *National Assembly Debates 1958* (20 June 1958) pp. 117-118, C.S.C. 450, British Library (Boston Spa, UK).

[364] A. Mumuni Bawumia, *Memoirs of Alhaji Mumuni Bawumia: A Life in the Political History of Ghana* (Ghana Universities Press, 2004) pp. 142, 164

[365] Mumuni Bawumia, *Memoirs of Alhaji Mumuni Bawumia,* pp.32-34.

need. The Nayiri (Paramount Chief) aimed to convince the missionaries by arguing that the people and chiefs in Upper Volta (Burkina Faso) and Northern Togo still paid 'allegiance to him' and so would be patients for the hospital too. Moreover, to prove that apart from Gambaga and Walewale which were Muslim dominated, the rest of the area had no particular religion Bawumia even produced a map. As expected the Baptists agreed to build a hospital on the land that the Naa offered.[366] Bawumia knew how to play missionaries to his own advantage, partly because he knew what they wanted and how they worked. This was not because he desired Christian evangelism, Bawumia was a Muslim. It seems far more likely that it was ploy to create local political power and garner foreign investment.

Whilst Bawumia's experience was of CPP opposition to the mission at Nalerigu, it was actually with Nkrumah's help that the Baptist Hospital was built; this Bawumia may have taken as a general principle for political operation in national government. After the mission decided to settle at Nalerigu and applied to reside there, the CPP Minister of Health (J. H. Alhassani) blocked the process because the Nayiri did not support the CPP. However, Bawumia out-manoeuvred him by using his relationship with Richard Akwei who had lived in Gambaga in the Medical Field Units as Principal Secretary. Akwei was unsuccessful at first but Bawumia went to Accra to force Akwei into pleading to Nkrumah for the hospital. Awkei did and was successful in convincing Nkrumah, going over the Minister of Health's head, who was extremely dismayed again because of the Naa's opposition to the CPP. In response Nkrumah argued that 'if the people were not CPP today they could be CPP tomorrow'.[367] Three years later and three days after joining Nkrumah's Party when Bawumia clearly advocated for medical mission, he may have been utilising his experience with Nkrumah during the conflict over the mission at Nalerigu.[368] Bawumia was probably aware of how he could sideline other CPP members and ingratiate himself to Nkrumah. Whilst Nkrumah's rhetoric about missions might have fooled some, as shown in his autobiographical reflections on Nkrumah's intervention at Mamprugu, Bawumia knew better. It may be that Bawumia took this as a general principle to use for political advantage: that Nkrumah's socialism had boundaries when it came to medical missionaries.[369]

Buwumia was not alone in supporting missions from within Nkrumah's Party, associating missions with modernity could be a useful political tool for other Ghanaian nationalists. J. E. Appiah, the United Party (opposition Party under the One-Party state) member for Atwima Amansie, proclaimed in a major speech to the National Assembly that medical mission should provide for a huge proportion of Ghanaian healthcare, just as mission education had produced 'ninety per cent of those of us who sit in this House':

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366 A. Mumuni Bawumia, *Memoirs of Alhaji Mumuni Bawumia: A Life in the Political History of Ghana* (Ghana Universities Press, 2004) pp.32-34.

367 Mumuni Bawumia, *Memoirs of Alhaji Mumuni Bawumia,* pp.32-34.

368 J. Arjarquah, E. A. Mahama, Mumuni Bawumia and J. D. Wireko, 'Oral Answers to Questions: Ministry of Health: Missionary Hospitals/Dispensaries at the National Assembly' *National Assembly Debates 1958* (20 June 1958) pp. 117-118, C.S.C. 450, British Library (Boston Spa, UK).

369 A. Mumuni Bawumia, *Memoirs of Alhaji Mumuni Bawumia: A Life in the Political History of Ghana* (Ghana Universities Press, 2004) pp.32-34.

> We know that in the far North, in Agogo, in Brong-Ahafo, all over the country, these missions have tried to satisfy the health needs of our people by setting up hospitals. I know that in some places it is the misery of the people that has compelled them to set up these emergency hospitals, as I call them. I have always felt that whenever and wherever a missionary body has done a thing like that the Government of the day should be ready to help them in all ways without their crying for it. Look at the hospital at Wenchi, for example; it is satisfying a growing need in a very large area and yet building facilities, accommodation and so on are very poor because it is the work of the Methodist Mission. I know that they have not got much funds and they could only do what their purse would allow them to do. The accommodation of the doctor in that hospital, not to take even of that of the nurses, cries to high heaven to deliverance.
>
> Another example is the Agogo Hospital. The number of people who stream into that hospital from all over the country, makes one feel that here is a job that has been well done again by a mission. I happen to know that if they have the wherewithal they will expand the hospital to meet the growing needs of the people who come from far and wide. It always a source of pity to go to Agogo Hospital and see people standing outside the gates because all the beds are full…I have seen in this terrible congestion in this place and I am almost constrained to say that I beg the Ministry to do something about this missionary hospital.[370]

Appiah went onto argue that not only should mission hospitals be far better funded, the government should do more to restrict 'herbalists' and 'witch-doctors'. As he put, 'we cannot mix up science with superstition'.[371] Given the historic animosity between medical missions and the 'juju' of their African counterparts, Appiah was not only promoting their hospitals, he was also repeating the traditional tropes of their struggle.[372] In this and in showing himself to be a defender of Agogo, a mission hospital in Asante which represented the heights of modern biomedical achievement with its ophthalmology unit funded by the German Blinden mission. It seems likely that Appiah was trying to associate himself and the region with the drive for national modernity.

This type of missionary modernity was in contrast to the 'tribalism' of the Asante chieftaincies and Asante politicians such as Appiah, which were under fierce attack within Nkrumah's Ghana.[373] Particularly significant to Appiah was that Nkrumah's charge of anti-modernity and colonialism had been levelled at the National Liberation Movement (the previous opposition Party to the CPP) in the earlier 1950s because of its

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[370] J. E. Appiah, 'Motion: Ministry of Health' *National Assembly Debates 1960* (30 August 1960) pp.969-974, C.S.C. 450, British Library (Boston Spa, UK).

[371] J. E. Appiah, 'Motion: Ministry of Health' *National Assembly Debates 1960* (30 August 1960) pp.969-974, C.S.C. 450, British Library (Boston Spa, UK).

[372] J. E. Appiah, 'Motion: Ministry of Health' *National Assembly Debates 1960* (30 August 1960) pp.969-974, C.S.C. 450, British Library (Boston Spa, UK).

[373] R. Rathbone, *Nkrumah and the Chiefs: The Politics of Chieftaincy in Ghana, 1951-60* (Oxford: James Currey, 2000).

association with Ashanti. In 1951, during an escalation of violence in Ashanti, the CPP had proposed to break up the region into two administrative regions, capitalising on divisions between the Kumasi chiefs and those in the Brong region. At this point, an Asante himself, Appiah left the CPP to join the NLM. This was a big blow to Nkrumah as Appiah had been one of his close companions and a delegate at the 1945 Pan-African conference. However, what was crucial was that Appiah with the NLM could now turn the charge of 'tribalism' back on the CPP, claiming that they wanted power over Asante not national unity. However, by the 1956 election, the CPP had been able to regain ground; they propagated the message that the NLM would cause an Asante invasion of the South, they decreased internal CPP rivalries and they allied with the chiefs in the North. Continuing support from school-leavers who had moved the South, the CPP won in 1956 and the NLM were forced into appealing to the United Nations and to the British colonial office for an independent Asante. In 1957, the Secretary of State, Lennox-Boyd did promise safeguards in the constitution to the NLM leadership protecting the region's autonomy and chieftaincies. Yet, when Nkrumah consolidated power in the late 1950s he destooled pro-NLM chiefs, empowered pro-CPP chiefs, ended chiefly power within local councils and divided the Asante region.[374] By contrast, the chiefs in the Northern Territories were largely untouched and continued to form the basis of the Northern People's Party (NPP), a vital political bloc following the downfall of Nkrumah in 1966.[375] As for Appiah and the NLM Asantes, they were left with the burden of their earlier attempt to sidestep Nkrumah and were now easily labelled as 'tribalists' who did not support modernisation. Thus, given the political culture that Nkrumah had set up, associating with national 'modernity' rather than Asante 'tribalism' was vital to retain a political footing within the one-party state.[376]

Nkrumah and CPP members like Appiah valued associating with missions as supportive of the modernisation process because they were could be used to bolster claims to scientific advancement, biomedicine and technology. Far from being backward stooges of tradition, Appiah's comments show how missionaries could also be viewed as the key holders to a postwar developmentalism in the sort of terms which Joseph Hodge describes with the Swynnerton Plan in Kenya and Sabine Clarke argues for the Colonial Office.[377] As Clarke argues there was technocratic turn in official Colonial Office thinking between the 1940s and 1960s when development solutions were rationalised based in a faith in science and influenced by the large-scale research projects of E. B. Worthington and Lord Hailey's African Survey. Nkrumah and Appiah may have been influenced by these as well, perhaps through development economists brought into Ghana

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[374] R. S. Gocking, *The History of Ghana* (Westport, Ct.: Greenwood Press, 2005) pp.123-124, 104-111.

[375] P. Ladouceur, *Chiefs and Politicians: The Politics of Regionalism in Northern Ghana* (Longman Group Ltd., 1979) pp.212-272.

[376] R. S. Gocking, *The History of Ghana* (Westport, Ct.: Greenwood Press, 2005) pp.123-124, 104-111; R. Rathbone, *Nkrumah and the Chiefs: The Politics of Chieftaincy in Ghana, 1951-60* (Oxford: James Currey, 2000); J. Allman, 'Phantoms of the Archive: Kwame Nkrumah, a Nazi Pilot Named Hanna and the Contingencies of Postcolonial History Writing' *The American Historical Review* 118.1 (February 2018) pp.104-129.

[377] J. M. Hodge, 'British Colonial Expertise, Post-Colonial Careering and the Early History of International Development' 8.1 *Journal of Modern European History* (April 2010) pp.24-46.

such as William Arthur Lewis.[378] Yet, going beyond that which Clarke argues, this was alongside the longer-term missionary traditions of challenging 'superstition' and indigenous practices perceived as demonic.[379]

However, visions of missions as development surrogates coexisted with Nkrumah's links between missions and colonial legacies of inequality; that these two perspectives on missions should have co-existed demonstrates the complexity of Nkrumah's development vision. Modernity was related to national unity and the sidelining of the Asante chiefs. It was not modernity at all costs but it was specifically in order to defeat regional political opposition. Depending on its utility to national political control, for Nkrumah and others, missions could either be cast as colonial manipulators or modern medical scientists. In postcolonial Ghana, development could reduce the significance of missionary proselytism and divides. As shown across various national assembly debates in the late 1950s and 1960s, missions could be cast instead as neutral drivers of necessary development projects to help the Ghanaian people. In some ways this corroborates James Ferguson's famous thesis that development can function as anti-politics machine in which the performance of 'extremely sensitive political operations involving the entrenchment and expansion of institutional state power' can be undertaken invisibly through 'neutral, technical mission'.[380]

In Nkrumah's socialist CPP the response to the promotion of mission medicine was generally positive. C. S. Takyi (CPP Wenchi East) directly agreed with Appiah in the same debate in 1960 that:

> We have Mission hospitals at Berekum, Techiman, and Wenchi but these hospitals do not get subsidies from the Government; they operate on their own. I am suggesting that the Government should give them sufficient grants.[381]

Though it must be noted in another debate the following year Takyi was furious that Government officials were not being allowed to use mission hospitals free of charge and therefore had to travel 40 to 50 miles elsewhere. He also criticised mission hospitals that 'were not giving their best' and should be taken over by Government. For Takyi, promoting mission hospitals was, as for Nkrumah, pragmatic on the basis of what the Government could get out of their facilities or how they could control them through funding contracts.[382]

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[378] R. L. Tignor, *W. Arthur Lewis and the Birth of Development Economics* (Princeton: Princeton University Press, 2006) esp. 250-251.

[379] S. Clarke, 'A Technocratic Imperial State? The Colonial Office and Scientific Research, 1940–1960' *Twentieth Century British History*, 18.4 (1 January 2007) pp.453–480.

[380] J. Ferguson, *The Anti-Politics Machine: "Development", Depoliticization and Bureaucratic Power in Lesotho* (Cambridge: Cambridge University Press, 2000) p.256.

[381] C. S. Takyi, 'Motion: Ministry of Health' *National Assembly Debates 1960* (30 August 1960) p.986, C.S.C. 450, British Library (Boston Spa, UK).

[382] C. S. Takyi, 'Motion: Ministry of Health: Progress Report' *National Assembly Debates 1961* (4 May 1961) p.36, C.S.C. 450, British Library (Boston Spa, UK).

On the other hand, some CPP members were more concerned about how the Government was failing the voluntary sector. For example, Daniel Buadi, from Asim argued in 1960 that:

> The hospital at Fosu is being run by the Roman Catholic Mission. Originally, it was decided that a Health Centre would be built at Fosu but because of the Roman Catholic Church hospital the plan has been suspended. I am asking the Minister to see to it that whatever the Government have provided for the putting up of a Health Centre at Fosu, must be given at once for the work to be put in hand.[383]

Not all of attempts to finance missions would be effected; at no point was 90% of Ghana's healthcare run by missionaries as Appiah had hoped, but much was added. Already in 1959 the Ministry of Health set out its plans to provide a 'new 24 bedded ward…for isolation and Tuberculosis cases' at the Basel Mission Hospital at Bawku.[384] In addition, they 'proposed to erect an X-Ray Department at Bawku' with necessary equipment in the same year.[385] By 1960 there were plans to double the number of hospitals beds which, by that point, were at one for every 1,750 (including Government, mission and mining hospitals). Part of the plan began with adding additional wards of 32 beds to the mission hospitals at Axim and Mampong.[386] In 1960 a second female ward was provided for Bawku for £14,000.[387] In May 1961, missions provided a quarter of the total national bed strength.[388] Overall, between 1960 and 1961 mission hospitals £G290,000 was earmarked by government.[389]

Other major politicians under Nkrumah advocated for the expansion of medicine on the basis that doctors were performing the miracles of Christ - not those of modern science. J. A. Owusu-Ansah, the U.P. representative for Offinsu Kwabre, made a long statement in a debate on hospital staff in 1958 in which he argued that doctors were the 'most important people in this country' because they 'perform miracles in the same way as Jesus Christ did when He was on earth'. Therefore, their working conditions should be 'fitting

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[383] D. Buadi, 'Motion: Ministry of Health' *National Assembly Debates 1960* (30 August 1960) p.992, C.S.C. 450, British Library (Boston Spa, UK).

[384] Mr. Asumda to J. Awuni, 'Oral Answers to Questions: Health and Social Welfare: Bawku Hospital' *National Assembly Debates 1959* (23 July 1959) p.893, C.S.C. 450, British Library (Boston Spa, UK).

[385] A. Asumda to J. Awuni, 'Oral Answers to Questions: Health and Social Welfare: Bawku Hospital (X-Ray)' *National Assembly Debates 1959* (27 July 1959) p.1016, C.S.C. 450, British Library (Boston Spa, UK).

[386] L. R. Abavana (Minister of Health), 'Motion: Ministry of Health' *National Assembly Debates 1960* (30 August 1960) p.960, C.S.C. 450, British Library (Boston Spa, UK).

[387] J. Kodzo (Ministerial Secretary to the Minister of Health), 'Oral Answers to Questions: Health: Bawku Hospital (Female Ward)' *National Assembly Debates 1961* (27 February 1961) p.267, C.S.C. 450, British Library (Boston Spa, UK).

[388] L. R. Abavana, 'Motion: Ministry of Health: Missions' *National Assembly 1961* (4 May 1961) p.350, C.S.C. 450, British Library (Boston Spa, UK).

[389] L. R. Abvana, 'Motion: Ministry of Health: Progress Report' *National Assembly 1961* (4 May 1961) p.381, C.S.C. 450, British Library (Boston Spa, UK).

and proper…in order encourage them' because they are 'our saviours'.[390] The connection between Christian ministry and surgery particularly was emphasised but in a further statement he argued that, given that doctors are miracle-makers then they 'should not be confined to the municipal towns alone; rather, they should be given every encouragement to help the rural areas too'. Owusu-Ansah continued to extend his vision for Christ's healing on earth through medicine when in 1965 he advocated that 'the health needs of the people will continue to receive urgent attention of the government and party. Our aim is to provide free health facilities for the entire people of Ghana by the end of the Seven-Year Development Plan period'.[391] Not all Ghanaian politicians chose to claim medicine for modernity, others chose to use it to bolster their claims to promote Christianity.

In other cases, medical mission was supported for its commitment to Ghana in direct attacks on unpatriotic Ghanaian doctors who were leaving the country. In the National Assembly in 1965, J. Awuni (Kumasi Central) argued that a medical mission in the North was a model for Ghanaians, in saying this he girded it with attacks on colonial limitations on African potential:

> In one of the mission hospitals in the North, there are about five doctors attending to patients and they do not have time for closing. Sometimes they even sleep in the hospital…In spite of the volume of work they always say their prayers each morning before the commence their daily work. These people do not complain that they have left their homes thousands and thousands of miles away to come and serve here in the North. These doctors have not come from Germany to serve their fellow white men but they are here to serve us the black. It is high time that our doctors follow the example set by these white doctors. Even some of our people who are qualified abroad do not want to come back….It is unfortunate that I am not a doctor but it is not my fault. If the imperialists had allow me, I would have become a doctor.[392]

Given Awuni's constituency he was not trying to gain money for a local mission hospital out of pragmatic reasons, he was using actually making a larger argument about the brain drain of Ghanaian doctors training abroad. In doing this he spent a considerable portion of his speech proclaiming the diligence, self-sacrifice and faith of the Basel mission hospital at Bawku. Awuni contrasted the failure of Ghanaian doctors with the heroism of German doctors. It was not simply modernity that made missionaries useful to Ghanaian politicians, it was also in arguments about character and national identity. The model of missions could be used as a political weapon in arguing for increased dedication to the cause of Ghanaian postcolonial success on the behalf of Ghanaians themselves. For Awuni himself, clearly this is linked to his own patriotism, he

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[390] J. A. Owusu-Ansah, 'Motion: Hospital Staff Service Conditions' *National Assembly 1958* (29 August 1958) pp. 1944-1946, Balme Library, University of Ghana (Boston Spa, UK).

[391] K. Yankah, 'Point of Order: A Note on Language in Parliament' *Graphic Online* (8 March 2004) citing *Parliamentary Debates 1965* p.113.

[392] J. Awuni, 'Ministry of Health: Estimates' *National Assembly Debates 1965* (8 February 1965) pp.851-852, Balme Library, University of Ghana (Accra, UK).

notes in concluding that he would have committed so sacrificially if the 'imperialists' had allowed him. Perhaps in the ensuing intense political battles in the final stages of Nkrumah's regime, Awuni's claim to loyalty to his country and his challenge to the loyalty of the doctors, was an important performance to secure his government position.

Crucially, in spite of all these advocates for medical mission in Government there were socialists who were confused by Nkrumah's mixed messages on mission, development and modernity; in the Northern Territories in 1961 'leftists' took over of the Catholic hospitals near Navrongo and had to be stopped by Nkrumah. Given the slippages and contradictions between Nkrumah's rhetoric, development needs and structural legacies of the Ghanaian state, some socialists misunderstood - perhaps wilfully but also perhaps unsurprisingly - the attitude of CPP to medical missions. In 1961, the White Father and Regional Superior, J. Alfred Richard wrote to the Reverend Richard Walsh in the central Padri Bianchi (White Father) offices in Rome that socialists had stolen the mission Hospitals in response to news put out by 'leftists' and 'pressure groups':

> Hospitals run by the Missions were to be taken over this year according to the T.U.C. the big Trade Union here.[393]

In response Nkrumah officially denied any involvement and enacted counter measures. The missions had their hospitals returned 'indefinitely' and even more money was given to the missions. As Richard explained, in the aftermath of the conflict, 'more grants than ever are available for our hospitals' and they were urged by Nkrumah to 'open more school and especially staff schools for the government'.[394] Unfortunately there is no evidence as to exactly how the leftist usurpers responded to this stamping out by a government to whom they were allied. What this does show is either how confusing socialism in Ghana could be at the time or how Trade Unionists and socialists locally could act for their own concerns without national legitimacy. Whatever the case, Nkrumah was able to enforce the mission hospitals' return demonstrating the extent to which he was able to control the Northern Territories, in spite of not eradicating chiefs in the area. It also represents Nkrumah's concern to encourage missionary healthcare even at the expense of alienating his own leftist foot soldiers.

After 1961 medical missions were in more conflict with Nkrumah's increasingly paranoid and authoritarian regime but in general mission grew and was supported by pro-mission African Christians, some of whom held considerable power. Around 1961, particularly after an assassination attempt, Nkrumah clamped down on civil liberties and threw out foreigners he suspected of being spies. For example, Colin Forrester-Paton wrote back to the Scottish Mission board of 'a drive by the governing and almost all-

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[393] Box 686, J. A. Richard to Richard Walsh, Rg A1, 145-213 (1960-62, 1963-65) White Fathers Archives (Rome, Italy).

[394] Box 686, J. A. Richard to Richard Walsh, Rg A1, 145-213 (1960-62, 1963-65) White Fathers Archives (Rome, Italy).

embracing Convention People's Party to form branches within the congregations of the Churches'. However, Forrester-Paton also wrote of how this was:

> quietly and successfully resisted by the authorities of all the Churches in the Christian Council; and even more important, there has been no spontaneous move by the many C.P.P. members within the Churches to form such branches, despite a propaganda campaign directed to this end.[395]

As Forrester-Paton wrote there was considerable Church resistance to Nkrumah's reaching out to claim power or rhetorical claims about planting CPP members of churches. Much of this was 'quiet' and did not to hit the headlines. Brian Stanley has argued in his edited book on missions and nationalism at the end of Empire that African churches could act as a hindrance to African nationalism and often stubbornly held their ground.[396] As Maxwell has argued, for postcolonial states, the body of the church was desired greatly partly because it was a critical mobilising unit.[397] With Nkrumah, even propaganda and infiltrating Party branches could not co-opt the Christian Council. Though perhaps deals were cut behind closed doors; according to Forrester-Paton, in public resistance was effective. For example, at the Ridge Church in Accra which Forrester-Paton helped to set up, alliances outside the state were formed. In spite of all the pressure, one Ghanaian friend from Ridge Church remained loyal to David Murray - the Medical Administrator for Korle Bu hospital and senior officer in the Ministry of Health (and eventually director of the medical services) - Michael Baddoo. He would visit them regularly, helping them out and tipping them off when there was trouble. Baddoo's wife was a white Englishwoman and both had attended Cambridge. Building this relationship at the Accra Ridge was vital for the Murrays maintaining their life in Ghana until the late 1960s.

By 1966, the year of Nkrumah's downfall at the hands of a coup, medical mission in Ghana had already grown considerably. In 1963 there were 51 registered medical practitioners, this grew to 84 in 1964, 101 in 1965 and in 1966 it was at 106 - over double what it had been three years earlier. 106 doctors was just under a third of the amount of registered medical practitioners in the Ghana which totalled 320 and had only grown by 9 since 1963 (though there were heights of 337 in 1964 and 159 in 1965). Moreover, there were 149 non-Ghanaian medical practitioners in Government service, though this had dropped from 192 the year before and 190 in 1963. By contrast, the amount of non-Ghanaians in non-Government service as medical

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[395] C. Forrester-Paton to Partners, 'Pressures on the Church in Ghana' (15 March 1962), Correspondence and papers of the Church of Scotland Overseas Council relating to Africa (1965-75) Acc 9638, Church of Scotland, National Library of Scotland (Edinburgh, UK).

[396] B. Stanley, 'Christianity and the End of Empire' in B. Stanley (ed.), *Missions, Nationalism and the End of Empire* (Wm. B. Eerdmans Publishing Co., 2003) pp.1-11.

[397] D. Maxwell, 'Post-Colonial Christianity in Africa' in H. McLeod (ed.) *The Cambridge History of Christianity: Vol. 9, World Christianities c.1914-c.2000* (Cambridge University Press, 2006) p.417 citing T. Ranger, 'Introduction', in T. Ranger (ed.), Evangelical Christianity and democracy in Africa (Oxford: Oxford University Press, 2006).

practitioners was 220, up from 134 in 1963, peaking in this period at 232 in 1964.[398] Child welfare clinic distribution had regrown by this point however, climbing to 242.[399] There were 160, 690 new antenatal cases, 362,511 old ones, and 47,059 postnatal cases.[400] Furthermore, out of 70,000 leprosy patients, 21,500 were receiving treatment.[401] Notably, two out of the four leprosariums were run by missions.[402] Moreover, mission hospitals were 'fully subsidised by the Government' according to a National Assembly debate in 1965.[403]

iii. THE CHURCHES AND THE CHIEFS: THE 'AFRICANISATION' OF MEDICAL MISSION IN DECOLONISING GHANA

In ways that were often detached from these high-level battles over modernity and colonialism, in local and regional contexts, missionaries continued to reformulate development in their own ways and by processes and localities that mattered to them. Whilst Nkrumah was able to create a political context to which missionaries had to be aware, medical missionaries generally cast the major changes within decolonisation in terms of the 'Africanisation' rather than in terms of modernisation or separation from colonialism. Whilst concerns for 'Africanisation' arrived with decolonisation they did not exactly match up with the perspectives of nationalists on development or mission. Nkrumah could not be ignored, but his efforts could be challenged in non-public ways, away from the symbolic centres of power such as Achimota. 'Africanisation' was divided by denominational changes, national churches' power, missionaries' awareness of their need to adapt and the choices of local chiefs. These processes did not directly parallel Nkrumah's rise and fall, instead they evolved in relation to changes in the national church and local chieftaincies. In general, the Protestant missions handed their hospitals over to Ghanaian church boards by 1967 which empowered them to challenge the state. By contrast, Catholic missions incorporated many Ghanaian nurses and health workers

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[398] The 1963 statistics are as at 1st March, 1963; 'Appendices: Table 1A: Registration of Medical and Dental Practitioners in Ghana 1963-67' *Republic of Ghana: Annual Report of the Medical Services of Ghana 1967* p.55, ACS0.1.48, LSTM (Liverpool, UK).

[399] 'Table 8: Distribution of Hospitals, Health Centres and Other Fixed Clinics by the Type of Institution and Region' *Republic of Ghana: Annual Report of the Medical Services of Ghana 1967* p.64, ACS0.1.48, LSTM (Liverpool, UK).

[400] 'Maternal and Child Health Services' *Republic of Ghana: Annual Report of the Medical Services of Ghana 1967* pp, 25 and 64, ACS0.1.48, LSTM (Liverpool, UK).

[401] 'Control of Communicable Diseases' *Republic of Ghana: Annual Report of the Medical Services of Ghana 1967* p. 10, ACS0.1.48, LSTM (Liverpool, UK).

[402] K. Vongsathorn, '"First and foremost the evangelist"? Mission and government priorities for the treatment of leprosy in Uganda, 1927-1948'*Journal of East African Studies 6.3* (August, 2012) pp.544–560.

[403] Owusu-Afriyie, 'Ministry of Health: Estimates' National Assembly (8 February 1965) p.805, C.S.C. 450, British Library (Boston Spa, UK).

but kept many of their hierarchies dominated by expatriate missionaries into the 1980s, this limited some of the hopes of African independency.

There is an intense debate within the history of mission over how quickly and how extensively the historic mission church 'decolonised' and 'Africanised' its hierarchies. David Maxwell argues that, often slightly in advance of political changes, ecclesiastical hierarchies were 'Africanised' through the decolonisation era, with the Catholic church making twenty African bishops in the 1950s. This proceeded apace with the Vatican II in the mid-1960s and gained a 'critical mass' with the second of wave nationalism in the 1970s.[404] By contrast, Elizabeth Isichei has emphasised how much missions were desperate to retain control of their health institutions. She also noted their slow transition generally, in sub-Saharan Africa there were 5502 expatriate Catholic priests in 1949 and 8703 in 1959, and by 1980 in sub-Saharan Africa there were still 30 to 40 thousand Christian missionaries.[405]

However, 'Africanisation' can be defined more broadly than simply the incorporation of Africans into the running of churches and hospitals. It can also be considered in terms of changing methods, structures and ideas in response to perceptions of 'African-ness'. As Ogbu Kalu has argued that the 'theological state' had imploded and the mission's 'passive revolution' failed to respond to African initiated churches (AICS) and African indigenous Christianity. Kalu has argued that between 1965 and 1975 'people increasingly found the missionary version of indigenization to be unsatisfactory and restrictive.'[406] This chapter's final section will contribute to this debate by showing how medical missions could both retain power over their structures, methods and ideas, but simultaneously be seen to 'Africanise' by incorporating more Ghanaians into hospital work. The Catholics did this by training up many Ghanaians in low level healthcare and holding onto the major positions of control within hospitals and clinics. By contrast, the Presbyterian shifts were more profound as they had to transfer power to an 'Africanised' ecclesiastical hierarchy, though as with the Catholics they too were limited by a lack of Ghanaian doctors. Generally Africanisation was restricted to gradual institutional changes, though as chapter 5 and 6 will further detail, there were battles around notions of 'African-ness' which were elaborated by key Ghanaian individuals within national and international health (sometimes, as with Nkrumah, these lay claim to the legacy of Aggrey).

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[404] D. Maxwell, 'Decolonization' in N. Etherington (ed.) *Mission and Empire* (Oxford: Oxford University Press, 2005) p.293.

[405] E. Isichei, *A History of Christianity in Africa: From Antiquity to the Present* (SPCK, 1995) pp.325-327, 344.

[406] O. U. Kalu, 'Passive Revolution and Its Saboteurs: African Christian Initiative in the Era of Decolonization, 1955-1975' in B. Stanley and A. M. Low, *Missions, Nationalism and the End of Empire* (Grand Rapids, Michigan: Wm. B. Eerdmans Publishing, 2003) pp.265-277.

Image: VIII 'A course was recently held at Kwaso, in Ashanti, for traditional village midwives, and proved of immense value. This picture shows Miss Agnes Ofori, the midwife in charge of the course, lecturing village women on child welfare (c.1950s) 966.7/618.2, National Archives at Kew (London, UK).

Image IX : Princess Marie Louise Hospital, Gold Coast, ‘Miss Pittock, Health Nursing Sister giving a lecture in the Lecture Rooms’ (c.1950s) 966.7, National Archives at Kew (London, UK).

The Presbyterian Church of Ghana (PCG) announced in 1967 that it had 'Africanised' all its hierarchies and taken national control over the Presbyterian missionary health infrastructure, but there were limits.[407] By the early 1960s, new medical missionaries were being paid for by the PCG such as the Scottish Presbyterian nurse, Doris Hodds, who was employed to move to Sandema to run the clinic. The Ghanaian Presbyterian Synod Clerk recorded that 'her salary is to be paid by the PCG which will also be responsible for her accommodations at Sandema'. Moreover, this was described in Afro-centric language, instead of 'missionary' Hodds was described as being 'engaged primarily as a "fraternal worker"'. Writing to the Permanent Secretary of Health, A. L. Kwansa declared that: 'the Church of Scotland…is fully integrated in the Presbyterian Church of Ghana'.[408] In 1967 and 1968 the PCG produced a report to assess their healthcare system in which their control over the medical system was emphasised: 'For the first time in the history of the Presbyterian Church of Ghana, members were asked to sponsor the medical work of the church which is done in six places in Ghana'.[409] For the large, symbolic Basel mission hospital at Bawku, the PCG proclaimed the 'considerable change… made in replacing expatriates with Ghanaians, as part of the Africanisation'. Though most of the main medical positions were occupied by expatriates, the report proudly explained that 'the following posts held by fraternal workers were taken over by qualified Ghanaian personnel: Pharmacist, Nursing-Tutor, Laboratory Technician and Ward Masters'.[410]

In terms of perspectives on theologies of medicine, there was little that was shaped by a uniquely 'African' perspective; yet, the PCG did ensure surveillance that their own standards for evangelism were consistently met. The 1967-1968 report shows how there was inspections of standards of moral education through healthcare. These were detached from government perspectives on mission and modernity at the time, and detailed how Christian mission was being extended. For example, at Agogo hospital, one chaplain fiercely denounced the leadership for dropping 'Bible studies' and instead was encouraged by 'the branch of the Scripture Union which is gaining grounds among the Pupil Nurses'. An inspector wrote of the daily morning services and intercessional prayers on 'Saturdays for our patients and sick-friends' which were ensuring that the hospital's true mission was being practised. Furthermore, the inspector wrote of nurses'

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[407] S. G. D., J. ST. G. Warmann: Regional Services Division, Ministry of Health and Social Welfare, 'Letter to Synod Clerk', (07/07/1961) Further papers, mainly ca. 1970-1995, but many earlier, relating to Church of Scotland and other Scottish Presbyterian Missions, and Scottish Churches abroad, Acc 12398, Church of Scotland National Library of Scotland (Edinburgh, UK).

[408] A. L. Kwansa, 'To the Permanent Secretary of the Ministry of Health', (Accra: 20/02/1959) Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner Scheme of the Reverend Colin Forrester-Paton, in the Gold Coast, later Ghana, 1954-71, Acc 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK).

[409] Presbyterian Church of Ghana, 'Medical Work Report 1967/8', (1968) Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner Scheme of the Reverend Colin Forrester-Paton, in the Gold Coast, later Ghana, 1954-71, Acc 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK).

[410] Detailed analysis of the PCG and the Basel Mission can be found in P. Schmid, *Medicine, Faith and Politics in Agogo: A History of Health Care Delivery in Rural Ghana, ca.1925 to 1980* (Lit Verlag GmbH & Co. KG Wien, Zürich, 2018).

evening services in the wards, 'guest preachers' and in-patients being 'given bibles and tracts to read'.[411] Yet, the PCG were not looking to extend their independence to the extent of financial self-reliance. On the report on the Bawku hospital, the account began by registering the 20,000 National Cedis (NC) provided by the Ghanaian government and the 14,000NC given by the Basel Mission to underwrite the hospital. In the analysis of Agogo, the Presbyterian contribution of 20,000NC was printed alongside the Government contribution of 50,000NC and the Basel's mission donation of 30,000NC.

Scottish Presbyterians, who by this point who had been separated from closeness with the government for more than two decades, generally found the PCG's authority an important safeguard against nationalist excesses. Some expatriate Presbyterian missions saw the Ghanaian leadership as a bulwark against the kind of over-reaching of state power as they had experienced under Nkrumah. Colin Forrester-Paton wrote in his penultimate letter to the Partners in January 1970, that the PCG were an important ally in the need to be vigilant and 'to prevent the abuse of power'. This was especially the case as 'the problems of unemployment and the drift of people into towns, and of course the old evil of corruption, remain as daunting obstacles'.[412] On the other hand, Forrester-Paton also could find the PCG difficult and inefficient. In the mid-1960s the PCG wrote to one of the Sandema missionary leaders explaining the necessity of training the nurse, Doris Hodds, at Navrongo or Bawku because of her 'lack of experience'. Forrester-Paton noted in the margin of the document, 'I am not clear how Dr. Warmann deduced this' and that he could not see why she could not be moved straight to the mission when they were so desperate for help. This was a part of the PCG attempting to systematise healthcare practice under their control, for example in 1968 'Sister Lewis Fraser…(had been) taught for five months at the Nurses Training School at Agogo and was transferred to Sandema in February 1968 to replace Sister D. Hodds for another period'.[413] Given the freedom with which Forrester-Paton mission had been able to run the Sandema mission in the previous thirteen years, at times he resented PCG oversight, especially when they set up bureaucracies which left the mission understaffed in the short term.[414]

Another aspect of Africanisation was chiefs becoming more intimately involved with the local running of medical missions. At the Sandema Presbyterian medical mission, the first Builsa Presbyter was Johnson Akobrika. Akobrika was a member of the Sandema Nab family and in the late 1950s took over the mission

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[411] Presbyterian Church of Ghana, 'Medical Work Report 1967/8', (1968) Further papers, mainly ca. 1970-1995, but many earlier, relating to Church of Scotland and other Scottish Presbyterian Missions, and Scottish Churches abroad, Acc 12398, Church of Scotland, National Library of Scotland (Edinburgh, UK).

[412] C. Forrester-Paton, 'Letter to Partners', (19.01.1970), Correspondence and reports home, under the auspices of the Church of Scotland's Missionary Partner Scheme of the Reverend Colin Forrester-Paton, in the Gold Coast, later Ghana, 1954-71, Acc 11977, Church of Scotland, National Library of Scotland (Edinburgh, UK).

[413] F. Konotey-Ahulu (et. al.), *Report of the Committee Appointed to Investigate Hospital Fees* (1971) pp.27-36, George Padmore Research Library (Accra, Ghana)

[414] S. G. D., J. ST. G. Warmann: Regional Services Division, Ministry of Health and Social Welfare, 'Letter to Synod Clerk', (07/07/1961) Further papers, mainly ca. 1970-1995, but many earlier, relating to Church of Scotland and other Scottish Presbyterian Missions, and Scottish Churches abroad, Acc 12398, Church of Scotland National Library of Scotland (Edinburgh, UK).

work at Chuchiliga in the late 1950s.[415] From early on Akobrika had become indispensable to the Presbyterians ability to settle in the area; yet, his involvement went further than a standard intermediary role. With his leadership as Chuchiga, Akobrika also became a supervisor to Presbyterian clinic, chapel and health centre.[416] The effect was wider than just for the mission itself, Akobrika's role in taking over some of the key supplies of healthcare in the area and co-opting the Presbyterian mission led to him being able to unite the Sandema chieftaincy with the Chuchiliga chieftaincy. The chiefs had tied themselves to the medical mission and in doing so resolved a power battle at the centre of Builsa regional politics. At local level, as well at national, Ghanaians were able to drive institutional change in medical missions for their own agendas and by their own priorities.

For the Catholics at Berekum, the local chief was relied upon to ensure their continued expatriate control and independence from the government. As Anne Louise von Hoene put it the Nkrumah years were a :

> period to keep away from government as much as possible…(there were) hidden training camps (and) He had idea of becoming ruler of all of Africa.[417]

Instead the MMS built close relations with the local chief. Von Hoene explains that not only had the chiefs given them the land for the hospital, they invited them to events and would later help them with a strike. Crucially, in the 1950s and 1960s, the chief local to the MMS was battling with Nkrumah and, therefore, could be an important an ally in their aim to sustain their mission away from government and from African church control.[418] As Richard Rathbone has argued, Nkrumah's government embarked upon wholesale legal and administrative changes in order to eradicate the traditional constituents of Ghanaian social and political life.[419] The chiefs in the late 1950s began to infiltrate the Church as well as co-opting it from the outside. The strategy for the chieftaincy from the late 1950s was to draw foreign interests into a local political structures, with the chief as sort of head manager as Justin Willis describes. Moreover, as Willis has argued that chiefs detached themselves from state failings through continually reinventing their traditionalism.[420] At Berekum, it appears that the chiefs were also tying themselves to non-state providers of welfare like the Church.

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[415] R. Duncan and L. Duncan, 'Sandema District (II)' in A. A. Berinyuu (ed.) *History of the Presbyterian Church in Northern Ghana* (Accra: Asempa Publishers, 1997) pp.135-141.

[416] F. Kruger, http://www.buluk.de/Buluk4/Presbyterian%20Church.htm (Accessed 12.07, 05/06/2015).

[417] Interview with Author, A. L. von Hoene, Medical Mission Sisters, Fox Chase, Philadelphia USA (9 November, 2016).

[418] Interview with Author, A. L. von Hoene, Medical Mission Sisters, Fox Chase, Philadelphia USA (9 November, 2016).

[419] R. Rathbone, *Nkrumah and the Chiefs: The Politics of Chieftaincy in Ghana, 1951-1960* (Oxford: James Currey, 2000) p.48.

[420] J. Willis, 'Chieftaincy' in J. Parker and R,. Reid (eds.) *The Oxford Handbook of Modern African History* (Oxford: Oxford University Press, 2013) pp.208-23.

By contrast, with the Presbyterians, foreign funding allowed some Catholic missions' independence from political changes. The Holy Family Hospital at Berekum and their sister dispensary at Techiman consistently turned down government funding. As noted in chapter 2, in 1956 the Hospital had turned down a £21,000 grant from the government.[421] Again in 1957, C. S. Takyi asked the Minister of Health if he would provide funds for the expansion of the dispensary at Techiman, but he was told that all of the £143,000 in the Annually Recurrent Estimates for 1957/8 were committed because:

> The Roman Catholic Mission that operates hospitals in Techiman and Berekum are not eager to have financial help from the government.[422]

In another debate mentioned in the previous chapter it was noted that the Government could not force them to take the money. It was not only Catholics who could sidestep government power, in 1961, Takyi asked which were the mission hospitals rejecting government funding, and was informed that the Baptist mission hospital at Nalerigu had turned grants down as well.[423] Government development perspectives and narratives sometimes effected little how missions viewed themselves or their work. The MMS were keen to maintain their independence and, unlike other missions described in previous chapters, they could afford to do so. As will be explored in chapter 4, part of the reason was that they were receiving large amounts in donations from the Netherlands and West German Catholics.

Catholic medical missions in Ghana produced nurses' training and by the 1980s the majority of health workers in Catholic hospitals were Ghanaian; yet, it was often still expatriates who were the doctors and senior staff. Table III is produced from available records in the Catholic health services survey from 1982 which show whether staff were expatriate or Ghanaian. The survey shows that there were many Ghanaians working as enrolled and state registered nurses, auxiliaries, labourers and assistants within Catholic hospitals. Some hospitals, such as at Apam, had no expatriate personnel at all by this point but mostly Catholic health institutions were a mix of Ghanaian and expatriate. Generally, where expatriates were available they occupied higher ranking positions such as doctors, senior nurses and medical officers, whereas

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[421] J. G. Awuah to F. K. D. Goka, 'Oral Answers to Questions: Berekum Holy Family Hospital (Government Subsidy)' *Gold Coast Legislative Assembly 1956-57 Vol. 1* (27 August 1956) pp.295-296, Balme Library, University of Ghana (Accra, Ghana).

[422] C. S. Takyi to F. K. D. Goka, 'Oral Answers to Questions: Ministry of Health: Techiman Holy Family Dispensary' *Parliamentary Assembly* (27th June 1957) p.1415, C.S.C. 450 British Library (Boston Spa, UK).

[423] C.S. Takyi to Kodzo, 'Oral Answers to Questions, Mission Hospitals (State Aid)' *Parliamentary Assembly Debates* (28 July 1961) pp.836-837, C.S.C. 450 British Library (Boston Spa, UK).

Ghanaians generally did not. As is noted on the statistics on Holy Family Hospital at Nkawkaw 'All the senior nursing sisters are expatriate personnel with considerable nursing experience'.[424]

Catholic medical missionaries were more concerned with 'Africanisation' in response to decolonisation, than 'modernisation'. It was through the construction of difference in terms of race, that the missionary development narrative was given definition and identity. From 1953, the Hospital at Berekum had also been beginning to develop a facility for training nurses, this struggled in the first four years with many not being able to pass state examinations and others leaving the hospital discouraged. In 1957 the programme was rearranged and by 1958 'nine students received their caps' and a further three passed preliminary examinations in 1960.[425] Training of locals as nurses was a key part of the way in which the MMS imagined the distinctions between themselves and Ghanaians, creating nurses both facilitated their work's sustainability and it also showed clear separation between Ghanaians who were educated and developed, and those who were not. In material terms with their MMS-style uniforms, trained nurses embodied racial and human development within Berekum. By 1982, only 13 of the 193 staff at Berekum were expatriate missionaries, only another 8 were MMS. 47 of the Ghanaians working at Berekum were enrolled nurses.[426] In terms of hierarchy little had changed though the nursing work had hugely expanded. Racial difference mattered for how medical mission was imagined and practiced.

Whilst the Catholic historic mission church was empowering African Bishops, its healthcare institutions were continuing to ensure some dominance of European and American Catholic doctors - both laity and in religious congregations. Catholic medical mission in Ghana continued the control of expatriates partly *because* and not in spite of Vatican II. Expatriate medical mission sisters, such as the Holy Family Hospital at Berekum, were effected by Vatican II but in ways that actually contributed to their control. Vatican II did not only encourage the making of African bishops it also ensured that nuns did not always have to wear habits in public. For the Medical Mission Sisters (MMS) at Berekum this meant they could do work in ecumenical and secular settings more easily. This extended well beyond the 1960s, in the 1970s a MMS, Anne Louise

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[424] P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) pp.42-46, 66, Private Archives of the National Catholic Secretariat (Accra, Ghana)

[425] 'Holy Family Hospital, Berekum, Gold Coast (Ghana) 1948-1967', pp.195-196, MMS Archive, Fox Chase, (Philadelphia, USA).

[426] D. Maxwell, 'Decolonization' in N. Etherington (ed.) *Mission and Empire* (Oxford: Oxford University Press, 2005) pp.285-306; D. Maxwell, 'Post-colonial Christianity in Africa' in H. McLeod (ed.) *The Cambridge History of Christianity*, vol. 9, *World Christianities c.1914-c.2000*, (Cambridge: Cambridge University Press, 2006) pp.401-421; P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) pp.192-198, Private Archives of the National Catholic Secretariat (Accra, Ghana)

von Hoene, was able to become the chair of the board of the Christian Health Association of Ghana in the 1970s.[427]

Continued expatriate power was also partly a wider issue of training and immigration. From the 1950s, Catholics had been training Ghanaians to become nurses but not in higher level qualifications. At Berekum where there was a nursing training college, there were 67 enrolled Ghanaian nurses and midwives but only one Ghanaian doctor out of a total of 5. This was generally the case across Ghana. The cadre of Ghanaian doctors was limited and missions did little to help this process. As will be explored in chapter 5, Nkrumah's attempt to create a medical school faltered and, as will be described in chapter 6, in the economic and political crises of the late 1970s and early 1980s, half of Ghana's doctors and nurses left the country, ensuring further expatriate control.[428]

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[427] Interview with Author, A. L. von Hoene, Medical Mission Sisters, Fox Chase, Philadelphia USA (9 November, 2016).

[428] 'Issues, Problems, And Priorities of the Health System in Ghana: Background paper prepared by the Ministry of Health, for the National Health Symposium, State House, Accra, June 7-8, 1988' (Ministry of Health, Accra, 31 May 1988) p.1, Private Archives of the National Catholic Secretariat (Accra, Ghana).

Function	Ghanaians	Expatriates	Total
Enrolled Nurse/Midwife	605	0	605
State-Registered Nurse/ Midwife	99	66	165
Chaplain	7	6	13
Doctor	7	26	33
Laboratory Personel and X-Ray Technicians	80	0	80
Ward Assistant/ Auxiliary Staff/Health Aid/	621	0	621
Matron	9	7	16
Administrator/Clerk	79	4	83
Labourers/Domestic Auxiliary	569	2	571
Medical Officer	0	4	4
Pharmacist	1	3	4
Senior Nursing Sister	0	20	20
Village/Community Health Workers	41	1	42
Tutor	8	5	13
Qualified Registered Nurse/Midwife	15	0	15

Table III - Compiled using statistics from the surveys contained in: P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) Private Archives of the National Catholic Secretariat (Accra, Ghana)

iv. CONCLUSION

The two narratives of the missionary relationship with colonial and postcolonial development were in tension in Nkrumah's Ghana. Navigating these competing identities was one of the critical aspects for Ghanaian nationalists such as Bawumia and Appiah in retaining their foothold within the one-Party state. The analysis of both shows how concerns about missionary modernity could be bound up with long-term political battles over regional independence, local political power and tribalism. Battles over who controlled development, as Frederick Cooper has shown, were central to claims to independent African rule. In this, missions more commonly figured as an asset to Ghanaian nationalists but they could be perceived also as a challenge to government sovereignty over development, disrupting the connection between state and citizens. Generally, for Nkrumah the historic mission church might obstruct some of his grand visions but it was a vital part of his state. It offered the sorts of biomedical, scientific technologies of modernity that he wanted for his development policies. Medical missionaries' association with colonialism and British rule was only a major issue in the symbolic centres of power. However, these complex layers could confuse even loyal socialists who in 1961 took over the mission hospitals around Navrongo, only to be thrown out again by Nkrumah himself. Not everyone could navigate the tensions in missionary identities for political gain.

Within these contests over the possible identities of medical mission, the result was that medical mission grew. By 1966 34 mission hospitals had been built as well as many dispensaries, clinics and mobile stations. Medical missions' experiences and perspectives were generally were separate high level debates in the Parliamentary Assembly. Medical missions reformed their development practices and their hierarchies in response to decolonisation in terms of 'Africanisation', not in terms of the modernisation or detachment from colonialism that mattered to nationalists. From the 1960s onwards, both Catholic and Protestant medical mission did 'Africanise' but in different ways. These differences were shaped by local and regional actors, and changes in the national and transnational churches, as much as by government politics. Whilst both Africanised a great deal from the 1960s, expatriate Catholics retained much control over the hierarchies of their healthcare. This was in contrast to the Presbyterian Church of Ghana which took power over all the former Scottish and Basel missions, yet there were significant limits to their ability to Africanise. For all missions, the lack of Ghanaian doctors, especially in the late 1970s and 1980s, meant long-term expatriate control. Crucial to this process was not only local separation from state power, but also huge new streams of foreign funding from West Germany and Netherlands, and staff from North America and Europe.

Chapter 4

REFRAMING POSTCOLONIAL INTERNATIONAL HEALTH: WEST GERMAN AND DUTCH CATHOLIC MEDICAL MISSION IN DECOLONISING GHANA, c.1957-1983

Historians have traditionally framed postcolonial international health in two, broad ways: the US and the Soviets in a global Cold War battle to control the 'third world' or the former colonial powers trying to retain their control over the new nationalist rule of their old colonies.[429] In addition, recent work of development studies has also examined 'South-South' international health. Finally, Erez Manela in his work on Smallpox Eradication Programme (SEP) has, following Akira Iriye, emphasised that US involvement was not determined by the Cold War or imperial expansion. Instead the US place in SEP centred on 'the growth and articulation of a global community'; this was through NGOs which were an expression of an older international idealism within 'technical' health fields.[430]

However, this chapter will argue that there is another, significant, framing that has so far been largely absent from the historical literature on international health: old colonial powers establishing health development through medical mission in areas that they had *never* ruled or which had almost no relation with since before the 1880s imperial 'scramble'. From the late 1950s, West Germany and the Netherlands conducted international health work in Ghana - an area to which they had previously had almost no connection. This was elaborated without the 'global community' of the WHO and UNICEF. It was a process not simply determined by Cold War agendas or by old colonial patterns or by the emerging global community, but was truly fresh development work in a decolonised setting. These arguments challenge Iris Borowy's categorisations of East German international health and development aid to Nicaragua in terms of 'Cold War logic', North-South relations and international health models. Instead, this chapter will show how West German and Dutch Catholic medical mission transcended these categories.[431]

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[429] As Corinna Unger puts it: 'Most scholars agree that the initially humanitarian impetus in the aftermath of World War II was marginalized by Cold War-inspired geostrategic concerns in the late 1940s. Thus, while modernization thinking in many ways constituted a revised and expanded version of earlier development discourses, its implementation in the form of professional development aid was very much a post-1945 phenomenon' C. R. Unger, 'Histories of Development and Modernization: Findings, Reflections, Future Research' H-Soz-Kult (12 September 2010) http://hsozkult.geschichte.hu-berlin.de/forum/2010-12-001.

[430] E. Manela, 'Globalizing the Great Society: Lyndon Johnson and the Pursuit of Smallpox Eradication' in F. J. Gavin, M. Atwood Lawrence (eds.) *Beyond the Cold War: Lyndon Johnson and the New Global Challenges of the 1960s* (Oxford: Oxford University Press, 2014) p.166 citing A. Iriye, *Global Community: The Role of International Organisations in the Making of the Contemporary World* (Berkeley: University of California Press, 2002).

[431] I. Borowy, 'East German medical aid to Nicaragua: the politics of solidarity between biomedicine and primary health care' *História, Ciências, Saúde – Manguinhos* 24.2 (Rio de Janeiro, Abr.-Jun, 2017) p.411-428.

West Germany and the Netherlands funded Catholic healthcare in Ghana from the late 1950s into the 1990s to a huge extent. This was entirely new process and represents a major change in medical mission, development and international health. Between the 1950s and 1980s both the Netherlands and West Germany, supplying millions of Deutschmark and Guilders, established many Catholic medical missions in independent Ghana. In spite of their lack of colonial heritage in Ghana, there was a massive growth of Catholic medical mission in Ghana after the 1950s from West Germany and the Netherlands. The two countries not only financed their own new institutions, they also funded European and American Catholic missions such as the Medical Mission Sisters (MMS, based in Philadelphia) with a million Deutschmark and Guilders at a time. Furthermore, when Indonesian nationalist-led revolution ended Dutch rule in the mid to late-1940s and then again when the republic became an authoritarian dictatorship in the 1960s, Dutch Catholic missions fled - not home - but to Ghana. There they came in droves setting up new hospitals and supporting old ones.

Neither the Netherlands or Germany had had a significant national colonial presence in the Gold Coast since 1871. Before the British ruled the Gold Coast, it was named the Dutch Gold Coast or Dutch Guinea and had been controlled by a Netherlands colonial government since 1598. Yet, without a large settler population, when the Gold Coast was ceded to the United Kingdom in 1870-1871, the Dutch role in the colony almost completely disappeared. The transition to British rule was well documented in Douglas Coombs history in 1963; however, in national Ghanaian history, other than notable fortress landmarks, the Dutch are almost as forgotten as the Portuguese who preceded them.[432] The Swiss and German Protestant presence through the Basel and Bremen missions has had more of a mark on Ghanaian national life. Their flagship hospitals at Agogo and Bawku forged international reputations for high-level of service, such as in ophthalmology. The Basel mission workers were involved in planting the first cocoa crops on which independent Ghana's economy was based. However, there was little national German power in the country and these missionaries were swiftly ejected by the British government in the First and Second World Wars. The Gold Coast was strategically vital as the base for the American air force and the British RAF to launch campaigns in Europe and North Africa.[433] Overall, Germany and the Netherlands' role in colonial Gold Coast was, by the 1950s, a feature of either the distant past or restricted to a specific Protestant group.

This chapter will first explore how and why the Dutch and West German Catholics funded such a great deal of medical mission in Ghana. It will argue that West German Catholics chose to identify with a denazified, Catholic internationalist and democratically liberal narrative which emphasised shared humanity with other Europeans and shared suffering at the hands of the Nazis. This was physically embodied in the Misereor Lent collection campaigns in which West German Catholics fasted and thus suffered to help the world's hungry and the poor. Crucially, the second half of this chapter will shown how these development

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[432] D. Coombs, *The Gold Coast, Britain and the Netherlands, 1850-1874* (Oxford: Oxford University Press, 1963).

[433] J. Roberts, 'Korle and the Mosquito: Histories and Memories of the Anti-Malaria Campaign in Accra, 1942-5' *The Journal of African History* 51.3 (2010) pp.343-365.

narratives in West Germany were detached from the ground level realities and concerns of medical missionaries who were partly funded by Misereor. This emphasises the many layers of international health and how the religious motivations could be complex, varied and divided between local, regional, national, and international contexts. It shows how these contexts were perceived, how various actors wished to construct them and how they performed specific identities within them.

For West Germany and the Netherlands, international Catholic mission networks provided an alternative route to lay claim to a development narrative, different from old colonial connections, new US-led Cold War strategies or the emerging international community. This argument builds on the work of Nils Brimnes who shows that, for the Danish, Tuberculosis aid was used to separate themselves from claims of Nazi collaboration. In the late 1940s and 1950s initiatives began as an 'effort to create good-will in war ravaged Europe' before UNICEF funding turned into a large-scale international health campaign.[434] Moreover, the Danish worked in India where they too had had no previous colonial role. For West German and Dutch Catholics, development in Ghana offered a way of joining in the postwar reconstruction efforts of the Europeans and the US who were presenting an internationalist vision of a reborn humanity after suffering the violence of war. Moreover, instead of simply trailing the old colonial paths or aiding the emerging global community, West Germans could build upon an older, traditional Catholic development. Again, one which could be linked to a different Catholic war narrative of suffering and resistance not collaboration or acquiescence.

The focus of this chapter will be on German medical mission in Misereor and the second section will examine the Catholic missions funded by Misereor in Ghana. It will explore the limits and power of what Misereor could achieve in these settings and how they were experienced on the ground, who staffed the missions and how they thought about their work. It will conclude by showing that Dutch and West German Catholic postwar medical mission was a global phenomenon including Asia, Africa and Latin America. It will argue that the influx of Dutch and West German Catholic medical missionaries to Ghana, for example, Dutch missions fleeing from Indonesia after its independence was part of a global phenomenon. Table V will show the sheer range of Catholic medical missions in Ghana to which Misereor and the Dutch Catholic organisation MEMISA (Medische Missie Actie) made contributions.

i. THE REVERBERATIONS OF 'FASTENAKTION':
WEST GERMAN AND DUTCH CATHOLIC DEVELOPMENT AND HUMANITARIANISM, 1959-1983

Through Konrad Adenauer's tax policy and huge donations from West German Catholics, Misereor was extremely well-funded in the 1950s. From 1949 to 1963, Adenauer was the Chancellor of the Federal

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[434] N. Brimnes, 'Vikings against tuberculosis: the International Tuberculosis Campaign in India, 1948-1951' *Bull Hist Med*. 81.2 (Summer, 2007) pp.407-30.

Republic of Germany (FRG) and chair of the foremost political Party in West Germany, the Christian Democratic Union (CDU). In West German public politics Catholics dominated; though the CDU included both Protestants and Catholics, Adenauer himself was a devout Catholic. As Tony Judt has described, Dutch and West Catholic communities became far more integrated with wider political culture after the war and Adenauer emphasised ecumenism in order to gain national support and reduce church-state conflict.[435] The CDU had cross-denominational support even in Bavaria.[436] Continuing older German policies, Adenauer apportioned tax money to churches depending on their members, which benefitted Misereor particularly.[437] Yet, at the same time, Catholic and Protestant aid programmes were separated, with Catholic Bishops gaining especially massive amounts of donations from West German churches.[438] Misereor emerged out of the World Union of Catholic Women's Association and the West German branch of the Pax Christi movement, which in the mid-1950s campaigned against starvation and leprosy overseas. Out of this the German Bishops began fasting in 1958 to protest against worldwide hunger under the banner of 'misereor super turbam' (pity for the crowd), raising money for poverty relief. In 1959, Misereor collected over 34 million Deutschmarks (DM) in donations from West German Catholics; this would reach hundreds of millions by the early 1960s.[439]

Misereor's work was mostly confined to work amongst West Germany Catholic churches because of historic regional affiliations. The smaller German Protestant relief organisation 'Bread for the World' also began in 1959, focusing on the famine in India and gaining tens of millions of Deutschmarks. Combined the total was over 50 million DMs, which exceeded the West German parliament's international aid budget.[440] Unlike Misereor, which could rely on West Germany alone, Bread for the World also collected 11.8 million DM from East Germany in the first three years of its operation. By contrast, East German Catholic Bishops did not collect in East Germany until 1968 when their efforts were organised as 'Need in the World' which

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[435] T. Judt, *Postwar: A History of Europe Since 1945* (Pimlico, 2007) pp.264-267.

[436] Thanks to Henning Grunwald for these comments, guidance and other advice relating to postwar German politics and the Nazi persecution of Catholics, any errors are my own.

[437] J. Hitchcock, *History of the Catholic Church: From the Apostolic Age to the Third Millennium* (San Francisco: Ignatius Press, 2012) p.386.

[438] G. Witkoski, 'Between Fighters and Beggars: Socialist Philanthropy and the Imagery of Solidarity in East Germany' in Q. Slobodian (ed.) *Comrades of Color: East Germany in the Cold War World* (New York: Bergahn Books, 2015) pp. 80-85.

[439] Misereror, 'Geschichte' (https://www.misereor.de/ueber-uns/geschichte/ accessed on 13/10/2017); 'Papstdank für die Deutsche Fastenspende' *Passauer Neue Press: Niederbayerische Zeitung*, Ausgabe Nr.149 (03 July 1959); P. Kearney, *Guardian of the Light: Denis Hurley: Renewing the Church, Opposing Apartheid* (NY, New York: The Continuum International Publishing Group Inc, 2009); H. E. Bacareza, *A History of German-Phillipine Relations* (National Economic and Development Authority-APO Production Unit, 1980) p.214.

[440] W. Bruchhausen, 'From Charity to Development: Christian International Health Organizations, 1945-1978' *Hygiea Internationalis: An Interdisciplinary Journal for the History of Public Health* 13.1 (December 2016) p.121.

was separate from Misereor and mainly funded non-aligned or communist former colonies.[441] As Dora Vargha has shown for Hungary, in some cases international health was shaped by Cold War rhetorics and in others threats such as Polio offered a safe place for 'unprecedented, open cooperation among governments on the two sides of the Iron Curtain'.[442] Catholic development aid from Germany, where collaboration crossed the Iron Curtain or not, depended as much on deep historic regional loyalties as on more recent Cold War divisions. For example, as will be further elaborated below, particularly places in Bavaria provided a great deal of Misereor funding, ensuring they did not need East German help.

The scale of aid from West Germany and Misereor to key postcolonial states was large. In 1962, West Germany was the first member of the Development Assistance Committee member to start co-financing.[443] In one instance in 1967, the West German government gave $200,000 to the Medical Mission Sisters' (MMS) nursing programme in Berekum, Ghana, alongside a grant of $58,000 from Misereor and 25 per cent of the costs from the MMS itself.[444] In 1965, for a project from 1966 to into the 1970s, the West German government gave 7,783,000 DM to a Plan between the Vatican, Misereor and the Indonesian bishop. A further 65,000,000 rupees was to be paid by the Indonesian bishops, joint funded with Misereor.[445] Simultaneously, the Ghanaian government was being given massive loans by KFW (Kreditanstalt für Wiederaufbau) the German development bank. Between 1966 and 1969, 10 million DM were lent to the Ghanaian government, which was around 12 million new cedis, for the first phase of a national electrification project. The second phase after 1968 was funded by the World Bank. This was crucial for wider Ghanaian development aims such as the aluminium smelter. KFW funded Ghana again in 1989, extending electrification to the North for the first time.[446]

In the Netherlands too, Catholic medical mission was given massive funds from the early 1960s. In the Netherlands co-financing programmes, in which matching grants were distributed to development agencies, had a similar consequence for both Catholic and Protestant aid, and secular organisations were given a far smaller share. As C. H. Biekart put it, these: 'German and Dutch aid agencies that were founded in response

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[441] G. Witkoski, 'Between Fighters and Beggars: Socialist Philanthropy and the Imagery of Solidarity in East Germany' in Q. Slobodian (ed.) *Comrades of Color: East Germany in the Cold War World* (New York: Bergahn Books, 2015) pp. 80-85.

[442] D. Vargha, 'Between East and West: Polio Vaccination across the Iron Curtain in Cold War Hungary' *Bulletin of the History of Medicine* 88.2 (John Hopkins University Press, Summer 2014) pp.319-342.

[443] J. Randel and T. German, 'Germany' in Stakeholders in I. Smillie and H. Helmich (eds.) *Stakeholders: Government-NGO Partnerships for International Development* (New York: Earthscan Publications Ltd., 1999) p.114.

[444] B. Mann Wall, *Into Africa: A Transnational History of Catholic Medical Missions and Social Change* (New Brunswick: Rutgers University Press, 2015) p.53.

[445] K. Steenbrink, 'The Power of Money: Development Aid For and Through Christian Churches in Modern Indonesia, 1965-1980' in S. Schröter (ed.) Christianity in Indonesia: Perspectives of Power (Berlin: Lit Verlag, 2010) p.109.

[446] H. Marwah, 'Institutional Failure or an Unsustainable Foreign Debt Burden? Financing and Management of Ghana State-owned Electricity Distribution 1960-2002' (Unpublished Paper presented at the ESSHC conference in Belfast, 5 April 2018).

to official co-financing programmes would later become the largest private aid agencies in Europe'.[447] As Karel Steenbrink has shown, modelled on Misereor, the Dutch Catholics set up 'Lenten Campaign' (Vastenactie) in 1961, in 1963 they partnered with Protestant development organisations and gained government funding. In 1965, the Dutch government co-financed both Catholic and Protestant development agencies with five million guilders. In 1946 the newly-formed Catholic People's Party (KVP) went into coalition government with the social democratic Labour Party until 1956. Between 1958 and 1965, the KVP dominated Dutch politics supplying every single Prime Minister in the period. According to Steenbrink, from then on it became 'common policy that the government supplemented up to 75% for development programmes ignited by Christian churches with their overseas partners'.[448] Steenbrink further shows how in 1971 the Dutch Catholic medical organisation MEMISA gained 20 million Guilders in its first television campaign event, its second in 1975 gained 8 million guilders. Alongside the Protestants the 1972 television even KOB I collected 58 million guilders in the campaign.[449] In interview, the Medical Mission Sisters at Berekum, who were receiving funding from the West German government and Miseroer, noted that they were also given millions of guilders from MIMESA. Further to this a former MEMISA manager, Béatrice Looijenga, explained that Ghana was a focus country and that she remembered roughly 500,000 guilders were being given annually to Catholic aid there in the 1970s.[450]

There have already been studies of Dutch and German (both East and West) development aid being poured into their old colonial territories, but their role in previously disconnected nations has not been studied. Carola Rensch and Walter Bruchhausen have explored how West German relations with Africa were fostered through development aid given to Togo, an old German model colony, and to Gabon where the notable mission doctor Albert Schweitzer had been based. West Germany also financed international cooperative efforts through the WHO. For Togo, much of their reasoning is similar to the work of Manela - that the benefits to technical expertise and longer-term capacity building for research were the drive behind funding: '"development aid' claimed to bring and the promises of science' and modernity.[451] Furthermore, implications for German aid to Africa in the Cold War have also been discussed; most notably, the ideological affinity East German held with Nyerere's socialism in Tanzania resulted in development aid to bolster their shared endeavour. For example, John Iliffe has noted this with regard to East German doctors staffing hospitals in East Africa, though Iliffe particularly emphasises the long-term colonial connections

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[447] C. H. Biekart, The Politics of Civil Society Building: European Private Aid Agencies and Democratic Transitions in Central America (International Books, 1999) p.67.

[448] K. Steenbrink, 'The Power of Money: Development Aid For and Through Christian Churches in Modern Indonesia, 1965-1980' in S. Schröter (ed.) Christianity in Indonesia: Perspectives of Power (Berlin: Lit Verlag, 2010) pp.107-109.

[449] Steenbrink, 'The Power of Money', pp.119-122.

[450] Correspondence to Author from CORDAID, Netherlands (5 October 2017)

[451] C. Rensch and W. Bruchhausen, 'Medical Science Meets 'Development Aid' Transfer and Adaptation of West German Microbiology to Togo, 1960–1980' Med Hist 61. 1. (Jan 2017) pp.1–24.

with the area.[452] There were also disjunctures in German relations with their former colonies. With the UN taking trusteeship over Namibian territories and handing control to South Africa, as soon as independence occurred for Namibia in 1990 Germany began giving development aid - before that relations were restricted.[453] However, there was far more that was new and independent with regards to German aid than this. It must be noted at this point that Matthias Egg in his doctoral dissertation at the Universität Bonn has, in German, detailed some elements of German Catholic mission work across the colonial/postcolonial divide for Zimbabwe, Cameroon, the Congo, Namibia and Ghana.[454]

Identifying with a denazified, liberal political culture was vital to the reconstruction of West German and Dutch politics postwar. As Christoph Müller has argued, many West Germans in the late 1940s, 1950s and 1960s were hostile to the modernisation and globalisation of their country, as a defence against this 'West-German anti-Americanism could be found in all social strata'. In an attempt to articulate a resurgent German nationalism, there was a desire to find a place for Germany between the East-West blocs.[455] Moreover, Barbara Marshall argues that dislike of the denazification process actually stopped a resurgent Nazism by ensuring that the occupation forces soaked up animosity which could have been directed at German political parties.[456] Lutz Niethammer famously argued that denazification's greatest effect was to produce a 'mitläuferfabrik' or a 'follower factory'. This was distinct from restricting the definition of denazification to the official America programme which was abandoned by the West German government in 1951. The initial American programme had had practical issues with too many Germans with Nazi pasts conducting necessary work such as in the civil service, difficulty with enforcement and recording, and Cold War expediency requiring the rapid restoration of West Germany. Instead, by only convicting a small section of the population and releasing the majority of them, the denazification process after 1951 provided most Germans with clean Nazi pasts. Combined with the consistent effort of the West German government and the Catholic church not to address the Nazi past, the most obvious result of denazification was that it swept the horrors under the carpet and it was not until at least the 1970s that liberal culture would consider them properly again. As Ian Turner and Barbara Marshall have suggested, denazification helped stop any political

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[452] J. Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998) pp.34, 200-220.

[453] R. Kössler, *Namibia and Germany: Negotiating the Past* (Windhoek: University of Namibia Press, 2015) p.237.

[454] M. Egg, *Krankenfürsorge im Spannungsfeld von Medizin, Glauben und Gesundheitspolitik Die Gemeinschaft der Missionshelferinnen,1952–1994* (Inaugural-Dissertation zur Erlangung des Doktorgrades der Hohen Medizinischen Fakultät der Rheinischen Friedrich-Wilhelms-Universität Bonn, 2015)

[455] C. Muller, *West Germans Against The West: Anti-Americanism in Media and Public Opinion in the Federal Republic of Germany, 1949-1968* (Palgrave Macmillan, 2010) pp..5, 15-16.

[456] B. Marshall, 'The Democratization of Local Politics in the British Zone in Germany: Hanover 1945-7',Journal of Contemporary History 21.3 (Jul. 1986) p.414.

resurgence of Nazism by eliminating Nazis for long enough that a new political culture could develop.[457] This political culture was heavily dominated by a quietist Catholicism which washed over national guilt.

Like Germany, the Netherlands also had an intense denazification process resulting in the internment of around 100,000 collaborators.[458] The Netherlands too had to re-establish a fresh political culture, they could not root out everybody that had pro-Nazi allegiances and too chose to base their state on Catholic democratic politics. The KVP became incredibly powerful in the 1950s and 1960s, only waning in the 1970s. Moreover, much of the Catholic development efforts, as Steenbrink noted, were directly copying initiatives like Misereor in West Germany. Catholicism, as in West Germany, offered a safe set of moral norms that seemed to have been overturned under the violence of National Socialism; yet, they also did not overturn many of the gender politics that had been popular in the 1930s and 1940s. Catholicism offered a version of the national past that could ignore the horrors of nationalism and recall an international order around the Holy Roman Empire and the Vatican. It offered a different political fit that neither subjected itself to Cold War blocs or to the older colonial traditions. Even if the latter did not have the bad odour of the former, given the annexation of many old colonial territories for Germany at least, another route was required.

Dutch and West German Catholics identified with a common European political culture based on older missional traditions, Empire and development. For both the Netherlands and the West Germans the liberal international order, the global community, forged largely by the Allies and including new nationalist states, may not have been actually that popular (though more study would need to be done here). By contrast, missional Roman Catholicism, given the amount given in donations and through the government, clearly was a very popular alternate kingdom and form of international belonging. Crucially, these development efforts were not simply a response to war guilt but about identifying with a narrative of shared suffering with other nations, distinguishing themselves from collaboration and Nazism. Colonial administration and European integration could go hand in hand, postwar commonalities could be expressed through Empire, rather than it being a field of competition. In the case of West German and the Netherlands, development in a colony administered by the British offered an opportunity to enter into the commonalities of a shared imperial past as well as shared suffering. Development in Ghana offered a seat at the table in European reconstruction. Just as Brussels laid claim to the European machinery, West Germany had to attain a role in the reconstruction of Europe and European empire, but were shut out from gaining too much institutional power. Therefore, they forged their own path in the emergence of the international order within a flourishing Catholic internationalism, which in the early 1960s was spreading across the United States and Latin America. In the latter liberation theology was encouraging priests and nuns to the front-line of social justice issues from the

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[457] I. Turner, 'Denazification in the British Zone' in I. Turner (ed.) *Reconstruction in Post-War Germany: British Occupation Policy and the Western Zones, 1945-55* (Berg Publishers, 1989) p.11; Marshall, 'The Democratization of Local Politics in the British Zone in Germany', pp.414, 447.

[458] C. Mudde, *The Ideology of the Extreme Right* (Manchester: University of Manchester Press, 2000) p.117.

1950s.[459] Moreover, perhaps if we consider Ghana as a British context even in the 1960s, West Germany could also have been showing its ability to be effective in development work, in ways better than perfidious Albion who were being pushed further out. As Frederick Cooper has shown with African nationalists, so too with West Germany, showing leadership in development proved on some level being suited to leading in colonial government and democracy. This was significant given that West Germany was blocked from developing its former colonies in Southern Africa. Instead, it could join in with a Catholic internationalism that was widely resurgent in the 1960s, during Vatican II, the attendant social justice movements, and the pioneers of the 'preferential option for the poor'. Whilst some Dutch Catholics fell out of favour at Vatican II, there was still a significant movement here, amidst decolonisation, in which a development leadership and European commonality narratives could be proved in Catholic medical mission.

Developmentalism through Catholic mission was a form of civil society-state coordination which distinguished West Germany from the tyranny of Nazism. In the aftermath of the fall of the Nazis the German Evangelical churches collectively apologised in the 'Stuttgart Declaration' for 'not loving more ardently'. By contrast, Pope Pius XII postwar radio broadcast eschewed the collective guilt narrative in favour of emphasising Catholics as themselves victims at the hands of the Nazis.[460] The German postwar state was underpinned with the 'Persilshein' attitude in many areas of national life in which those who previously had worked in key positions regained them without reproach. Though not nearly to same extent, the Netherlands too had issues with Nazi pasts with political consequences such as the empowerment of Catholics. Vital to the maintenance of the denazified narrative, given the contrary realities, was that civil society was shown to have an active role in keeping the government accountable, putting checks on the overuse of power and showing the healthiness of state institutions which were not closed to associational life. These features of liberal democracy, especially in the American setting, were important to perform to the world. In the case of development, driven by the Catholic Bishops, funded by citizens themselves and then supported by the state, it showed aspects of German liberal governance and was crucial to the denazification process.

These ways of understanding the meaning and purpose of Misereor's development work were articulated most notably by the Federal President, Heinrich Lübke, at large rally in Cologne in 1964. Alongside the CDU Chancellor, Ludwig Erhard and the famous Nazi resistor who helped to start Misereor, Cardinal Frings, Lübke lauded the work of Misereor to more than a thousand guests in early 1964. Key parts of the speech were recorded and further disseminated in national and regional presses. The most significant aspect of the speech repeated in newspapers was the connection between Misereor's work in development in its rebounding effect for German unity and restoration. In *Der Spiegel*, Lubke was quoted as having said that

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[459] M. McAlister, 'The Global Conscience of American Evangelicalism: Internationalism and Social Concern in the 1970s and Beyond' *Journal of American Studies* 51.4, Exploring the History of American Evangelicalism (November 2017) pp.1197-1220.

[460] B. A. Griech-Polelle, 'Review of S. Brown-Fleming, *Holocaust and Catholic Conscience: Cardinal Aloisius Muench and the Guilt Question in Germany*' *H-German, H-Net Reviews* (September, 2006).

'the unselfish works' of Misereor would 'reverberate' back upon Germany and thus 'all who serve sacrificially and cooperatively' and who contribute to aid for the needy would be also be working 'simultaneously to restore German unity'.[461] This added to links between national unity and Misereor's development work being forged with everyday items such as national stamps which depicted the charity branding alongside ears of corn. Moreover, in the Bavarian newspaper *Passauer Neue Presse* who also reported on the Cologne speech, this quote was extended to include the relationship with the Nazi past. They described how Lubke had explained that 'the German people must earn peace, freedom, and unity, as a result of what was done in the last 30 years' and that 'they (the German people) will be shown through development aid a way in which they can effectively help others'. Particularly Lübke encouraged the German youth to join in this development aid in order to gain the adventure that they sought in places that were 'waiting' for them.[462]

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[461] 'Zitate' Panorama: Deutschland, *Der Spiegel* 14 (01 March 1964) p.20.

[462] 'Lübke würdigt Misereor-Werk der katholischen Kirche: Kundgebung in Köln zum fünfjährigen Bestehen der Aktion gegen Hunger und Krankheit auf der ganzen Welt' *Passauer Neue Press*, Ausgabe Nr. 57 (09 March 1964).

Image IX: Misereor Stampe, Deutsche Bundespost
(Date of Issue: 27 February, 1963)

In tying the funding of Misereor's development aid to the traditional fasting period of Lent, there was a sense in which Germans were choosing suffering in order to alleviate the suffering of others. *Passauer Neue Presse* commented on this major event and Lübke's speech, and regularly featured articles and adverts about Misereor between 1961 and 1964, perhaps because of the large Catholic contingent in Bavaria. There were articles on how much the Bistums Passau diocese had raised their giving from year to year (such as in 1963, which was said to be up 33 per cent on 1962) and from a local Bishop encouraging even more donations because of the scale of global need.[463] These articles were featured along with pieces on developing countries such as Ghana. For example, in one article Kojo Botsio, the Minister for Foreign Affairs in Ghana between 1961 and 1965, welcomed young doctors from overseas because Ghanaian healthcare urgently needed them.[464] These overtures about need, hunger and the desire for help from 'developing countries' were tied to fasting for a cause with the term 'Fastenaktion'. Donating to Misereor was a collective Catholic act during Lent in which churches would give up food, money or habits in order to provide for the hungry in poorer countries. Such a physical embodiment of purposeful suffering had restorative aspects, both in terms of participating in the redemptive suffering of Christ and in the narrative of European suffering during the Second World War. In 1958, Cardinal Frings had made similar points at the outset of Misereor, arguing that misery had entered the German consciousness and they had become aware that most of the world was hungry.[465] In 'Fastenaktion' Catholics were invited to literally participate in the pain of the world in order to help it recover.[466] As many articles in *Passauer Neuer Presse* showed, they did so in their droves.[467] In 1963

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[463] 'Adveniat: Spenden sehr grosszügig' *Passauer Neue Presse*, Ausgabe Nr. 22 (28 January 1964); 'Bischof Simon Konrad ruft die Katholiken des Bistums Pissau' *Passauer Neue Press*, Ausgabe Nr. 85 (11 April 1962); 'Bischof Simon Konrad ruft die Katholiken des Bistums Pissau' *Passauer Neue Press*, Ausgabe Nr. 80 (04 April 1963); 'Bischof von Essen: An die katholischen Leser dieser Zeitung!' *Passauer Neue Press*, Ausgabe Nr. 298 (27 December 1963)

[464] 'Deutsche Hilfe für Aufbau des Arbeitsdienstes: 30,000 Arbeitskräfte sollen Strassen und Brücken bauen - Schulungszentrum und Arbeitsgerät erwünscht' *Passauer Neue Press: Niederbayerische Zeitung*, Ausgabe Nr.190 (19 August 1965).

[465] '24. Juni 1963 - Der Deutsche Entwicklungsdienst (DED) wird gegründet' WDR (24 June 2013) accessed at https://www1.wdr.de/stichtag/stichtag7594.html.

[466] 'Fastenopfer brachte 32 Millionen DM' *Passauer Neue Press*, Ausgabe Nr. 93 (23 March 1959); 'Papstdank für die Deutsche Fastenspende' *Passauer Neue Press: Niederbayerische Zeitung*, Ausgabe Nr.149 (03 July 1959); 'Vierte Misereor-Kollekte: Köln' *Passauer Neue Press*, Ausgabe Nr. 47 (26 February 1962); '"Misereor" Aktion angelaufen: Bonn' *Passauer Neue Press*, Ausgabe Nr. 75 (30 March 1962); 'Pallaeur Nachrichten: Haute beginnt die Fastenaktion' *Passauer Neue Press*, Ausgabe Nr.49 (27 February 1963); 'Wieder Fastenaktion: Aachen' *Passauer Neue Press*, Ausgabe Nr.51 (01 March 1963); 'Misereor will die Not in aller Welt lindern: Die Fastenaktion soll eine Botschaft von Gottes Ordnung sein' *Passauer Neue Press*, Ausgabe Nr.62 (14 March 1963); 'Fastenopfer wird eingesammelt: Aachen' *Passauer Neue Press*, Ausgabe Nr.76 (30 March 1963); 'Ein Tropfen auf einen heissen Stein? Wider Sammlung für die Fastenaktion "Misereor"' *Passauer Neue Press*, Ausgabe Nr. 76 (30 March 1963); 'Neue Fastenspende: Köln' *Passauer Neue Press*, Ausgabe Nr. 33 (10 February 1964); 'Fastenopfer 1965 erbrachte 46 Millionen' *Passauer Neue Press: Niederbayerische Zeitung*, Ausgabe Nr.120 (26 May 1965).

[467] 'Opfer gegen Hunger und Krankheit: Hamburg' *Passauer Neue Press*, Ausgabe Nr.83 (09 April 1962); 'Hohes Misereor-Ergebnis: Mainz' *Passauer Neue Press*, 85 (10 April 1963); 'Über 3 Millionen DM gespendet: Passau' *Passauer Neue Presse*, Ausgabe Nr.66 (19 March 1964); 'Deutsche Hilfe für Aufbau des Arbeitdienstes in Ghana' *Passauer Neue Presse: Niederbayerische Zeitung* Nr.190, Seite 2 (19 August 1965).

alone the Bistum Passau diocese donated 552,584 DM. In 1964, the Passauer Pfarrelen gave 70416 DM to Misereor, slightly less than the 72577 DM the year before. Almost like competition results, printed figures in the press were even broken down by individual church donation, for example, Pfarrel St Nicola in 1964 donated 13553 DM.[468] It was these kinds of contributions across Germany that ensured Misereor gained hundreds of millions of DM annually in the 1960s. In 1961 Frings' Adventiat campaign had gained 170 million DM.[469]

The effects of these development narratives and denazification processes were not paltry, medical mission in Ghana gained millions of Deutschmarks as a result. One of the old international Catholic networks that benefitted most from this process were those in medical mission in Ghana which gained substantial grants from Dutch and West German governments and Catholic development agencies between the 1950s and 1980s. From its beginning in 1959 to 1990, Misereor gave around 40 million DM to Catholic healthcare in Ghana. This began at a time when the Deutschmark was one of the strongest currencies in the world. The breakdown of the financing can be viewed in Table IV, it has been converted into Euros. According to this table, in the 1960s around 7 million DM were given to Catholic medical mission. However, given the tendency for loans to be converted in grants because Hospitals could not repay the money, the figures may have been even higher than suggested. It must be noted that, given the array of different denominations in which donations were made and the difficulty of comparing across decades of changing exchange rates, Table IV represents the most consistent information on how much Misereor was giving. For a simple breakdown, it shows that between 1950 and 1990 over 40 million Deutschmarks were spent on Catholic medical mission in Ghana (around 18.3 million euros) by Misereor.[470] David Maxwell has showed that in Katanga, European issues such as Irish conflict were being replayed in the mission field between Catholic and Protestant.[471] In Ghana, from the 1960s, issues over German reconstruction were being outworked in the mission field with large-scale consequences.

Partly as a result, Catholic growth was out of step with Protestant mission growth generally in Ghana across the period, which may have slowed in the late 1960s in comparison to the previous two decades. In 1967 there were 39 hospitals, 50 health centres and 11 health posts under the Ministry of Health. By 1972 this had grown to 49 hospitals, 54 health centres, and 58 health posts. In 1975 this had reached 54 hospitals, 59 health centres and 78 health posts. Government health expenditure as a percentage of GDP had grown

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[468] 'Gebefreudigkeit hat night nachgelassen: Misereor-Spenden der Passauer Pfarrelen so gut wie 1963' *Passauer Neue Press*, Ausgabe Nr. 66 (19 March 1964).

[469] 'Blick in die Welt: Die stille Entwicklungshilfe der Kirchen: Katholische und evangelische Kirchen sommelten 170 Millionen DM für Notleidende in aller Welt' *Passauer Neue Presse*, Ausgabe Nr. 278 (02 December 1961).

[470] 'Bischöfliches Hilfswerk MISEREOR e.V.: Ghana - Anzahl und Bewilligungssumme de bewilligten Projekte der DAC-Gruppe 1 im Zeitraum 1959-1990' Bischöfliches Hilfswerk MISEREOR e.V. 11.05.2017 ZI: Statistik/En Archiv/ MV, Statistik für Herrn Benjamin Walker. Courtesy of Valentin Moser, Misereor Archives (Aachen, Germany).

[471] D. Maxwell, *Christians and Chiefs in Zimbabwe: A Social History of the Hwesa People, c. 1870s-1990s* (Edinburgh: Edinburgh University Press, 1999) pp.69-102.

steadily from 1.11 per cent in 1966/7, to 1.48 per cent in 1973/4 and 2.21 per cent in 1975/6.[472] Unfortunately consistent statistics across these decades are not available for mission beds or expenditure. By 1971 missions had only increased an extra one hospital to 35 from 34 in 1966 (however, this may have been the result of greater focus on health centres or health posts), this then rose to 36 in 1972.[473] Moreover, by 1971 there were 5218 hospital beds in government health institutions (the largest amount of these, 1761, were in Greater Accra) and only 2950 mission hospital beds. The largest amount of mission beds, 800, were in the Eastern region, showing the continued division between government priorities in the South and missionary priorities further north and in the East.[474] By contrast, there were 511 mines hospital total beds and 200 private hospital total beds. The total across all the institutions meant that there was 1 bed to every 830 Ghanaians in 1971.[475] By contrast, by 1985 the Christian Health Association of Ghana (CHAG), including the majority of Catholic hospitals and health institutions, had 30 hospitals, 33 clinics and 4 Primary Health Care (PHC) projects, resulting in a bed capacity of 4400. In 1982, 2.5 million outpatients were seen in CHAG institutions with 1 million being children. Crucially, 69 per cent of CHAG was made up of Catholic health institutions. Only 17 per cent were Presbyterian, 7 per cent Salvation Army, 2 per cent Evangelical Presbyterian, 2 per cent Methodist, 1 per cent Baptist, 1 per cent Anglican, 0.5 per cent pentecostal and 0.5 per cent church of God. By the 1980s, Catholic growth had outstripped Protestant growth, making Catholics the main actor within CHAG.[476]

The new funding streams from Misereor and MEMISA fit into a continued large scale funding of medical mission by the national Ghanaian government as well as local contributions from patient fees. A large proportion of mission hospital funding came from government in the 1960s and 1970s, consistent with earlier patterns. This continued until at least the mid-1970s, after this unfortunately statistics of government expenditure on mission are unavailable. However, in Table V, Catholic hospitals' data shows that they were gaining a lot of government funding as well as patient fees in 1982. For example, Jirapa Hospital in the Northern Territories had 95.5 per cent of its total income derived from the national government. In 1975-1975, the government estimated to give around 15 million cedis to mission hospitals out of a total 200 million cedis on health generally and compared with 128.5 million cedis given to the Ministry of Health. As

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[472] R. G. Brooks, 'Ghana Health Expenditures 1966-80: A Commentary' *Strathclyde Discussion Papers in Economics* 80.1 (Glasgow, Strathclyde: University of Strathclyde, 1981) pp.41, 50.

[473] 'Ghana Medical Facilities' *Second Ghana International Trade Fair* (1-14 February 1971) pp1-27, PRAAD (Accra, Ghana); 'Appendix 9: Geographical Distribution of Hospitals (1973)' *Ghana* (Department of Health and Social Security, October 1976) The National Archives (Kew, UK).

[474] 'Ghana Medical Facilities' *Second Ghana International Trade Fair* (1-14 February 1971) p.9, PRAAD (Accra, Ghana).

[475] 'Ghana Medical Facilities' *Second Ghana International Trade Fair* (1-14 February 1971) p.18, PRAAD (Accra, Ghana).

[476] 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) pp.1-9, Annexes I-III, SOAS Library and Archives (London, UK).

Government expenditure fluctuated in the 1970s, Protestant growth slowed but Catholic mission was still benefitting from both national and international sources.[477]

CHAG, dominated by Catholic health institutions by the early 1980s, was also largely funded by MEMISA, Misereor and the Dutch government. As will be discussed further in Chapter 6, the organisation CHAG, which coordinated missions in Ghana ensuring they could lobby as a group from 1967, was largely funded by MEMISA and Misereor. Whilst CHAG was set up by the CMC (Christian Medical Commision) to which Misereor also donated, Dutch and West German aid actually facilitated its work. Given the large percentage of Catholic health institutions within CHAG this is hardly surprising as it gave them a stronger voice in voluntary sector negotiations with the government and trade unions. This further allowed Catholic medical mission in Ghana to expand and dominate the health landscape from the late 1960s onwards. Vitally for CHAG and for PHC, MEMISA and various other Dutch organisation also supplied drugs in 1981. The donations totalled 300,000 DFL. Furthermore, in 1983 emergency donations during the refugee crisis in Ghana, when over one million Ghanaians entered the country from Nigeria, were given by the Dutch Government (260,000 DFL), Misereor (750,000 DFL), the Christoffel Blind Mission (500,000 DFL), ECHO and the Christian Council of Ghana. This was added to with a further Dutch government grant of 2,000,000 DFL. These were recorded as having covered 'all the needs of the CHAG units for at least 1 to 2 years'. In addition to all this, in 1985 EZE (German Protestant Association for Cooperation in Development) gave a further 2,000,000 DM for the drug supply programme and ICCO (Interkerkelijke coödinatie commission ontwikkelingsprojekten/interchurch coordination committee for development projects) gave 750,000 DFL.[478] MEMISA contributed 200,000 Nfl, Brot für die Welt gave 250,000 DM, Cebemo gave 300,000, Eén voor Afrika Relief gave 150,00 Nfl., Christian Aid gave £40,000 and CIDA gave $50,000.[479] As chapter 5 will show, combining with Canadian aid was not unusual. What was incredibly striking about these numbers, as chapter 6 will show, is that they aimed to bolster CHAG and Catholic medical missions' ability to continue building PHC even against international trends away from the movement.

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[477] R. G. Brooks, 'Ghana Health Expenditures 1966-80: A Commentary' *Strathclyde Discussion Papers in Economics* 80.1 (Glasgow, Strathclyde: University of Strathclyde, 1981) pp.34-36, 52.

[478] 'ICCO' (28 May 1985, DbB/ap) SOAS Library and Archives (London, UK); 'Ghana: CHAG Drug Supply Programme', CMC Pharmaceutical Advisory Group held at DIFÄM, Tübingen, FRG' (1-2 April 1985) SOAS Library and Archives (London, UK).

[479] 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) pp.1-9, Annexes I-III, SOAS Library and Archives (London, UK).

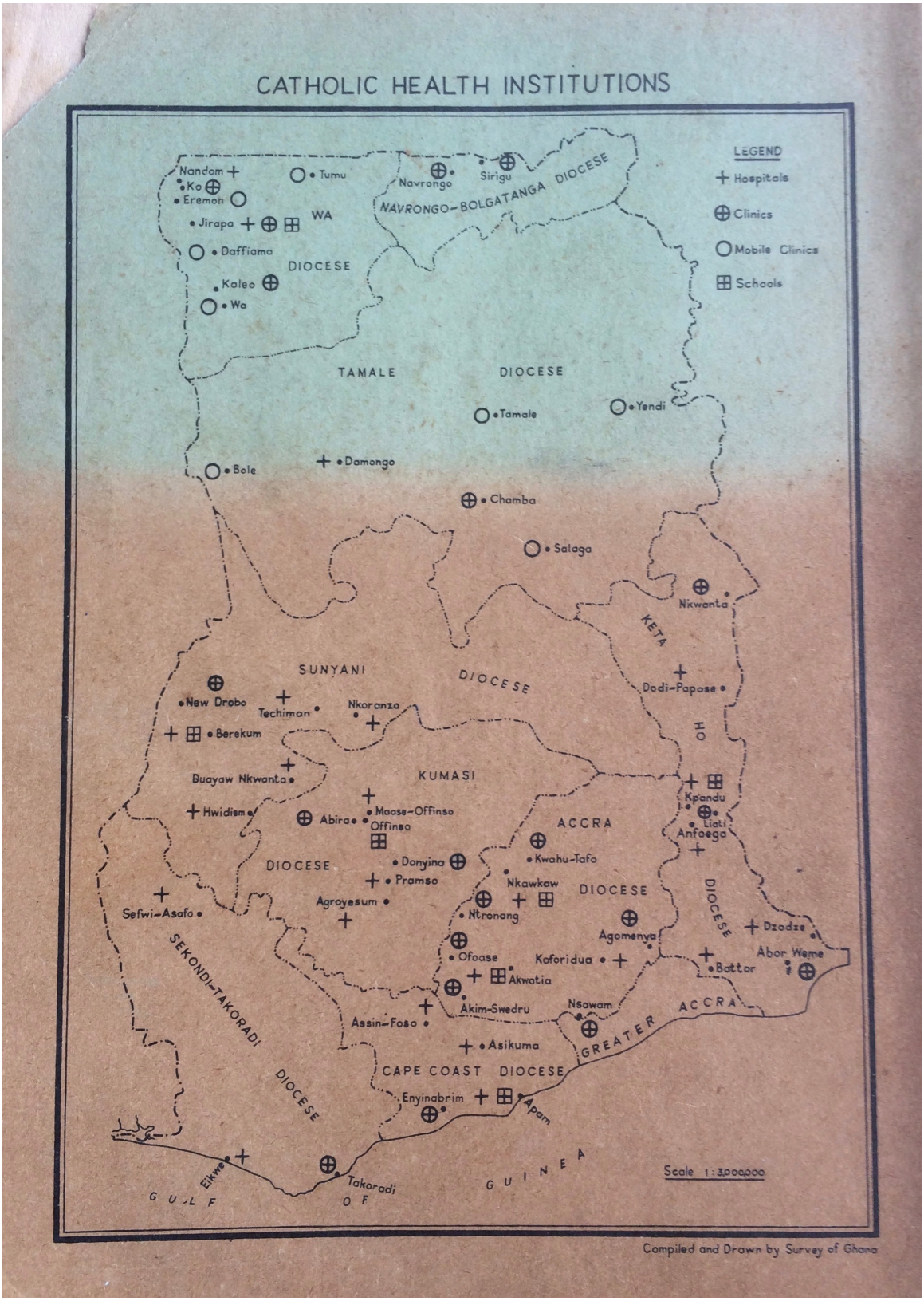
Bischöfliches Hilfswerk MISEREOR e.V.

Ghana - Anzahl und Bewilligungssumme der bewilligten Projekte der DAC-Gruppe 1 im Zeitraum 1959 - 1990

	1959-1970		1971-1980		1981-1990		Summe 1959-1990	
DAC	Anz	Bewilligssumme €	Anz	Bewilligssumme €	Anz	Bewilligssumme €	Anz	Bewilligssumme €
100	0	0,00	0	0,00	5	116.574,55	5	116.574,55
103	4	53.039,35	17	1.258.775,05	43	3.447.084,21	64	4.758.898,61
111	33	3.302.383,14	26	1.511.455,50	69	6.921.533,72	128	11.735.372,36
112	1	43.255,29	7	426.417,42	15	1.089.051,72	23	1.558.724,43
113	0	0,00	1	14.316,17	0	0,00	1	14.316,17
114	0	0,00	0	0,00	4	123.732,64	4	123.732,64
116	0	0,00	3	8.819,78	0	0,00	3	8.819,78
Summe	38	3.398.677,78	54	3.219.783,92	136	11.697.976,84	228	18.316.438,54

Bischöfliches Hilfswerk MISEREOR e.V. 11.05.2017 ZI: Statistik/En Archiv/MV
Statistik für Herrn Benjamin Walker

Table IV - Misereor Expenditure Statistics for Ghana in Euros; Misereor-Archive, Aachen, Germany.



Map II.

P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra), Private Archives of the National Catholic Secretariat (Accra, Ghana).

ii. MISEREOR AND WEST GERMAN CATHOLIC MEDICAL MISSION IN GHANA, c.1959-1983

Through Misereor a wide range of Catholic medical mission in Ghana was extensively funded but this did not mean that it could impose its development narrative on medical missions. Grand visions of German restoration and humanitarianism were detached from the lived experiences and priorities of medical missionaries themselves. Moreover, local circumstances and national changes shaped what was possible for mission. Mission relied on Misereor but they also continued to need patient fees and government grants.

Misereor was involved in financing a wide set of Catholic medical missions in Ghana from the early 1960s onward. As Barbra Mann Wall has shown Family Hospital at Berekum received a considerable amount, including $200,000 in 1967 from the German government.[480] In the 1970s (beginning in 1971 with an initial grant of around 5000 Cedis and ending in the early 1980s) the Holy Family Hospital was granted over 1,037,000 DM for a hospital extension.[481] Misereor also had an array of other projects. In 1961, the committee gave 134,400 DM as an aid loan to help complete the St Martin's Hospital at Agroyesum.[482] In 1963, the Hospital at Kpandu received 286,000 DM and a Nurses Training Centre received 214,000 DM, 300,000 DM of this total in donation and 200,000 DM in loans, with the majority of the loan being borne by the Nurses Centre which only received a 14,000 DM donation.[483] In 1971, the hospital at Kpandu received 72,910 Cedis for drainage. In 1974 the hospital at Assim-Foso received 90,000 DM for X-Ray apparatus.[484] In 1980, at St John's Clinic and Maternity at Akim Ofoase, at Holy Family Hospital at Nkawkaw, and at St Michael's Maternity Clinic at Ntronang, Misereor built staff accommodation costing a combined total of 240,000 DM.[485]

These large amounts from Misereor were also combined with local Catholic initiative and financing, which Misereor managed to exert some control over. In 1979 the Misereor worked with the National Catholic Health Council, Diocesan Health Committees and the Catholic Bishops Conference in Ghana to produce an 'Essential Improvements Fund for the Preparation of Church Health Institutions in Ghana for

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480 B. Mann Wall, *Into Africa: A Transnational History of Catholic Medical Missions and Social Change (*New Brunswick, NJ: Rutgers University Press) p.53.

481 'Erste Ausbaustufe des Holy Family Hospitals in Berekum, ZU:130-4/3 Z 1233*' Projekt Nr. 130-009-0001*, DAC 111, *Bewill Jahr 1973, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

482 'Ausbau Des St. Marten's Hospitals Agroyesum' Projekt-NR 130-004-0001, DAC 111, *Bewill Jahr 1961, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

483 The document did not specify DM or Cedis, it is most likely that this is DM; Ausbau Krankenhaus Errichtung Pflegerinnenschule Kpandu Ghana' *Projekt-NR 130-003-0001 A, DAC 111, Bewill Jahr 1961, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

484 'Röntgengerät für das Hospital in Assen Foso' *Projekt-NR 130-002-0016A, DAC 111, Bewill Jahr 1975, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

485 'Construction of Staff Accommodation at Various Health Care Institutions in the Diocese of Accra' *Projekt NR - 130-0/4- KH 789* (16 Dec 1980*) Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

Basic Health Care Work', i.e. to equip hospitals, clinics and mobile clinics to support Primary Health Care. The fund was to improve water supplies, sewage systems, electricity and minor auxiliary buildings but not new wards, staff buildings or running expenses such as salaries or drug supplies. On average the financial split was around 25% local and 75% from the Misereor fund. This amounted to a local contribution of 340,000 DM and a fund contribution of up to 1,000,000 DM.[486] By 1986, the local Catholic Diocese and Archdiocese had contributed 2,032,085.05 Cedis.[487] Monitoring and evaluation would be done by independent agencies and the Ministry of Health. In another case in 1982, 60,000 Cedis was collected from the National Catholic Secretariat in Ghana for the Papase Hospital, Dzodze Hospital and Weme-Abor Clinic. This was transferred to the Procure in Oosterbeek, Holland on the account of the Bishop - rather than being kept in Ghana.[488] Well after formal Ghanaian independence, by working with local Catholic networks Misereor significantly extended their financial power in a range of projects and even could gain direct control over local Catholic fundraising.

Misereor funding was divided up in range of amounts between a variety of projects and could draw in other financial actors such as the government, as well as the local church. In 1981 Misereor set up a mobile eye clinic out of Nandom Hospital for 7023.35 Cedis.[489] Smaller amounts of funding, as in this case, may not have been able to ensure a hospital functioned without support but they provided leverage to gain funding from other areas too. Continuing the long stream of government funding for mission hospitals, in 1981 the Hospital at Nandom also received 397,500.00 from the government, 350.00 in ambulance fees and 86,817.78 in patient fees, and 15,215.76 in other income through fees. As in the original set up of Nandom, built by the government in an area of long-term Catholic medical mission and staffed by the Catholic church in 1965, the effective application of even small grants could have a wide-ranging effect.[490] The small eye clinic out of Nandom Hospital may have been at the lower end of Misereor funding but it was part of a network of income streams which had to be combined to make the institution function. Moreover, because the government-mission relationship had been established over the long-term, each of Misereor's grant could encourage more spending from the state in certain areas by pooling resources. At St Anthony's Hospital at Dzodze too Misereor consistently contributed 11.36% of funding, which amounted to around 40,000 DM a

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[486] 'Essential Improvements Fund for the Preparation of Church Health Care Institutions in Ghana for Basic Health Care Work' *Projekt-NR 130-0/31 Z 2894* (1979) *Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[487] 'Report of the Auditor to the Department of Health, National Catholic Secretariat on the State of Affairs of the Essential Improvement Fund' (14 Jul 1986) *Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[488] 'Misereor Hospitals' Improvement Fund - Last Payments' *Projekt NR- 130 - 0 - 3 NT 2894* (30 Dec 1981) *Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[489] 'Mobile Eye Clinic Nandom Hospital, annual report 1981' *Projekt NR-130-7/2* (23 Feb 1981) *Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[490] 'Nandom Hospital: Statement of Accounts: Yearly Report For Year Ending 31st Dec. 81' *Projekt NR- 190-7-2D* (1980) *Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

year between 1979 and 1981, combining with local contributions and project revenue of 30,000 DM to ensure that the Hospitals continued functioning.[491] The sheer range of Misereor involvement, with the West German government, MEMISA and the Dutch government, is shown in Table V. In a wide variety of Catholic medical missions across Ghana they were cooperating with local authorities and smaller scale non-governmental agencies to produce a range of projects and healthcare institutions.[492]

Misereor also worked alongside a variety of international health organisations and could use these to ensure their independence from the Ghanaian national government. In 1961, in a project to construct a hospital at Papase, the Germans worked with both Dutch and Northern Irish Catholics. MEMISA contributed 70,000 Florins, Father Smith in Northern Ireland collected 50,000 Florins and Misereor only needed to add 55,000. In combination they were able to put forward 185,000 DM to the Bishop of Keta to begin construction. However, as will be explained later on, given the lack of government funding to help repay the loan, the Bishop of Keta had to decline the money.[493] By contrast, at Berekum, Misereor spent even more in grants-in-aid. Though it must be said, given the general pattern of combining resources the Holy Family Hospital at Berekum may have been something of an anomaly. By dividing up funding between different projects at different levels and in different ways, alongside other Catholic international health organisations, Misereor could manage the level of involvement of local governance. Again, as can be seen in Table V, Misereor and MEMISA fit into a patchwork of funding for Catholic medical mission for which they were one of the most common donors.

Misereor did not have a freehand in every area but they were incredibly powerful and resourced Catholic mission across the length and breadth of Ghana. They used a variety of different projects, cooperating and collaborating with other international health organisations, local churches, national governments, medical missions and communities. In some cases their attempts at certain plans, health innovations or theologies were obstructed by opposing institutional interests, hostile nationalists, difficult circumstances and long-term infrastructural patterns such as with hospital care. Nevertheless, by using intermediaries and building networks of trust, they hugely financed Catholic medical mission and ensured that even in the 1980s, when healthcare in Ghana all but collapsed, mission hospitals were the only ones left with resources, staff and funding. The scale of their aid work in Ghana shows the significance of West German Catholic aid. They fit within older networks and also with other new actors, whilst ensuring that Catholic missions negotiated from a position of financial strength.

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[491] '3-years continuation of preventative-medical programme St Anthony's Hospital Dzodze, Volta Region' *Projekt NR-130-3/5 C Z 3149* (30 August 1979) *Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[492] P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra), Private Archives of the National Catholic Secretariat (Accra, Ghana).

[493] 'Bau eines Krankenhauses in Papase' *Projekt NR-130-003-0001I* DAC 111, *Bewill Jahr 1961, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

All these new initiatives were shaped by political instability and economic decline in Ghana. Rural decolonising Ghana was in some ways a traditional mission field and in other ways a completely new landscape of a rapidly decolonising nation which by 1972 entered a period of successive political coups, economic failure and racial tension. Whilst West German development narratives mattered in Germany, in Ghana development work itself was reformulated by specific contexts, circumstances and groups. In the 1970s Ghana underwent the disastrous military dictatorship of Emmanuel Acheampong (1972-1978), who in his own terms wanted to make 'war' on the economy. This was followed by further labour repression, protests and violence by the state under the first regime of Flight-Lieutenant Jerry Rawlings. Between 1957 and 1971 economic growth had been slow and fluctuating, but after 1971 it went into massive decline, culminating in total collapse by 1983. Between 1975 and 1978 cocoa income plummeted and between 1975 and 1983 real output per head fell by 40% to a quarter below the level it was at independence. By 1983 the currency was valued at 5% of the official exchange rate and GDP had been declining by 5 per cent each year (it would increase 5 per cent annually in the forty years after structural adjustment in 1983).[494] Thus, around Berekum, and in the Ashanti region which had been historically strong in capitalist development and the creation of a cash-economy based on cocoa, the 1970s and 1980s were extraordinarily impoverished times. Resources were extremely limited and the black market was rampant which producers attempting to sell outside the price controls and heavy taxation of the state.

The West German development narrative of suffering, restoration and international commonality was performed and constructed within Ghana but it was not generally experienced or perceived as such by missionaries themselves. The German development narrative had to be constructed within this context, but it could not simply be deployed exactly as its European interests would have liked. Given the negotiations with Nkrumah and struggles with economic decline, there were far more pressing concerns than the reverberations on German society of missions medical work in rural Ghana. Mission had greater issues with adapting to new circumstances, negotiating with locals, growing the local mission and ultimately evangelising. Misereor's grander visions were detached from missionary realities. The missions, as several of the Medical Mission Sisters suggested by the way they described difference with Ghanaians in interview, was defined by how it survived within this situation, by how they stayed against the mass exodus of Ghanaian doctors, not by dreams of German unity.[495] In an impoverished landscape, the physical realities of poverty and emigration gave physical shape to what the postcolonial medical mission meant. Missionaries themselves often lived by older 'master narratives' of missionary self-sacrifice and dedication. These were created by MMS

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[494] G. Austin, 'Ghana, the Perennial Test-Case in Africa's Dramatic Development History, 1957-2011' (Unpublished paper delivered at the European Social Science History Conference in Belfast, 5 April 2018).

[495] Interview with Author, A. L. von Hoene, Medical Mission Sisters, Fox Chase, Philadelphia USA (9 November, 2016); Interview with Author Sister M. A. Tregoning, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 November 2016); Interview with Author, Sister S. Maschek, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10th Nov 2016).

missionaries who were not German themselves but often American and African (a general shift in mission make-up from European to American and African which Adrian Hastings has mapped).[496]

Catholic medical missionaries were focused on the theological intent of their medical aid. Unlike in broader international histories, it is often assumed within historical literatures on international health that in the 1960s at the latest, organisations had secularised and that medical missions had left behind evangelistic priorities in favour of biomedical ones. However, Misereor in the early 1980s were still theological in their motives, at least in that they were directly collaborating with those who were, such as the National Catholic Secretariat. This evangelism was more subtle and more about the defence of the faith and the expression of the values of faith in bodily care rather than direct proselytism. For example, at the outset of the National Catholic Health Council meeting in 1980, Bishop J. Owusu's address asked that the groups would in their discussions continue 'the Church's tradition of dedicated service based on Gospel values'. He continued, preaching that 'in the world today, confronting us lie many challenges to our values and beliefs along with numerous risks…The temptations are many'.[497] In another meeting with two more Misereor delegates, Owusu also encouraged freedom from reliance on foreigners and also as Christians to give back to health care as they had received from God through Misereor. He explained that rural health care, the sort Misereor had financed with capital grants, was that which Ghanaian Christians should take on themselves:

> Let the love of Christ be deepened in us through prayer and expressed by the giving of ourselves, our time, our talent in the spirit of self emptying for the sake of our people in the rural areas…in bearing our trials with fortitude…following Christ in the Gospels each in his own work as a committed Christian.[498]

In the following talk from Professor A. Foli and then from the Sister Ancilla, Misereor was praised as offering help to the Catholic Secretariat medical missions, without which they would be in a 'bad way'.[499] The aim of Owusu's talks was not to attack foreign aid, though independence was a high priority, but to walk in the footsteps of Misereor Christian mission. Misereor's medicine was to them an expression of faith which they too wanted to produce. How the Misereor delegates felt about these convictions and interpretation of their work is not clear but the continued funding and close relationship with the Secretariat suggests that their Catholic theological priorities were in some accord.

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[496] A. Hastings, *A History of African Christianity 1950-1975* (Cambridge University Press, 1979) pp.225-228.

[497] J. Owusu, 'Opening Address' Report of National Catholic Health Council Meeting (4-7 November 1980) *Ghana - Bewilligungen 1959-1980*, Misereor-Archive (Aachen, Germany).

[498] J. Owusu, 'Opening Address' Report of National Catholic Health Council Meeting (4-7 November 1980) *Ghana - Bewilligungen 1959-1980*, Misereor-Archive (Aachen, Germany).

[499] J. Owusu, 'Opening Address' Report of National Catholic Health Council Meeting (4-7 November 1980) *Ghana - Bewilligungen 1959-1980*, Misereor-Archive (Aachen, Germany).

Misereor's German developmentalist concerns were not considered very much in Catholic medical mission in Ghana itself. As shown in the chapter 2 and 3, whether evangelism or a particular development narrative was expressed on the ground and how it happened, depended on the mission station itself, the particular missionaries and the timing of an encounter. However, to some extent, there were Catholic specific trends and theologies as can be seen in the MMS at Berekum. At Berekum in 1961 the MMS produced a film documenting their hospital and nurses training, in it they concluded that their work achieved the unification of the care of the body and the care of the soul:

> We are all of one kind, alike in body everywhere in God's creation, each of us alike in his immortal soul. The soul the end. The care of the body the means. End and means made one through the medical mission apostolate.[500]

The film also emphasised the commitment to science against the 'juju' of the 'fetish priest'.[501] Their version of proselytism was expressed through the boundaries they put on their scientific work - what was acceptable and what was not. Moreover, wearing of the habit - a striking white feature amidst a local Ghanaian market - performed the purity and holiness of the medical mission. This was not explicit Gospel preaching as Seventh Day Adventists and Scottish Presbyterians did in other areas of Ghana, it was performing a set-apart, modern community of belonging through disciplines like the sacrifice of caring for the sick, scientific practice and white habit. After interview and in response to this film, one of the MMS, Sister Suzanne Maschek reflected on the meaning of their vision for medical care and evangelism:

> the terminology of *medicine being a bargain for conversion* just does not cut the motivation of why we go to another country and culture and share our lives and talents with others who become special to us. It is ultimately about love **and justice** and realizing that we are all brothers and sisters…We are alike in our humanity and made in God's image, worthy of respect and dignity. Loving one's neighbor follows Jesus' command. Justice in sharing the gifts of education and professional expertise and training the local people to carry on are important elements. It led to establishing relationships with the local healers, educating them in what was harmful and demonstrating good practice without arrogance or putting them in a bad light with their clients. Unlike the daily prayer of the Presbyterians at Agogo Hospital where clinic stopped at 10:00, MMS did not display religious practice in that way. It was more by personal example and caring. Especially after Vatican II, salvation was not tied to baptism or conversion.[502]

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[500] *Film of the Medical Mission Sisters at Holy Family Hospital, Berekum* (1961) MMS Archive, Fox Chase, (Philadelphia, USA).

[501] Note the similarities between this language and that of J. E. Appiah discussed in chapter 3 (p.115).

[502] Correspondence to Author, Sister A. L. von Hoene, (16 November 2016) Medical Mission Sisters, Fox Chase, (Philadelphia, USA).

Comparing to the Basel Mission at Agogo, Anne Louise von Hoene describes how religious belief was not displayed in spiritual performance but through exemplars of virtue and the building of relationships based on care. Whilst her memories do not provide a pure window into exactly how Mission Sisters viewed or practiced their work at the time, it does have traces of the kind of divisions in practice that they lived by.

Though Misereor managed to retain a great degree of control over local actors and their funding, Ghanaians also had agency to manipulate Misereor to support their own agendas - they may even have helped to change the whole course of Misereor away from an early preoccupation with hunger. In 1959, Joseph O. Bowers, the Bishop Accra managed to gain 66,000 DM of funding for a 'Hospital for Crippled Children' from Misereor. He did this through a variety of persuasion tactics. First, he made an emotional appeal that had almost no relevance to his actual bid but that emphasised the scale of health need and the lack of interest of the government to the care of children. He attached a newspaper clipping in which there was a story of 71 babies dying a period of only four months in Agona Abodom with no apparent cause and no medical officer going to examine the epidemic. Perhaps another reason that Bowers used the article was that it wrote that health officers that tried to get Mothers to send their children for medical treatment by having the Abdomhene beat gongs found that some 'expressed reluctance because of religious faith'.[503] He may have been trying to show the dangers of not allowing the historical mission church to continue its authority over health, as those mothers:

> would continue to prefer spiritual healing at open air church services where the sick are subjected to all forms of blessing with ultimately end with presentation of a holy crucifix.[504]

Given the challenge the ecstatic Pentecostal congregations could pose to traditional medical mission, Bowers may have been looking to foster the image of a shared enemy of the true Church. Second, Bowers added to this newspaper clipping, a vicious attack in his own words on the government in a letter to Misereor, aligning himself with the Catholic Church rather than the evils of the secular state:

> We are in the process of establishing the ONLY HOSPITAL FOR CRIPPLED CHILDREN in Ghana. The Brothers of St. John of the God are despite their many obligations bearing the major part of the financial burden for this urgent work of mercy. Unfortunately, the government seems to pursue the pagan policy of leaving such works for the deaf, dumb, lame etc. almost entirely to Voluntary Agencies, and despite assurances

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[503] J. Owusu, 'Appeal to the Most Reverend Members of the Hierarchy of Germany for Assistance for Clinics of the Accra Diocese' (6 May 1959) in *Projekt NR-130-001-0002 Einrichtung Fuer Das Hospital in Koforidua* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[504] S. N. Addo, 'The Village of Death - Agona Abodom' *Daily Graphic* (27 April 1959) p.6, in *Projekt NR-130-001-0002 Einrichtung Fuer Das Hospital in Koforidua* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

> given in Parliament cannot be moved to give timely assistance to this project for which also we have been making appeals to various sources without adequate success.[505]

Finally, adding to his critique of the 'pagan' and deceitful government, Bowers emphasised his ties of concern to the foreign Catholic missions already attempting to do this work. Not only was he arguing that it was incumbent on Christians to do such an 'urgent work of mercy' he argues that other Catholics have already heeded the call but are not being supported. Later in the letter, Bowers further tried to speak a language of universal brotherhood in Christ, attempting to build trust and a kinship of passion in order that his specific aims might be met:

> I wish to conclude by thanking our numerous benefactors in Germany who under the direction of their Shepherds in Christ are contributing so efficaciously to the spread of the faith in Africa and the Diocese of Accra, and by assuring them of my prayers for a double portion of the rewards that Christ has promised to those who assist even the humblest of His little ones.[506]

Drawing on both Biblical invocation to help children and also on a tradition of mission work in which Africans (particularly African children) were viewed as lower, needy group of humanity requiring Christian charity, Bowers hammered home his message.[507] The Misereor response from G. Dossing in May 1959 encouraged Bowers to go through the official process of 5 separate petitions and also to consider agricultural projects which, given the starvation and hunger about which Misereor were particularly interested.[508] Nevertheless, by November, Bowers had been given his 66,000 DM for a 'Hospital for Crippled Children' in Koforidua.[509] Whilst Misereor may have already been considering widening their approach by this point, it is clear that local agents like Bowers were also shaping the change in policy and gaining from it.

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[505] J. Owusu, 'Appeal to the Most Reverend Members of the Hierarchy of Germany for Assistance for Clinics of the Accra Diocese' (6 May 1959) in *Projekt NR-130-001-0002 Einrichtung Fuer Das Hospital in Koforidua* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[506] J. Owusu, 'Appeal to the Most Reverend Members of the Hierarchy of Germany for Assistance for Clinics of the Accra Diocese' (6 May 1959) in *Projekt NR-130-001-0002 Einrichtung Fuer Das Hospital in Koforidua* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[507] J. Owusu, 'Appeal to the Most Reverend Members of the Hierarchy of Germany for Assistance for Clinics of the Accra Diocese' (6 May 1959) in *Projekt NR-130-001-0002 Einrichtung Fuer Das Hospital in Koforidua* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[508] G. Dossing, 'Your Excellency' (12 May 1959) in *Projekt NR-130-001-0002 Einrichtung Fuer Das Hospital in Koforidua* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[509] 'Zucuhuss Misereor 66,000DM' (4 Nov 1959) in *Projekt NR-130-001-0002 Einrichtung Fuer Das Hospital in Koforidua* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

The development narratives that were prevalent in West Germany and that fuelled Misereor were detached from the realities and concerns of medical mission in Ghana itself. Misereor policy could also be shifted by local agents by not repaying loans. In 1975 A. Konings, the Bishop of Keta, informed Misereor that they would not be able to repay the loan for the completion of the Kpandu Hospital and Construction of Nurses Training Centre (this had been financed with government money too). The 140,000 DM loan would not even be met in part. This was due partly to the collapse of the Ghanaian economy in the mid-70s, following several coups and the slump of cocoa prices worldwide in the 1960s, amongst other problems. Konings wrote four points explaining, firstly, that:

> on account of the devaluation of Ghana Cedi by approximately 30% I could no more be held accountable for refund of 140,000 DM but only for the 25,200 Ghana Cedis at whatever the rate of foreign exchange that might be
>
> 2. Since that time two more devaluations of the Ghana Cedi took place with the result that now the foreign exchange value of 25,200 Ghana Cedis is just over 50,000 DM
>
> 3. I kept the loan of 25,200 Cedis up to last year, 1974, but due to the sharp increase in prices of medicines, drugs and hospital salaries I was forced to put all financial resources at my disposal, including the loan of 25,2000 Cedis into the hospital to keep it running, the alternative being having to close down the hospital completely.
>
> 4. I was hoping that the situation would improve, but instead of this is is still deteriorating, because we cannot increase the hospital fees from the patients, as the people are relatively poor and the Government in its hospitals also charges no fees at all, or very small ones, it any.[510]

Furthermore, 'world inflation' had destroyed any possibility of repayment Konings wrote.[511] Given the relative strength of the Deutschmarks to many other currencies, it is strange that this eventuality was not planned for in the initial loan or the funding kept in Deutschmarks until it was needed. Perhaps it was not expected that the Cedi would collapse so considerably. In 1961, Ann Van den Ende had written to Father Odam at the medical administration in the Bishops' House: what would happen if private hospitals were taken over, would loans be repaid by government instead?[512] Nevertheless, questions of what would happen

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[510] A. Konings (7 Jul 1975) in *Projekt NR-130-001-001 Kpandu* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[511] A. Konings (7 Jul 1975) in *Projekt NR-130-001-001 Kpandu* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[512] A. Van den Ende S.V.D. (16 May 1961) *Projekt NR-130-004-001 Ausbau Des St. Marten's Hospitals Agroyesum 1961* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

if the economy collapsed seemed to take a back seat to concerns about political turmoil. Perhaps without having another obvious option or out of mercy or long-term trust, the Prälat G. Dossing wrote back to Bishop Konings saying that the full 140,000 DM 'has been converted from a loan to a grant on a decision by the Episcopal Commission of Misereor'.[513] Whilst Misereor had considerable control as they held the purse strings, once money had been distributed it was hard to get back and power could be diffuse throughout the medical mission network, with Ghanaians having many strategies they could employ from below.

Government could also hinder what Ghanaian Catholics and Misereor wanted to do, extra international health aid and shrewd negotiation were needed. The same Bishop of Keta, A. Konings, wrote to Misereor in 1961 that he would have to retract a request for aid even though the desired amount of 185,000 DM had already been offered by Misereor, MEMISA and a Northern Irish cleric. This was for the Hospital at Papase, mentioned above. Konings wrote that, since the offer had been made:

> the situation has changed completely. The Government no longer allows me to build a hospital at Papase, but only a so-called Health Centre, which comprises an outpatients department, maternity and a maximum of 15 beds for inpatients. It would be impossible for to refund a heavy loan from the small income which such a Health Centre produces because the running expensive are proportionately identical to those of a hospital. I do not at the moment know what to do in the matter, but you will appreciate that I cannot at this juncture undertake commitments and responsibilities which I would late on not be able to honour.[514]

In this statement there suggests why Misereor may have forgiven the other debt at Kpandu in 1975. It was not mismanagement on the Bishops' part, he was careful not to ask for many loans he could not repay. Instead the issue at Kpandu was genuine unforeseen change and Misereor had a long-term relationship of trust with the Bishop so they were not going to coerce a repayment. As H. Marwah has shown with the electrification development project in Ghana, it was not managerial failure but economic crisis following the 1971 devaluation which caused rising costs and the burden of foreign debt. By 1975 the government of Ghana was maintaining the existing exchange rate but the Cedi was collapsing on parallel markets, by 1982 the Cedi was valued at one 20th of what it was worth officially. This was followed by debt restructuring, structural adjustment and other crises such as the West African drought between 1982 and 1984. However, between 1961 and 1966, the Cedi was worth almost as much as the dollar, and was relatively healthy.[515] It

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513 G. Dossing to A. Konings, in *Projekt NR-130-001-0002 Einrichtung Fuer Das Hospital in Koforidua* DAC 111, *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

514 J. Owusu to G. Dossing, 'I acknowledge with a deep sense of gratitude' *Ablage 130-3 1/2* (7 Nov 1961) in Projekt NR-130-3/2 'Bau lines Krankenhauses in Papase', *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

515 G. Austin, 'Ghana, the Perennial Test-Case in Africa's Dramatic Development History, 1957-2011' (Unpublished paper delivered at the European Social Science History Conference in Belfast, 5 April 2018).; H. Marwah, 'Institutional Failure or an Unsustainable Foreign Debt Burden? Financing and Management of Ghana State-owned Electricity Distribution 1960-2002' (Unpublished Paper presented at the ESSHC conference in Belfast, 5 April 2018).

was clear that Misereor were happy to take risks in this period on both local Catholic leaders and on the continued funding of mission hospitals by the Ghanaian government. Given the Ghanaian government track record of funding mission hospitals hugely and given that they often tried to force money into the hands of the Sisters at Berekum, without the benefit of hindsight this probably was not considered a particularly dangerous gamble.

Even though Misereor could not directly impose its narrative of development, missions relied on it to ensure the survival of their own work. As with Bishop Keta in the mid-1970s, Ghana's economic collapse meant that mission hospitals would have had to stop growing or even running at all, without large-scale funding from abroad. By this point, the Ghanaian government could not financially ensure that any shared policies would be possible. Misereor had to finance mission hospitals with conversions of loans into grants and resolve urgent issues in institutions that they already supported. On the other side, Misereor needed trusted intermediaries like the Bishop at Keta to help them navigate the changing economic situation. Otherwise they were offering money that they would never see returned. Crucially, this dialogue also shows how much missions still depended on government well past formal political independence from the British Empire. Offers of funding were not simply supportive to mission projects, without the backing of Nkrumah in 1961, the Hospital at Papase could not be built at all. As mentioned in the previous chapter, 1961 was a turning point for Nkrumah when he became incredibly suspicious of foreign actors and the Church. In most cases funding continued. However, In 1961 something occurred that meant the Bishop of Keta fell out of favour or Misereor could not navigate Nkrumah's increasing authoritarianism and socialism. Nevertheless, by 1963, Konings was able to construct a health centre at Papase with other sources of money that did not need to be refunded.[516] However, Misereor did not stop - the St. Mary Theresa Hospital at Dodi-Papase was also built in this year.[517] According to the 1982 Catholic report, its income was made up of government grants (41%), patient fees (46%) and private subsidies (15%). Donations were also being received from Misereor, MEMISA, KOOK (Holland), Wor and Wand (USA), and Areon.[518] Perhaps by adding in further actors, or by converting the loan to a grant or by negotiating with the Ghanaian government, they were able to negotiate past the roadblock and construct through different means.

Misereor was not totally empowering, missions still needed government funding and patient fees making them subject to local and national changes. The majority of Catholic missions in Ghana largely were funded by patient fees and they were vulnerable to local and national disputes, such as with Trade Unions. This again shaped the kind of development narrative being created. In general, Table V shows the extent of the

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[516] J. Owusu to G. Dossing, 'Health Centre at Papase' (7 Feb 1963) in Projekt NR-130-3/2 'Bau lines Krankenhauses in Papase', *Bewill Jahr 1959, Ghana - Bewilligungen 1959-1980 DAC 1*, Misereor-Archive (Aachen, Germany).

[517] Rotary, 'Mary Theresa Hospital in Dodi Papase (Ghana)' (accessed 10.34am 13/10/2017) http://www.rotaryleuven.be/diensten/DodiPapaseProject.html

[518] P. A. Twumasi, 'Mary Theresa Hospital, Dodi-Papase' *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) pp.119-123, Private Archives of the National Catholic Secretariat (Accra, Ghana)

dependence on patient fees across the Catholic medical missions in Ghana in 1982. In the Holy Family Hospital, Barbra Mann Wall has shown how in the 1979 nationwide strike of the Ghana Registered Nurses Association over salaries 'nurses and midwives did not come to work for five days at a time'. Thus, the missionaries had to use 'Traditional Birth Attendants', these Ghanaians were probably unqualified in biomedical practice but 'left their families and farms to staff sixteen shifts at Holy Family Hospital'. When the strike continued the MMS had to use to local chief to negotiate with the employees to return to work.[519] In interview, Sister Anne Louise von Hoene remembered how it was her that called the chief when the employees went on strike in the 1970s. She also recalled how Terry Waite, the Anglican humanitarian and negotiator, helped them to broker a deal. He had not approved of their tactic in bringing in the chief because they had called in their top person (perhaps because this could have been construed as coercive). In the end, there was a one day strike and Anne-Louise agree to pay them for the day.[520] Whilst there is little evidence of missions actively stopping the nationalisation of healthcare (often they were politically quiescent, except in Trade Union disputes already raised), missions relied on patient fees for their continuation and would not have promoted any government attempts at more radical redistribution.[521] Overall, all these challenges and constraints shaped the terms by which Catholics in Ghanaian health work narrated their position in the larger tradition of historic mission, its adaptation and its survival, not by those laid out by Lübke in Cologne.

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[519] B. Mann Wall, *Into Africa: A Transnational History of Catholic Medical Missions and Social Change* (New Brunswick, NJ: Rutgers University Press). p.56.

[520] Interview with Author, A. L. von Hoene, Medical Mission Sisters, Fox Chase, Philadelphia, USA (9 November, 2016)

[521] However, reliance or otherwise on patient fees was only very loosely linked to a mission's location and was connected to a wider set of factors. The significance of patient fees makes it worth considering whether or not some missions had to be positioned in areas where patients had access to cash in order to pay for the service. Table V shows that the Catholic missions in the Upper East, Upper West and North, were generally more dependent on government grants and in many cases smaller percentages of their funding came from patient fees. At Jirapa, Nandom and Navrongo-Bolgatanga (all in the North, as Map II shows) the patient fees for hospital contributions are paltry compared with those at St Joseph's Clinic in Ashanti and the Holy Family Hospital at Berekum. Northern mobile clinics such as at Jirapa do have a far higher patient fee contribution and the clinic at Yendi, 100% of contributions came from patient fees. Perhaps in the North where the cash economy was less developed as the area had been colonial labour reservoir patient fees were less reliable whereas in the South, in Asante and Brong-Ahafo some missions fared better at relying on clients. Though again, during the 1980s, ready cash was scarce across most of the nation. Overall, however, there is no strong correlation shown in the available data between patient fees percentage of overall income and regional location. There was also very little correlation between the size of the population in a 10km radius from the institution and patient fees percentage. Whilst these may have been factors they certainly cannot be regarded as determining ones. Instead, there were a range of factors such as urban connections, mobility, sizes, foreign funding and government links at play, location seems to have made only some difference to the make-up of contributions.

iii. CONCLUSION:
WEST GERMAN AND DUTCH CATHOLIC MEDICAL MISSION IN ASIA, AFRICA AND SOUTH AMERICA

By 1982 Catholic Medical Mission, funded by government, Dutch and West German Catholic mission organisations, local fees and churches, and a variety of other international health organisations, had proliferated and settled across Ghana. There were at least 54 Catholic mission health institutions, including hospitals, clinics, maternity centres and PHC centres, in 1982 and these were spread all over the country as shown in Map II. Combined they catered for hundreds of thousands, if not millions of patients. The list of donors is extensive and a surprising variety were present. The pattern and frequency of Dutch and West German aid is clear, they are involved in the vast majority of Catholic mission institutions, this has been highlighted in bold in Table V. Out of the 44 Catholic Mission institutions with reliable and detailed information on funding, at least 24 had Dutch and German aid involvement, and two others was indirectly supported through Jirapa Hospital and the Holy Family Hospital at Berekum (funded by Dutch and West German aid). This bald statistic is just the minimum amount, it seems likely that many more also were gaining funding from them. Holland and Germany were the most consistent and widespread donors, in the form of embassy aid, government donations, international organisation and mission funding.[522]

Given the scale and significance of West German and Dutch Catholic medical mission in Ghana, the question is: was this an exception or was it happening elsewhere too? Walter Bruchhausen and Carola Rensch have explored German postwar aid to Togo in which public health and academic research were combined from the 1960s.[523] Elsewhere, Bruchhausen has also shown that from 1961 West Germany was using Marshall Plan funding for development aid, and church projects were around 50 per cent financed by this. Medicus Mundi Internationalis was created to organise European Catholic efforts in West Germany and Austria, Belgium, Ireland and the Netherlands (though Bruchhausen notes, in this regard that Calvinists with the Netherlands government did restrict the activities of the large Catholic minority). Financed by lent donations, International Cooperation for Socio-Economic Development (CIDSE) followed this and was begun by one of the founders of Misereor bringing together eight bishops of Catholic development organisations to build on the secular-church collaboration work allowed after Vatican II.[524]

Furthermore, Mattias Egg has shown how between 1952 and 1994, the Medical Missionary Society (Gemeinschaft der Missionshelferinnen), the Medical Missionary Union (Missionsärztlicher Bund) and the

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[522] In some cases in which only the country of origin of aid is listed, unfortunately is unclear if the funding is from the national government or an aid organisation. The table covers the majority of Catholic medical institutions in Ghana in 1982, these can be located on Map II. Institutions without available statistics were not included.

[523] C. Rensch and W. Bruchhausen, 'Medical Science Meets 'Development Aid' Transfer and Adaptation of West German Microbiology to Togo, 1960–1980' Med Hist 61. 1. (Jan 2017) pp.1–24.

[524] W. Bruchhausen, 'From Charity to Development: Christian International Health Organizations, 1945-1978' *Hygiea Internationalis: An Interdisciplinary Journal for the History of Public Health* 13.1 (December 2016) pp.117-134.

Würzburg Medical Missionary Institute (Missionsärztliches Institut Würzburg) funded and staffed Catholic medical mission across Asia and Africa. Egg shows that a total of 109 sisters of the GMH were employed as health workers in twenty-six projects of varying size and duration in eight countries in Africa and Asia'. These were in Pakistan at Sargodha and around India: in Shrirampur (West Bengal), Jhansi (Uttar Pradesh), Shevgaon (Maharashtra), Chetput (Chennai), Thellakom (Kerala), Allahabad (Uttar Pradesh) and Bangalore (Karnataka). It was also across Africa in the Congo, Namibia, South Africa, Zimbabwe and Cameroon (as well as Ghana for which Egg analyses the work at Tumu, Navrongo and Eikwe). Egg argues that these organisations were vital to other West German missions' success:

> Due to their permanent mission the sisters of the GMH were able to act as mediators between the health policies and strategies of German institutions like MI and Misereor and the State and Church authorities in the missionary countries.[525]

Thus, a network of West German and Dutch aid was significant across large areas of Asia and Africa. Contrasting sizes, timing, duration and forms were linked up by common denomination, interest and nationality, creating very effective health infrastructures that in many cases could weather the storms of decolonisation. For example, in the case of GMH, they acted as 'mediators' for Misereor and MI because their 'permanent mission' ensured stronger local bonds.

There is a paucity of research on Catholic medical mission but in general it appears that in Africa, Asia and South America there was significant funding from all directions out of West Germany and Holland. Between 16th October 1959 and 31st December 1959 alone, there were request for almost 20 million DM from all over the world. The largest was from South America which in total requested 3.671.155 DM. Africa was at 3,152,412 DM, Asia 668,070 DM, Oceania 753,500 DM, and Europe 335,000 DM.[526] It is not clear stated which of these requests were met but it shows that Misereor was seen to be a donor across the world, and that world extended well beyond Ghana alone. As Gonzalo Navarro Sanz has shown the West German government began development work in Latin America in 1952 giving funds to the UN programme for technical assistance and forming the Economic and Development Cooperation Ministry (BMZ) in 1961. Whilst there were German immigrants to Chile, it was a Spanish colony, again this was a completely new form of colonialism. Crucially, Sanz also shows that West German Catholic foundations Misereor, Adventiat and the Konrad Adenauer Foundation (KAF) began even before the BMZ was established. In 1961 in the Christmas eve collection for Misereor was purposefully for aid to Latin America and collected 23 million

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[525] M. Egg, *Krankenfürsorge im Spannungsfeld von Medizin, Glauben und Gesundheitspolitik Die Gemeinschaft der Missionshelferinnen,1952–1994* (Inaugural-Dissertation zur Erlangung des Doktorgrades der Hohen Medizinischen Fakultät der Rheinischen Friedrich-Wilhelms-Universität Bonn, 2015) esp.p.188.

[526] Mistakenly placed on the back of a document in *Ghana - Bewilligungen 1959-1980*, Misereor-Archive (Aachen, Germany); Übersicht uber die vom (16 Oct-31 Dec, 1959) Misereor-Archive (Aachen, Germany).

DM, this then became an annual initiative for aid to Latin America.[527] By 1994, Misereor was active in 101 developing countries including in the Caribbean, Central Africa, Central Asia, South Asia, East Africa, East Asia, Mexico, Central America, Middle East, North Africa, Oceania, South America, South East Asia, Southern Africa and West Africa. Their budget total was $258,100,000 half of this from private sources and half from public.[528]

At the same time, amidst all this world funding, Ghana was a particular focus, partly because of its stability and acceptance of West German and Dutch Catholic medical mission. When the former Dutch colony of Indonesia became independent and authoritarian, Dutch missionaries hot-footed to Ghana instead. Some working for the Basel Mission, others for Catholic missions, and many were progressive idealists hoped to establish their own stations, many reading the Catholic medical theology of E. F. Schumacher and Liberation theology.[529] It was not only from Indonesia, with the general stream of Dutch mission others followed. As the 1969 Annual Report for St Michael's Hospital in Pramso claimed: 'Most of the mission hospitals are run by young, often Dutch doctors'.[530]

Dutch and West German missionaries arrived in swathes as a diverse cohort with differing views but all part of the same stream. One Dutch missionary, who read Schumacher and Liberation theology, was the anthropologist Sjaak Van Der Geest, whose wife worked for the Catholic Hospital in Kpandu and who arrived in Ghana in 1971. Van der Geest himself explained in interview that his own choice 'hardly rational' and it was:

> a coincidence that - as I later discovered - that there was a big Dutch representation both among missionaries and medical doctors and nurses in Ghana…I never found a good explanation for the many Dutch, we did not have colonial links (apart from business in slaves in the precolonial era. I suspect that the large number of Dutch doctors and nurses is linked to the large number of Dutch (catholic) missionaries. (but Dutch catholic missionaries were numerous all over the world in that period).[531]

Van der Geest also noted that some of the Catholic hospitals were in fact run by Dutch lay doctors who were 'agnostic and certain not practising Catholics'. The result was that in issues of Catholic opposition to fertility control and abortion they 'took a (perhaps concealed) more relaxed attitude'. Though 'some more

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[527] G. Navarro Sanz, 'Catholic International Cooperation: Social Research in the Society of Jesus' in F. Beigel (ed.) *The Politics of Academic Autonomy in Latin America* (Ashgate Publishing, 2013/Routledge, 2016) p.119-134.

[528] 'Allemagne' International Cooperation for Habitat and Urban Development: Directory of Non-Government Organisations in OECD Countries (Development Centre of the Organisation For Economic Cooperation and Development, 1996) pp.175-176.

[529] Correspondence to Author from Paul Jenkins (20 September 2015).

[530] St Michael's Hospital, Pramso (Ashanti) Ghana: Annual Report 1969 (1969) p.2, MMMP 17508, MEMISA archives, Katholiek Documentatie Centrum (Nijmegen, Netherlands).

[531] Correspondence to Author from Sjaak Van der Geest (22 September 2015).

enlightened nuns were mild and understanding and tried to help'; that abortion was 'the most common technique of birth prevention in 1972 among the youth' was a 'thorny issue'. He explained that in Kpandu:

> they would first get a long sermon from the doctor (a German Grail member, Dr Marquart). Getting a professional abortion was then extremely difficult, it was illegal, or rather criminal. One needed to have contacts in the medical world. Most young women tried some kind of self help abortion.[532]

There were diverse attitudes and faiths but they comprised one cohort. Marquart herself was also a significant member of the CMC and through this she worked closely with the Ghanaian Catholic Archbishop Peter Sarpong.[533] Dutch and German Catholic medical mission was a complex and even conflicting group, issues were contested and even viciously disagreed over, but what is clear is that there was a key focus on Ghana.

Ghana was so significant for Dutch and West German Catholic medical mission because of a combination of factors, in which old colonial ties were not important and the Cold War was only one in a range of concerns. This chapter has argued that postcolonial international health requires reframing in order incorporate postwar Dutch and German mission which does not fit into the current frames which emphasise Cold War causes, old colonial concerns in decolonised settings and the growth and articulation of the international community. The drive behind West German and Catholic medical mission may have incorporated some of these - West Germany's political shape was very influenced by the U. S. and the formation of opposing East-West blocs, and Catholic international health organisations were part of a growing international development community.

However, the prime causes were identifying with a development narrative that emphasised Catholic internationalism, liberal democratic credentials with strong civil society leadership and shared suffering under the Nazis. Focusing on the postcolonial nation of Ghana without a German or (for a long time) Dutch colonial past, and a nation with a strong Catholic heritage and network of missions, gave Dutch and West German mission a very effective focal point. Moreover, given the lack patterns of medical mission generally in Ghana and its reliance of mission, there was not the hostility that was encountered in other postcolonial nations such as Indonesia. This did not all mean that West German and Dutch Catholic medical mission operated with a free hand, they were constrained by Ghanaian national politics, local circumstances, economic fluctuations and the long-term priority of mission hospitals in Ghana. It also did not mean that missionaries imagined their development work in the same terms. Nevertheless, because of the scale of funding available, their relations with trusted intermediaries on the ground, available staff from Europe and America, and the combination of a variety of institutional forms in a network of Catholic international health

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[532] Correspondence to Author from Sjaak Van der Geest (22 September 2015).

[533] J. C. McGilvray, 'Appendix II' *Health is Wholeness* (German Institute for Medical Mission, Tübingen, Gesamtherstellung: Breklumer Druckerei Manfred Siegel, 1981) p.146.

organisations, they were able to grow considerably. Table V shows the sheer range of Catholic medical missions to which MEMISA and Misereor had contributed in Ghana by 1982. It was here that the performance of a suffering and rehabilitating West Germany and Netherlands found its home. The result was a well-resourced network of Catholic health institutions in Ghana that became a vital network for international health organisations and national programmes.

Table V - Catholic Health Services in Ghana, January-April 1982

Statistics and information are sourced from P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra), Private Archives of the National Catholic Secretariat (Accra, Ghana). Notes: This set is not a comprehensive list of all the Catholic medical missions in Ghana in 1982, but only those with available data.

Misereor itself financed the study and checked over the questionnaires. (p.4)

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
1. Sefwi-Asafo Hospital	60	10	15	10	5	21,000	59,301 (O)	- **Misereor** - Spanish Government - 'Campaign Against Hunger'
2. Eikwe Catholic Hospital	45	15	8	30	2	9900	93,165	- **Main Support: Overseas (West Germany)** - District Chief Executive - Private people - Chief and Elders of Eikwe
3. Assin-Foso Catholic Hospital	40	20	15	-	20	43,500	47,785	- Diocesan Executive Secretary - MIVA (ambulance) - **Misereor (drugs)** - **Dutch Hospital in Holland (drugs and equipment)** - IDA (drugs) - Sisters' congregation

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
4. Apam Catholic Hospital	30	50	-	20	-	25,000	22,925	- Apam Development Committee - Diocesan Executive Secretary
5. Breman Asikuma Catholic Hospital	47	20	16	16	1	35,000	89,005	- Diocesan Executive Secretary - **MEMISA (medical officers)** - **Misereor (building staff quarters)** - S.R.N. Sisters (recruited from Spain by the Sisters of Charity) - SIMAVI (water pump) - Sisters of Charity (Two Generators and others)
6. Notre Dame Clinic, Nsawam	95	-	5	-	-	202,000	25,785 (O)	- Catholic Relief Services, Accra - Diocesan Executive Secretary
7. St Michael's Maternity Clinic, Ntronang	90	10				22,000	4061 (O)	- **MEMISA (drugs, transport, generator)** - Diocesan Executive Secretary - **Misereor (paid for staff quarters)** - Parish Priest
8. Holy Family Hospital, Nkawkaw	54	32	-	14	-	76,000	101,000 (O)	- Chief of Nkawkaw

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
9. St Joseph's Hospital, Koforidua	40	30	20	5	5	150,000	86,456 (O)	- Diocesan Executive Secretary - Community individuals - 20% from Spain
10. St Martin's Clinic, Agomanya	68	19	6	7		36,500	46,327 (O)	- Diocesan Executive Secretary - **Donor Agency in Germany (drugs)** - Local Community
11. St Dominic's Hospital, Awkatia	68	22	-	10	-	62,735	120,833 (O)	- Ghana Consolidated Diamond Corporation - **Mother House of Germany** - Government of Ghana
12. Child Welfare Clinic, Akim Swedru	65	33	-	-	2	57187	33192	- Diocesan Executive Secretary - Community Health Nurses attached to Akim Oda Government Hospital - Terre des Hommes, Switzerland (milk powder)
13. St Joseph Clinic and Maternity Home, Kwahu Tafo	50	10	30	10	-	48,000 (175,680 in the Kwahu area)	76,369	- District Chief Executive - Diocesan Executive Secretary

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
14. St John's Clinic, Akim Ofoase	73	10	-	-	17	55250	20735	- Diocesan Executive Secretary - **Misereor (staff house, generator, a water tank and an ambulance)** - **MEMISA (drugs)** - Inter-care (drugs) - S.V. D. Brother, Austria (drugs)
15. Kpando Catholic Hospital, Kpando	60	30	10	-	-	470000	-	- 'Action Kpando' - Diocesan Chief Executive - **Misereor**
16. Dzodze Catholic Hospital	75	20	-	5	-	70000	-	- **Germany (drugs)** - **Holland (drugs)** - Diocesan Executive Secretary
17. Battor Catholic Hospital, Battor	50	25	25	-	-	15000	26593	- Local Council - Distrcit Chief Executive - Community - Diocesan Executive Secretary - **Germany (financial and material help)**

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
18. Roman Catholic Clinic, Nkwanta	50	40	-	10	-	24000	72,405	- **Misereor** - **MEMISA** - Friends in Ireland - Catholic Relief Service, Accra (food) - Diocesan Executive Secretary
19. Anfoega, Catholic Hospital	66	32	2	-	-	49000	65,635	- Chief and his Elders - Diocesan Executive Secretary - **Misereor** - **MEMISA** - Medical Firm (USA) - VALCO Fund
20. Mary Theresa Hospital, Dodi-Papase	46	41	15	-	-	34000	16994	- **MEMISA** - **Misereor** - **KOOK (Holland)** - Wor and Wand (USA) - Areon
21. Abor Roman Catholic Clinic	65	28	-	6	1	20,000	37141	- CHAG - **Holland** - **West Germany**
22. St Anne's Maternity Clinic, Donyina	25	33.5	12.5	25	4	49000	4498 (O)	- Diocesan Executive Secretary - Villagers
23. St Joseph's Clinic, Abira, Ashanti	100	-	-	-	-	56000	12325 (O)	- Diocesan Executive Secretary - Villagers
24. St Patrick's Hospital, Maase-Offinso	40	60	-	-	-	39355	22956 (O)	- Local Council and District Chief Executive - Local Chief and Chairman of the Local Council

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
25. St Martin's Hospital, Agroyesum	25	25	50 (with private gifts	50 (with private subsidies)	-	12800	28377 (O)	- Diocesan Executive Secretary
26. St Michael's Hospital, Pramso	69	25	-	1	5	83000	40031	- Diocesan Health Committee
27. Abease Primary Health Care Centre, Sunyani	64	24	-	-	-	6140	17777	- UNICEF (Government grant in the form of drugs supplied through UNICEF and Kintampo) - Local Council - District Council in Atebubu - District Chief Executive - Diocesan Executive Secretary
28. St John of God Hospital, Duayaw Nkwanta	52	39	5	4	-	21000	-	- **Misereor** - **MEMISA** - **Several hospitals in the Netherlands** - Private person from Europe ('Senior nursing Officers, the part payment of staff salaries and the supplies of drugs and medical equipment and instrument are made possible through their generosity')

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
29. Holy Family Hospital, Techiman	60.7	24.6	15.7	1.0	8.2	81000	-	- Techiman Local Council (2,000,000 cedis for primary health care work) - Hospital Advisory Board - Diocesan Executive Secretary - Ministries of Health, Agriculture, Social Welfare and Community Development - Overseas Aid
30. St Mary's Clinic, New Drobo	55	43	-	2	-		65961	- Diocesan Executive Secretary - Holy Family Hospital at Berekum - Diocesan Pharmacy - Ghana Government - **Catholic Mission, Holland (building a new OPD and a Ward with Ghana Government)**

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
31. Nkoranzaman Catholic Hospital, Nkoranza	38	55	-	5	2	129740	46690 (O)	- Ministry of Health, Government of Ghana (Annual Grant) - **MEMISA (essential drugs)** - **Misereor (Volkswagen Lt.35 Combi Bus)** - INTERCARE, UK (drugs) - Catholic Medical Mission Board, USA (drugs, bandages etc.) - **St. Canisuis Hospital, Holland (medical and surgical supplied)** - Simavi (generator)
32. Hwidiem Catholic Hospital, Sunyani	48	50	-	9	9	137100	35495 (O)	- Diocesan Executive Secretary - External Donors from abroad
33. Holy Family Hospital, Berekum, Sunyani	61.6	35.4	2.4	-	0.6	56046	103579 (O)	- Executive Secretary of the DGC - **Overseas Donors (including Misereor, MEMISA, German Government)**

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
34. Jirapa Hospital, Wa	3.7	95.15	-	-	1.15	70000	40282	- Diocesan Executive Secretary - British High Commissioner to Ghana (equipment and dressing) - **Orion, Holland (books** - Diocese of Wa (Linen and furnishing) - French Ambassador to Ghana (drugs) - **Germany (secondhand bed linen)** - Dr. Cumberbatch, England (dressing and equipment)
35. Dafiema Mobile Clinic, Jirapa	70	25	-	5	-	-	-	- Diocesan Executive Secretary - Villagers - Diocesan Pharmacy and Garage - Medical Field Units
36. Wa Mobile Clinic	80	20	-	-	-	-	-	- Diocesan Executive Secretary - Villagers - Diocesan Pharmacy and Garage - Medical Field Units
37. Eremon Stati Clinic, Jirapa	10	90	-	-	-	2506		- Diocesan Executive Secretary - Jirapa Hospital

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
38. Kaleo Static Clinic, Jirapa	75	25	-	-		2000		- Diocese - Diocesan Pharmacy - Credit Union investment
39. Nandom Hospital, Wa	10	80	5-10	1	-	60000	22800 (O)	- District Chief Executive - Diocesan Executive Secretary - Registered Herbalist - **MEMISA (all eye clinic equipment and drugs)** - **West Germany (V. W. Kombi bus)** - **Misereor (mobile eye clinic - Datsun pick up)** - **SIMARI (financial support for PHC project)** - Overseas Agency, Canada (45,000 cedis) - **Dutch Embassy (engine for water pumps, x-ray equipment)**

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
40. West Gonna Hospital, Damongo						40000	34067	- **MEMISA** - **Misereor** - INTERCARE (USA) - Agencies in Austria, Canada and England - Local Council and District Chief Executive
41. Catholic Clinic, Yendi, Tamale	100	-	-	-	-	65000	3059	- Rev. Fathers (administrative support, drugs, resources)
42. Chamba Maternity Home	30	-	-	70	-			- Private Benefactors
43. Kandiga, Mobile Clinic, Navrongo-Bolgatanga	25	1	65	9	-	40000	8291	- S. M. I. Sisters - **Misereor (Senior staff quarters, Land Rover) - Medical Mission, the Institute Wurzburg, Germany (2 Senior staff, car, drugs on a continuing basis)**

Health Institution	Patient fees (%)	Government grants (%)	Private Subsidies (%)	Private Gifts (%)	Other Sources (%)	People within 10km radius (km)	1981 total attendance (O - outpatient attendance)	Major Donors and Aid
44. Wiaga	20	10	52	10	8	48000	19419	- Local Council - District Chief Executive - Parish Priest - **Alexian Brothers, Germany** - USA and UK (drugs and finance) - Intercare, Montreal, Canada - Intercare, Leicester, England - **MEMISA, Holland** - **Simari, Holland** - Clinic Care International , England

Chapter 5

USAID, CATHOLIC RELIEF SERVICES AND THE 'GHANAIAN ABRAHAM LINCOLN', GHANA, c.1957-1983

There are a huge variety of actors and voices that make up 'international health'; yet, as an historical concept, the term is often reduced to only meaning the workings of elite policy makers, in the centres of international health organisations, in Geneva, New York and, Washington, DC.[534] As Sanjoy Bhattacharya showed, in Frank Fenner's history of smallpox eradication (SEP), the wide array of participants involved in the programme were silenced and national involvement, especially that of smaller nations, was particularly circumscribed.[535] This chapter considers a variety of scales and networks, and argues that in the negotiations between them, medical missionaries and Ghanaian Christians figured as negotiators, intermediaries and advocates. This chapter will tie USAID (United States Agency for International Development) and WHO (World Health Organisation) together with national health planning in the Ghana Measles and Smallpox programme and healthcare more widely. It will analyse particularly how Catholic medical missions facilitated USAID's PL-480 food aid programme across Ghana. In both cases missionaries enabled far greater capacity than otherwise would have pertained.[536]

This chapter will first explore the involvement of Ghanaians, the US, international health organisations and missionaries in the 'Ghana Smallpox Eradication and Measles Control programme in Ghana'. International health was hugely shaped by these Ghanaian actors who had long-term linkages to mission. Ghanaian Christians could straddle both mission and international health and thus use both to their own ends. This argument challenges the boundaries of the concept of 'medical mission' showing how, as Africanisation of medical science and medical mission proceeded, there were continuities with older traditions of historic mission. Ghanaian Christians could function as medical missionaries within the hinterlands of the state and away from the urban centres in which they were born and educated. This was through mission hospitals and clinics, but also within international health. International health campaigns could be imagined in similar terms to that of roving colonial evangelists and preachers travelling to remote communities to share the Gospel. Ghanaians also challenged older models; whilst international health actors may have imagined their inventions and use of missionaries as secular and technical, for Ghanaians themselves this work could be

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[534] S. Bhattacharya, 'Global and Local Histories of Medicine: Interpretative Challenges and Future Possibilities' in M. Jackson (ed.) *A Global History of Medicine* (Oxford: Oxford University Press, 2018) pp.243-263.

[535] S. Bhattacharya, 'International Health and the Limits of its Global Influence: Bhutan and the Worldwide Smallpox Eradication Programme' *Medical History* 57.4 (October 2013) pp.461-486; F. Fenner, D. A. Henderson, I. Arita, Z. Jezek and I. D. Ladnyi, *Smallpox and Its Eradication* (Geneva: World Health Organisation, 1988).

[536] B. N. Lawrance, E. L. Osborn and R. L. Roberts (eds), *Intermediaries, interpreters and clerks: African employees in the making of colonial Africa* (University Wisconsin Press, 2006).

seen as a truer expression of their faith than historic forms of medical mission. This first section will detail the driving role of Frank Grant in Measles and Smallpox control in Ghana. Grant was a Christian Ghanaian, son of the head of the Methodist Church, Medical Field Unit leader and nicknamed by his USAID colleagues as a 'Ghanaian Abraham Lincoln'.[537] It will further the exploration of the coordination of Ghanaians, missions and US aid work by examining the creation of a medical school. In these developments, long-term continuities in both the Africanisation of Ghanaian medicine and mission culture can be highlighted; yet, added to this USAID also wished to co-opt the Africanisation process to meet their own concerns for state stabilisation and modernization.[538]

The second section will explore the USAID nutrition programmes in the context of severe economic decline in Ghana in the 1970s. It will analyse the role of the US Catholic Relief Services (CRS) in distributing food in the USAID programme PL 480. It was not only Ghanaian doctors but expatriate missionaries were also working with and shaping international health in ways that linked to new streams of mission funding and personnel in the 1960s, and in a context of long-term continuities in the structure of Ghanaian healthcare. WHO and US medical aid in Ghana were shaped by powerful and well-resourced Christian networks as well as America's religious priorities and international health agendas during the Cold War. This will further the analysis of chapter 4 by exploring the postwar expansion of Catholic mission in Ghana. Crucially, the CRS's links to the global network of Catholic mission, to Misereor and to Ghanaian Catholic missions, extended logistical and imaginatively how USAID conceived of their food aid.

i. 'CHILDREN YET UNBORN': FRANK GRANT AND THE 'GHANA SMALLPOX ERADICATION AND MEASLES CONTROL PROGRAMME', 1957-1980

International health organisations offered Ghanaian Christian doctors and medical mission networks a new way in which to exert influence and control; this had wider repercussions for the international health campaigns of the 1960s and 1970s. Medical missionaries adapted to the new international health contexts and were incredibly useful to international health organisations, but also they were able to construct programmes in ways which were useful to them. In doing so they challenged the traditional structures and

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[537] F. E. Gilbert interviewed by W. Haven North (The Association for Diplomatic Studies and Training Foreign Affairs Oral History Project: Foreign Affairs Series, 4 September 1997) p.10.

[538] USAID had a changing relationship to modernization theory between the 1950s and 1980s, for research on state stabilisation, stages of growth, modernization theory and development aid, see D. C. Engerman, N. Gilman, M. H. Haefele and M. E. Latham, *Staging Growth: Modernization, Development and the Global Cold War* (Amherst and Boston: University of Massachusetts Press, 2003); N. Gilman, *Mandarins of the Future: Modernization Theory in Cold War America* (The John Hopkins University Press, 2003); M. E. Latham, *Modernization as Ideology: American Social Science and "Nation Building" in the Kennedy Era* (Chapel Hill and London: The University of North Carolina Press, 2000).

identities of historical medical mission (such as needing to be part of a specific denominational organisation) but they also gave mission new outlets, functions and postcolonial roles.

International health programmes often require validating at national level and are constructed by terms which are political useful to local actors. In her recent article on Portuguese India's relations with the WHO's SEARO (World Health Organisation's South East Asia Regional Office) in the 1950s, Monica Saavedra considered international health politics from a national perspective. In this she challenged common historical accounts, such as that of Nitsan Chorev, which focus on the institutional agency of the WHO, the import of its universal visions, the effect of its global agendas and its adaptations to political difficulties. By contrast, Saavedra looked at how SEARO was a 'product and locus of regional politics', how it served a national political agenda and how it was one of the forces which reshaped global health programmes. In this Saavedra builds on the work of Sanjoy Bhattacharya who, in his work on Smallpox control and eradication (SEP) in India between 1947 and 1977, argued that the WHO's programme was formed and made possible in negotiations with the complex national interests of Indian ministers and bureaucrats.[539] This point is made even more strongly in his work on SEP in Bhutan in which the WHO submitted to and had to negotiate with the demands Indian authorities.[540] Moreover, in the work of Sarah Cook Runcie, the Medical Field Units (MFUs) in Cameroon are shown to have been necessary to SEP being possible - again national structures and politics needed to be marshalled for international health programmes to function.[541] With Portuguese Goa and India, global medical programmes were imagined in terms of the national concerns which it legitimised on the international level. As Saavedra puts, it is important to consider 'multiple scales and actors when analysing the politics of international, and indeed, global health'.[542]

Whilst the smallpox eradication programme had international traction, it was actually controlling measles that made it useful locally. The young Ghanaian epidemiologist, Francis (Frank) Chapman Grant became the deputy director of the MFUs in Ghana in the early 1960s. Already by this point they had much contact with USAID through the malaria eradication programme in the mid 1950s which had ground to a halt because of a change in the direction of international health. By 1965, Grant had become the director of the MFUs and was named the head of the Ghana Smallpox Eradication and Measles Control Programme. How this programme was strengthened and formed by the international health community was not a unilinear process. It was neither the case of decisions from on high in Geneva controlling Grant and the MFUs, or Grant with a free hand creating programmes based solely on need. It was a mixture. Grant was particularly interested in

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[539] S. Bhattacharya, *Expunging Variola: The Control and Eradication of Smallpox in India 1947-1977* (New Delhi: Orient Longman Private Limited, 2006).

[540] S. Bhattacharya, 'International Health and the Limits of its Global Influence: Bhutan and the Worldwide Smallpox Eradication Programme' *Medical History* 57.4 (October 2013) pp.461-486.

[541] S. C. Runcie, 'Mobile Health Teams, Decolonization, and the Eradication Era in Cameroon, 1945-1970' (Unpublished Doctoral Thesis, Columbia University, 2017).

[542] M. Saavedra, 'Politics and Health at the WHO Regional Office for South East Asia: The Case of Portuguese India, 1949–61' 61.3 *Medical History* (July 2017) pp. 380-400.

measles because of the extremely high incidence of the disease in Ghana at the time, especially for children under 5. This was corroborated in interview with one of Grant's closest friend, Felix Konotey-Ahulu. In the 1950s there were rumours that 25% of all measles cases in Africa were occurring in Ghana which, whether true or not, suggests the sense of scale and concern amongst Ghanaian health workers.[543] At the same time, the CDC and USAID were focused on controlling and eradicating smallpox, so Grant combined the two in order to gain funding. Once Grant had the backing of the CDC and also the WHO, he then wanted to bring in USAID. The USAID program officer in the mid-1960s, Fred Gilbert, recalls how Grant forced his hand in getting the programme started.

> One of my first Ghana memories was that Gordon Evans handed me an airgram about the idea of a smallpox-measles program. He said, in effect, "I don't know what this is, but figure out what to do with it." When I finally found time to flip through it, my reaction was that it was an unrealistic, lobby-driven initiative from left field. It certainly hadn't followed a normal path through the AID programming process (not that there was much definition of that). CDC…and WHO were the instigators, and there had surely been some communications from either Washington or Atlanta with the Ghanaians because one day a wonderful man named Dr. Frank Grant (a Ghanaian) from the Ministry of Health came by and wanted to talk about smallpox and measles….He also had a message and said, "Maybe we should talk about this." That was a pain in the neck - it meant that I REALLY had to read the damn thing. It was clear that this wasn't something that would go away if we scoffed. It was coming at us a hundred miles an hour, and we really had to get moving even though we already had too much on our plates. And nobody else on either his side or mine could focus on the matter. So the two of us sat down and "whomped up" an agreement for an activity financed by AID, sponsored by WHO and implemented by CDC - thus fitting no model or guidance available in the Manual Orders - and got it signed with precious little fanfare - or, at least, none that I recall. And that exercise turned out ultimately to be a good, even fun, experience since Frank Grant was such a good guy. And then, lo and behold, all kinds of crazy things started happening. People started arriving. Soon CDC people were working out of a local office in close collaboration with the Health Ministry to implement the program. And that turned out to be one of the most successful things we've ever done. Now that I think back, I remember being sent in the summer of 1966 to CDC in Atlanta to brief a group of field officers who were to be stationed in Africa. These people turned out, in most cases, to be the staff of the Smallpox-Measles Program. Yet the Smallpox-Measles Program, per se, was a surprise…And, as with the embryonic Smallpox-Measles Program, one often had a frightening degree of latitude because no one else could focus on such matters.[544]

Gilbert's recollection in interview both emphasises the ability of an MFU leader like Grant to put something on the table of international health organisations, and also the 'frightening degree of latitude' local Assistant Program Officers had in programme initiation. Far from the post-hoc histories that have shown SEP to be

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[543] Interview with Author, F. Konotey-Ahulu, Harley Street, London (6th November 2016).

[544] F. E. Gilbert interviewed by W. Haven North (The Association for Diplomatic Studies and Training Foreign Affairs Oral History Project: Foreign Affairs Series, 4 September 1997) pp.10-11.

inevitable, Gilbert's statement emphasises just how contingent and a 'surprise' it actually was. As shown in an USAID memorandum in July 1965 and in a memorandum from Donald Henderson to the CDC and the Bureau of State Services in November 1965, USAID and CDC were reluctant to include Ghana in the overall smallpox and measles programme because of concern that the scope of the 'African problem' was too great for 'any one donor'.[545] WHO instigated the programme but it required Grant wanting to talk about smallpox and measles to ensure USAID financial backing. As David Newberry puts it 'WHO had nearly no contribution the Ghana program'.[546] There were complex negotiations on the ground and key individuals who by sheer will power and force of personality drove the early stages of the programme. WHO sponsored the initiative certainly and in doing so they certainly deserve a great deal of credit in being able to empower people like Frank Grant. However, the CDC, with people like David Newberry managing the MFUs, implemented it (as well as, in time, campaigns against yaws, yellow fever, guinea worm and EPI Immunization).[547] Moreover, it was actually USAID, who barely get a look in within official histories, who financed it. Coordinating these groups within Ghana and pushing forward with the vague plans of the WHO, fell to Frank Grant who ensured that for Fred Gilbert it became 'something that wasn't going to go away'. Grant used the landscape of health organisations already available, the contacts he had already made through the malaria eradication programme in the 1950s and his position within the Ministry of Health to tackle a local problem of measles, with a set of global solutions. In doing so, international health organisations both were agents of changes and also were shaped by Grant and Ghana's specific context and motivations.

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[545] F. Fenner, D. A. Henderson, I. Arita, Z. Jezek and I. D. Ladnyi, *Smallpox and Its Eradication* (Geneva: World Health Organisation, 1988) pp.856, 858.

[546] Correspondence with Author, D. Newberry (19th September, 2015).

[547] Correspondence with Author, D. Newberry (19th September, 2015)

Image X: CDC Staff Dinner, including Frank Grant sitting nearest the camera (1967)

Retrieved from: http:// globalhealthchronicles.com,

Image XI: ‘Children are vaccinated against smallpox by the Mobile Medical Field Unit working in the Trans-Volta-Togoland Region’ (19 October 1954)

British Official Photograph (Accra) 966.7/6/10 — K. 18157, National Archives at Kew (UK).

Grant was so concerned with measles because, before the 1960s, measles control had been neglected in Ghana in favour of Yaws and Trypanosomiasis. The biggest disease in Ghana, in terms of overall incidence in government in the 1930s had been Yaws at 64.84% of total incidence of infectious diseases in 1932-33.[548] In 1947, 10253 cases of Yaws were treated, between 1951 and 1953 children's hospitals and clinics treated 46878 cases.[549] Moreover, the anti-Yaws campaign begun in 1956 was assisted by the WHO and UNICEF.[550] By 1961, the MFUs' attack phase managed to reduce the incidence of Yaws in a given region by 75-90%, though they could not get incidence below 0.5%. Trypanosomiasis had also been given huge funding, £150000 for an institution, in the Northern Territories in 1951 because of the pioneering work and advocacy of Kenneth Stacey Morris in the previous two decades, though by 1961 this was struggling because of the expense of upkeep (tsetse control requires close attention to bush management around rivers and careful coordination of big game and livestock).[551]

Yet, measles had been neglected. In 1952, there were 24949 outpatient cases of measles, with this declining to 8095 the following year with 476 measles inpatients and 25 deaths.[552] Only in 1961 was measles control systematised by the MFUs. That year found incredibly high numbers of children contracting the illness. Surveying a population of 7515 under 15 years of age, they found 1134 cases in children in villages, an attack rate of 15.3 per cent in those communities. From this there were 38 deaths, with a case fatality rate of 3.3 per cent. Most of these, 90.8 per cent, were in the North-East. This the MFUs concluded was only a 'relative small part of the total which occurred' and if there was an epidemic as there had been in 1957 in which every community in the extreme north had been attacked, the staff were entirely 'insufficient'.[553] The view of locals that the disease was seen as a 'mild inevitable childhood experience' had 'serious consequences' according to the MFUs. In 1962 they saw 1366 cases of a total 8962 children examined and found a 15.2 per cent attack rate, 67.2 percentage of complications and 2.2. per cent fatality, with 30 deaths. This time the survey showed more spread across the North with 40 per cent in the North East and 45 per cent in the North West.[554] Internationally too, measles continued to be ignored, though for the CDC their West Africa programme was always, in fact, a smallpox-measles programme.

Measles was also a far more significant focus for Grant and Ghana because smallpox control had been successful since the early 1920s. It has been shown, particularly in Chapter 1, that the majority of smallpox

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[548] 'Infective Diseases Total Incidence, 96480' *Gold Coast Colony Report on the Medical Department for the year 1931-32* (Government Printing Office, Accra, 1932) Balme Library, University of Ghana (Accra, Ghana);

[549] *Report on the Medical Department for the year 1947* (1948) p.6, Korle Bu Teaching Hospital Library (Accra, Ghana); *Report of the Ministry of Health 1953* (1954) p.81, Korle Bu Teaching Hospital Library (Accra, Ghana).

[550] *Annual Report of the Medical Field Units 1962* (1962) p.15, Korle Bu Teaching Hospital Library (Accra, Ghana).

[551] *Medical Field Units Annual Report, 1961* (1961) pp.17-18, Korle Bu Teaching Hospital Library (Accra, Ghana).

[552] *Report of the Ministry of Health 1953* (1954) p.79, Korle Bu Teaching Hospital Library (Accra, Ghana).

[553] *Medical Field Units Annual Report, 1961* (1961) pp.20, 92, Korle Bu Teaching Hospital Library (Accra, Ghana).

[554] *Annual Report of the Medical Field Units 1962* (1962) p.33, Korle Bu Teaching Hospital Library (Accra, Ghana).

control was executed by the British colonial state. Except for in the 1940s, when generally the colonial state struggled to implement health programmes because of a lack of resources, they managed to immunise millions of Africans in the Gold Coast between the 1920s and 1950s. This corroborates William Schneider's argument that, whilst the global eradication effort was necessary to stopping smallpox's continued periodic outbreaks across Africa, writers such as Fenner and Donald Hopkins have emphasised this because of their own role in it and have neglected colonial initiatives.[555] In the Gold Coast and Ghana, the colonial state by the 1950s through the MFUs had a lot of the country immunised. In late colonial Gold Coast, smallpox control was a mixture of African health workers and colonial officers, with the MFUs partly operating out of Kintampo. The MFUs began in 1935 in order to tackle sleeping sickness but were soon expanded to other communicable diseases, in 1944 to yaws and 1949 to smallpox.[556] Taking over from G. T. Saunders in the 1940s the British colonial medical officer, B. B. Waddy led the MFUs with David Scott.[557] The efforts had begun with Accra in 1919, moved out beyond the capital after this, and in the 1950s began immunising across the North. As Addae has shown this was a generally successful process, though there were rises in incidence in the 1950s.[558]

It was not only between WHO and USAID that Grant figured as significant, his faith and Methodist identity also ensured that he was able to coordinate effectively with missions and local communities. Frank Grant's background in Christian mission and the Ghanaian Methodist church was key asset to the MFU's smallpox and measles control. One of Frank's colleagues in Ghana, David Newberry, from the CDC and USAIDs, recalled that:

> Frank and Mary Grant were deeply religious. Frank's father was Pasteur (sic) at the Presbyterian Cathedral… Working with Frank Grant we held a short prayer session before each day's work. Frank conducted religious training and both he and Mary were parish leaders…Unlike many African medial officers - Frank and Mary Grant applied their Christian values to everything they did. I traveled to the British System Rest Houses located in every regional area of Ghana. Some of these were local native huts and ill-kept. I never traveled to any such facility that had not recorded Dr. Frank Grant's previous visit![559]

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[555] It is mentioned in Fenner's volume that Ghana was the only country in which the MFUs spread across the whole country, they did recognise the postcolonial MFU contribution; F. Fenner, D. A. Henderson, I. Arita, Z. Jezek and I. D. Ladnyi, *Smallpox and Its Eradication* (Geneva: World Health Organisation, 1988) p.868; W. H. Schneider, 'Smallpox in Africa during Colonial Rule' *53 Medical History* (2009) p.193.

[556] 'Wider World: Health Services in Ghana' *The Lancet* (21 July, 1962) pp.142-144.

[557] D. Scott, *Epidemic Diseases in Ghana, 1901-1960* (Oxford: Oxford University Press, 1965).

[558] 'Graph 1: Annual Notification of Smallpox in Ghana, 1901-1962' *Annual Report of the Medical Field Units 1962* (1962) Korle Bu Teaching Hospital Library (Accra, Ghana); S. Addae, *Medical Histories Volume II: Diseases, Medical Institutions, and Biographies* (Accra: Eureka Foundation, 2012) pp.323-333.

[559] Correspondence with Author, D. Newberry (19th September, 2015).

This was a fairly accurate description of the energy for networking with local communities and also the faith of Grant. As Paul Greenhough has shown, in East Pakistan there were clashes between international health officials who supported the political and social mobilisation of volunteers in smallpox eradication, against those who believed that this a dangerous initiative without professional discipline.[560] For Grant, professional discipline and technical control were combined with religious mobilisation and social authority. Grant intermixed both professional and religious identities in order that he could ensure the trust and support of communities during vaccinations. Grant was born in Aburi in 1924 to the daughter of a chief, Nana Amonoo V of Anomabu and the Methodist minister, Francis Chapman Ferguson Grant (senior), who became the first President of the Ghana Methodist Conference. At the behest of J. E. K. Aggrey, the African international educator discussed at length in Chapter 1, Grant (junior) was transferred to the Kindergarten department at Achimota College in 1930. Grant stayed on at the school until, after a short hiatus as a Senior Science master, he went to study at Sheffield University Medical School. He graduated in June 1954 and returned to Ghana in 1957 to take up a career as a surgeon. Through a move to the MFUs and studying public health at the London School of Hygiene and Tropical Medicine in 1961, he effectively became Ghana's first epidemiologist.[561] This specific identity and training meant that Grant could link with local communities, international health organisations, government, chiefs and medical missions. According to Frank Grant's wife, Mary Grant, who later became the Deputy PNDC (Provisional National Defence Council) Secretary of Health under Flight Lieutenant Jerry Rawlings in 1985, Frank Grant's faith enabled him to connect to Christian communities that otherwise might have been difficult.[562] Moreover, as Mary Grant put it, for Frank Grant, Christ was everything. In interview Frank Grant's children suggested that he would wake everyday around 5 or 6am and pray and worship for an hour.[563]

Frank Grant, as Mary Grant explained, imagined his medical mission like that of his Father's evangelism and Aggrey's Africanisation of missionary internationalism. When his Father travelled around villages preaching the Gospel, Grant followed as a boy and later mimicked the same practice but with biomedicine.[564] This was not an unusual connection and one that Grant maintained throughout his work combining understanding of Methodist theology with 'local beliefs'. As Newberry explained:

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[560] P. Greenough, '"A wild and wondrous ride": CDC field epidemiologists in the east Pakistan smallpox and cholera epidemics of 1958' *Ciência & Saúde Coletiva* 16.2 (2011) pp.491-500.

[561] Memorial and Thanksgiving Service for the Late Dr. Francis Grant (Funeral Brochure, 2002) pp.6-37, Personal Archives of the Family of F. C. Grant (Accra, Ghana).

[562] Interview with Author, M. Grant, East Cantonments, Ghana (31st January 2016); Ghana, 'Former member of Council of State Dr Mary Grant dies at 88' myjoyonline.com (18 September 2016).

[563] Interview with Author, F. Grant, East Cantonments, Ghana (2 February 2016); Francis Grant is Frank Grant's son.

[564] Interview with Author, M. Grant, East Cantonments, Ghana (31st January 2016).

> We had many such conversations (about faith). His beliefs were strictly orthodox but he educated me on the tribal and local beliefs as well. He was the most respectful person that I knew. Frank intimated a persona that commanded respect, trust, likability and a great sense of humor. He was a sort of Ghanaian Abraham Lincoln…There was no hardship he wouldn't suffer for his people, or the poor or the sick.[565]

Grant's self-image and his identity to those around him, was similar to the medical mission model of sacrifice, inculturation and accommodation, prevalent across many of the missions discussed so far. Particularly he fits within the Methodist tradition of roving preaching and evangelism, rather than that of the Catholics and SDAs who used key institutions as a base for drawing into the missions. Whilst Grant was a Ghanaian, his identity was continuous with older medical mission narratives, especially the elitist and 'Christian character' developmentalism around Aggrey. This was a particularly African and internationalist vision of what it meant to be a medical missionary. When Grant attended a reunion with the notable Ghanaian theologian C. G. Baeta at Achimota in 1975 the group listened to depictions of the faith legacies of Aggrey in the context of how Ghanaian Christians should act today. Mourning Aggrey, even decades later, remained a key feature of how some Ghanaian Christians imagined their roles, their faith and their relations with foreigners. Baeta spoke of how Aggrey's faith, diplomacy and gentleness, as well as his striving for excellence, was still ministering to Ghanaians like them beyond his death.[566] Aggrey's parables, such as that of the eagle who was used to eating chicken feed but learned to fly, was used to exemplify how Ghanaians could collaborate with international actors, attack global injustice and reach for the heights of human achievement with the help of Jesus Christ. This challenged Nkrumah's reimagining of Aggrey in terms of the combination of modernity and traditional African culture.[567] It was a specific tradition of Africanisation, development and Christian mission which was embodied by Aggrey, ritualised through his memorial and practised by international health workers like Grant.[568]

For Grant and the Smallpox/Measles campaign, connecting with medical missions was important because of the vital role they played in Ghanaian healthcare; they could communicate regarding epidemics, distribute health messages and support MFU activities generally. Newberry recalled how churches, alongside local chiefs, communicated key messages about the Smallpox/Measles campaign in order to marshal and convince communities to cooperate.

> …collaborating with UNICEF we began a campaign to immunize against measles at 6 months and again at 12-18

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[565] Correspondence with Author, D. Newberry (4th October, 2015).

[566] C. G. Baeta, 'Address for the Service Commemorating the Centenary of Aggrey's Birth' Achimota School (19th October 1975) Personal Archives of the Family of F. C. Grant (Accra, Ghana).

[567] Discussed in chapter 3 (p.107).

[568] C. G. Baeta, 'Address for the Service Commemorating the Centenary of Aggrey's Birth' Achimota School (19th October 1975) Personal Archives of the Family of F. C. Grant (Accra, Ghana).

> months. About 5% to 15% of children infected with measles before 18 months of age were likely to die with measles. The Edmonson strain of measles vaccine had a very high immune response rate. The Churches formed groups that supported immunization and announced the campaigns right up to the day of the program. We collaborated with local chiefs and parish priests and local Catholic leadership.[569]

These contacts with churches and medical missions which Newberry recollects are backed up in United States Government memorandums from the late 1960s. In these there is evidence of Newberry as the Smallpox/Measles operations officer liaising between Catholic and Protestant medical missions, USAID, the MFUs and the Ghanaian Ministry of Health, to help control a yellow fever epidemic in Northern Ghana.[570] Newberry concluded that 'we truly depended on the various Christian missionary groups and services to support us in both treatment of suspected cases and surveillance'.[571] Grant's role in these emerges too, there is record in these memorandums of his surveying of yellow fever outbreaks and reporting back from remote areas.[572] Links between USAID, Grant, Foege (who worked in Ghana too) and Ghanaian medical officers were critical to sustain communication about epidemic outbreaks and coordinate effective responses.[573] As Grant's son said in interview, even when they were in Brazzaville in the Congo working in the WHO Regional Office in the late 1970s, Grant would use his son's organ playing skills to ingratiate himself to all the local churches.[574] Mission networks mattered to MFU medicine and those like Grant and Newberry who could link with them benefitted hugely.

Communication with local communities had been a long term problem for the MFUs. Sometimes local chiefs were helpful, other times they actively hindered efforts. Some communities were amenable, others wanted to dissuade and distract with disinformation. In the 1920s, in the first smallpox control efforts around Accra, Percy Selwyn-Clarke wrote that:

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[569] Correspondence with Author, D. Newberry (October 4th 2015).

[570] From D. Newberry (Operations Officer Ghana Smallpox/Measles Program, USAID/Accra) to R. Cashin (Director USAID/Ghana, Accra), 'United States Government Memorandum: GSMP Upper Region Yellow Fever Activities' (1 December 1969) RG 0286 United States Department for International Development, USAID Mission to Ghana/ Education Division, Entry# P 347: Subject Files 1969-1974, United States National Archives II (Maryland, USA).

[571] Correspondence with Author, D. Newberry (October 4th, 2015).

[572] D. Newberry, D. Dix and C. A. Herron, 'Report of a meeting held on Saturday, December 13 in the office of the S.M.C. (C.D.) Accra, to discuss the current Yellow Fever problem' (22nd December 1969) p.3, RG 0286 United States Department for International Development, USAID Mission to Ghana/Education Division, Entry# P 347: Subject Files 1969-1974, United States National Archives II (Maryland, USA).

[573] From C. A. Herron (Medical Officer, SMP/Ghana) to R. Cashin (Director, USAID/Ghana) 'United States Government Memorandum: Yellow Fever Problem, 1969-1970' (3rd January 1970) RG 0286 United States Department for International Development, USAID Mission to Ghana/Education Division, Entry# P 347: Subject Files 1969-1974, United States National Archives II (Maryland, USA).

[574] Interview with Author, F. Grant, East Cantonments, Accra (02 January 2016).

> …there were cases in which little or no reliance could be placed on the statements made by patients or their friends. Members of the Kroo tribe have a particularly unreliable memory and deliberate misstatements were frequently made in the hope that the health authorities would be led astray, in which case failure to trace the original sources of the disease would result , and the necessary action in the matter with regard to disinfection, isolation and vaccination of contacts could not be taken.[575]

By the 1950s, areas in the South had longer term contact with health authorities and were probably less likely to lead them astray, but expanding immunisation beyond those well connected areas was complex task. In 1975, Waddy explained in a discussion organised by the Royal Society of Hygiene and Tropical medicine that, before modern freeze dried techniques, the MFU practices in the 1940s and 1950s caused terrible ulcers in patients and it was difficult to control reactions.

> A point that has not been mentioned this evening is the acceptability of modern freeze dried vaccines, as compared with the older vaccines. When I was organizing mass vaccination in Ghana, in the 1940's and 1950's, the vaccines (and conceivably the technique) we were using did produce some very severe ulcers. People tended to run away rather than wait to be vaccinated, and one could not entirely blame them.[576]

As Waddy recalled, word about the negative consequences of vaccination and thus terror, spread more quickly than the teams could vaccinate. Furthermore, as O. A. Olumwallah and Melissa Graboyes have shown for medical work in East Africa, the legacies of repressive tax policies, military incursions or broken promises by previous medics and scientists could damage relationships between communities and foreign bodies.[577] Whilst Ghanaians were a part of the teams, the MFUs were not able to find intermediaries in every community and often the damaging side effects of the vaccines caused fear and fleeing.

By contrast, Newberry explains the success the MFUs had in the 1960s in using missions as intermediaries. Missions were often the only contact the communities had with white outsiders before the MFUs arrived:

> The children in these villages would run alongside of our vehicles - shouting ...Father, Father, Father!!! When I asked about this my MFU staff would tell me that the only white person they had seen before me was a Catholic

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[575] P. Selwyn-Clarke, *A monograph on smallpox in the negro and negroid tribes of British West Africa, with special reference to the Gold Coast Colony* (John Bale sons and Danielsson Ltd., 1921).

[576] K. R. Dumbell and Farida Huq (with B. B. Waddy), 'Epidemiological Implications of the Typing of Variola Isolates' 63.3 *Transactions of the Royal Society of Tropical Medicine and Hygiene* (1975) p.307.

[577] O. A. Olumwallah, *Dis-Ease in the Colonial State: Medicine, Society, and Social Change Among the AbaNyole in Western Kenya* (Westport, CT: Greenwood Press, 2002); M. Graboyes, *The Experiment Must Continue: Medical Research and Ethics in East Africa, 1940-2014* (Ohio: Ohio University Press, 2015).

> Priest. There were many other protestant and Catholic missionaries operating in the remote interior. The Baptists had a couple of hospitals too.[578]

Moreover, in a later interview Newberry described how some missionaries were particularly helpful because of their long-term relations with local communities, their knowledge of local customs and their interest in healthcare:

> There was a priest in the north West of Ghana who was a White Father out of Canada who totally revolutionized the major tribe in that area…He came into Ghana way back at the turn of the century by ship and a barge because there was no dock for ships. He trekked upcountry with natives carrying all his belongings. What an amazing person he was! He learned the language and later helped them develop a written language. He loved helping pregnant women who had no assistance other than traditional birth attendants who didn't even practice personal hygiene. So this priest built maternal hospitals and safe delivery facilities. Any time I visited him he would have me help building while we conducted business. I wanted to leave him a fridge so we could store vaccines with him. He pondered that simple request and after several days he turned us down because he said "He might be tempted to use it for himself"!…He was such a good man.[579]

Even if this Priest was not comfortable even keeping a fridge for vaccines, missions were key points of contact for the MFUs and connecting with them was indispensable in many areas.

Use of mission networks for international health was not unique to Ghana. In the work of Bill Foege in smallpox control in Eastern Nigeria it was critical in creating some of the main strategies for effective 'firefighting'. Again, as with Grant, Foege's identifying with both international health organisations and mission made him the ideal intermediary. In his recent memoirs Foege writes of how he decided that preventative medicine through international organisations was a better option for him than becoming a medical missionary. Though he was not fully sure and instead he moved between the two. He began working for the CDC, then became a Lutheran medical missionary before returning to the CDC in 1966 as consultant for its smallpox operation in Eastern Nigeria. Foege's most famous innovation was the smallpox containment strategy which became the basis for worldwide control and eradication. He describes in his autobiography how, in the latter role, he continued to use missionaries in order to action his eradication plan. Networks of missionary knowledge were as valuable for smallpox eradicators as networks of hospitals and clinics. The WHO was aware of this; that there were regular meetings and correspondence in order to combine local, national, and international levels of the programmes. Through missionaries' knowledge of indigenous populations and their expertise in various aspects of healthcare, they shaped what was thinkable as well as

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[578] Correspondence with Author, D. Newberry (October 4th 2015)

[579] Correspondence with Author, D. Newberry (October 4th 2015)

practically possible for smallpox eradication teams. Foege's ability to connect to missionary groups was vital in this, he writes:

> We could use the missionaries' knowledge of market patterns and family patterns to make predictions about high-risk areas for spread, but first we needed to know where the virus was at the moment. Acquiring this type of intelligence would be difficult even in a country like the United States. It seemed absolutely impossible in rural Africa. However, the missionary community's own support system offered an answer. There were no telephones, so every night at 7 P. M., the missionaries turned on their shortwave radios and checked in to make sure that no one was in need of assistance…missionaries up to some thirty or more miles distant, explained the situation, and, with maps in front of us, divided up the area. We asked each missionary to send runners to every village in his assigned area to ask if anyone had seen cases of smallpox…(we) were given the precise information we needed…based on the missionaries' knowledge of where the patients and their families usually travelled, we made some informed guesses regarding other places where the virus was most likely incubating…In many ways the strategy that stopped the virus was a logical extension of the firefighting principle that I was taught back in the summers of 1956 and 1957.[580]

Missionaries provided the necessary communication capacity for Foege's 'firefighting principle' to actually work and worked closely with him to make it happen. It was missionaries who knew Nigerian travelling patterns and it was missionaries who made the 'informed guesses' about virus distribution. However, it must be noted that in other cases, religious attitudes to biomedicine could directly stop smallpox control, as happened for Foege with the Faith Tabernacle Church in Abakaliki, Nigeria. This church refused vaccination and, according to Foege 'were responsible for a continuing outbreak in an area with greater than 90% smallpox vaccination coverage in 1967'.[581] Some groups were extremely difficult to survey or immunise against smallpox. Medical missionaries specific models of theology and biomedicine made them ideal contacts, whereas Pentecostal churches like Faith Tabernacle could sometimes create opposition.

For Foege and Grant, immunisation programmes represented a better version of historic medical mission, not a secular function of international health. International health campaigns have been variously represented in terms of human rights, scientific and technical solutions to problems, and unbiased aid work, as well in many other forms. However, the religious motivation for these campaigns has often been missed. For Foege, working for the CDC was not a rejection of medical missionary work but a proactive improvement on their models which expressed more fully the message of the Christian gospel. Foege originally left missionary work because of its lack of focus on preventative medicine and his concern that churches' 'medical work had become such a useful proselytising tool… (to) attract people and…leave them feeling indebted'. He wrote

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[580] W. H. Foege, *House on Fire: The Fight to Eradicate Smallpox* (University of California Press; Reprint edition, 2012) pp.56-57.

[581] Correspondence with Author, W. H. Foege (9th September, 2015)

how he found in Dr Wolfgang Bulle, the secretary for the Lutheran Church-Missiouri Synod, an 'unexpected ally'. Bulle encouraged Foege to begin mission in Nigeria and in 1967, he drew Foege into a conference of theologians and missionary medics at Conoor in India.[582] These conferences organised by the CMC were multiple and included many different missionaries, international health workers and ministers from all over the world. For example at the Protestant churches medical conference at Limuru in Kenya in 1970, Foege argued that:

> Only when healing is seen as a responsibility of becoming a Christian, part of our redemptive function in the world which needs no other justification, do we possess the freedom to plan our medical work on the basis of the priorities of need rather than the priorities of a church board. When we as a church can see people who need food be assured in advance that not one will be converted and still feed them, we have understood our responsibility as a church.

Foege was claiming that immunisation, preventative health and community healthcare, models lauded in organisations such as the CDC were actually expressing far better the 'redemptive function' of the church, than missions were. He blamed the lack of smallpox control in the past on the ways in which healthcare had been directed at individuals and not communities. Measles too, as with Grant, was tied to this vision for true salvific mission to communities and smallpox control:

> The second programme concerns measles. In West Africa 5 to 10 per cent of children die of measles. In some areas 20 per cent of hospital beds are involved in the care of children with measles and measles complications. In the past three years 18 million children have been vaccinated against measles in West and Central Africa. Although we have not been able to eradicate measles on the budget allotted, we have substantially reduced death and disease, and we have free hospital beds in the process.[583]

But this, according to Foege, was only a starting point for a far wider reaching agenda in 'community medicine' which missions needed to begin supporting. He argued that starting simply with surveillance and 'such things as smallpox, measles, malnutrition and the price of maize' would lead to missions and health workers being able to 'obtain the pulse of the community'. Moreover, this would mean that medical missions would be far more connected to the life of the church. Foege argued that medical missions should be:

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[582] W. H. Foege, *House on Fire: The Fight to Eradicate Smallpox* (University of California Press; Reprint edition, 2012) p.29.

[583] W. H. Foege, 'The Practice of Community Medicine' in Health is Wholenesss, The Limuru Conference, Protestant Churches Medical Association and Lutheran Institute of Human Ecology (Printed by Kenya Litho Ltd., Nairobi, February 1970) John Hopkins University Archives (Baltimore, USA).

> …using the local congregation extensively. It has been said that community medicine is far too important to be entrusted to the medical profession. Our history of medical missions, unfortunately, bears this out. Even in countries with advanced medical care the majority of healing is done by non-professionals. If I am sick I may see a professional healer for ten minutes, but it is my wife, children, and friends who cover for me, cook my meals and provide the support needed while I am a consumer rather than a contributor. It may involved the congregation accepting responsibility in the village, both for their congregation and for others…The congregation can be used in surveillance, as volunteers to provide advance publicity, as volunteers in the mechanics of assembling people, as a core group to learn and disseminate new health information.[584]

This concern built on Foege's success with smallpox and measles control in which missions had been critical in surveillance. However, he took it further and showed how this was linked to a greater concern for Christian service beyond the fold. Finally, using the phrasing of the ending of Psalm 22 (the Psalm which Jesus Christ quoted on the cross and which here linked to future generations remembering the Lord) Foege concluded that:

> Hospitals in some places may be a luxury which the church can afford but the local community cannot afford. It is your responsibility to find out. I have taken the risk of offending you, but I have taken this risk on behalf of a child who travels through life with his potential mental capacity not met because his mother did not understand the need for protein nor the risk incurred by having another child the next year. I have taken the risk on behalf of the father and mother who lose their child from measles in the shadow of your hospital, I have taken this risk on behalf of children yet unborn.[585]

Foege in certain contexts performed his role within the CDC as that of the technical advisor committed to modernisation. Yet, in this context, he constructs the relationship between mission and development as being vital to expressing the fundamental truths of the gospel. By reassessing historic medical missions through the lens of international health models prevalent in the 1950s and 1960s, Foege challenged the theological foundations of those missions. He argued that their hospital focus has neglected the malnutrition and high incidence of communicable diseases such as measles. In doing so Foege critiqued missions' use of development ensuring direct evangelism because it had come at the expense of the need of communities for disease control.

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[584] W. H. Foege, 'The Practice of Community Medicine' in Health is Wholenesss, The Limuru Conference, Protestant Churches Medical Association and Lutheran Institute of Human Ecology (Printed by Kenya Litho Ltd., Nairobi, February 1970) John Hopkins University Archives (Baltimore, USA).

[585] Psalm 22, King James Version; W. H. Foege, 'The Practice of Community Medicine' in Health is Wholenesss, The Limuru Conference, Protestant Churches Medical Association and Lutheran Institute of Human Ecology (Printed by Kenya Litho Ltd., Nairobi, February 1970) John Hopkins University Archives (Baltimore, USA).

Throughout the smallpox and measles programme, the MFUs and the international health organisations still relied on the infrastructure of medical missions across Ghana. In 1967 the field investigation report sent by the Ministry of Health in Ghana to the WHO about the latest smallpox outbreak, shows how much missions were still relied on. The report was from the Bawku district, one of the most remote areas of Ghana bordering Burkina Faso and Togo in the north-Eastern corner. At the time it covered around 1227 square miles of savanna and had a population of about 180,000. There were four local administrative councils and local authority was in the hands of village headmen and the Canton chief. In a poor, isolated rural and agricultural area, the Basel Mission Hospital in Bawku itself was a towering feature of biomedical, 'modern' life. In order to survey the health of the population the mission hospital was as much an asset as the local authorities. They picked up those were dying of smallpox in the 1967 epidemic, such as one three-year old unvaccinated boy who De Sario records as having died on 8 June in Bawku Hospital. The hospital diagnosed him and his mother who, on the day of the boy's death, also contracted smallpox. In order to obtain information about the spread of the epidemic, the Chief of the affected areas had brought it to the attention of the Health Inspector at Bawku through 'the Sanitary Headman'. However, for the Health Inspector to do anything he needed to travel and so had to borrow 'the hospital ambulance, the only means of transport at his disposal' to visit report cases. Information from local headmen was added to by the Regional Medical Officer of Health telegramming and cabling information to the Senior Medical Officer of Health in Accra. It was then De Sario with two US Public Health Service technical advisers who investigated and coordinated the control efforts. Again, this required assistance from the Bawku mission hospital where 'patients were admitted in the isolation ward…and treated there'. Overall there were 2708 contacts of cases but because of lack of transport and staff surveillance was 'impossible'. Local health staff and itinerant Rural Health Services had vaccinated 16,877 people at the point De Sario arrived, these were surveyed in markets, schools and on roads. Vaccination of primary contacts was, De Sario, concluded the primary factor in 'abruptly terminating the spread'. Thus, they also disinfected the hospital wards as well as local huts and compounds; however, this did not seem to do much.[586] Crucially, the rapid first response was most significant in containing the spread and that relied on help from local authorities, health inspectors and the mission hospital, before international health officials even arrived.

The very last cases and epidemics of smallpox in Ghana were in 1968, its success in the mid-1960s had global consequences for smallpox eradication and for Frank Grant. By 1968 and in continued vaccinations into the 1970s, the layered coordination of MFUs, USAID, the CDC, the WHO, local authorities, the Ghanaian health ministry and medical missions completed its eradication. When Grant wrote to the WHO Expert Committee in 1964 arguing that an eradication programme be implemented he claimed that total coverage could be finished within five years and 'satisfy all WHO requirements'. He was right. He noted that the 75 hospitals and 46 health centres in the country were strategically located in different regions, this

[586] V. de Sario (Epidemiological Division, Ministry of Health, Ghana), 'Field Investigation of an Outbreak of Smallpox at Bawku, Ghana: May-October 1967' *World Health Organisation* (Archived at WHO Library 19th September 1969) p. 1-10.

combined with rapid development of roads, meant that a fairly speedy eradication process was possible.[587] In Ghana there were smallpox notifications of 99 in 1959, 139 in 1960, 70 in 1961 and 135 in 1962. Up to this point, since 1951, over half a million vaccinations had been completed annually by the MFUs but they had not managed to cover most regions. In the Yaws campaign, UNICEF had provided vehicles for them to use, he added, as well as having some bicycles and motorbikes. 1967 was the last year of smallpox endemicity in Ghana.[588] By 1968 there were still 144 cases of smallpox reported and in 1968 there were 26 (this was probably higher as epidemiological information on the 1968 outbreak was not available). However, from 1969 onwards there were zero smallpox cases reported to the Senior Medical Officer of Communicable Diseases in Ghana. Vaccinations proceeded apace with 1,282,550 in 1967, 1,984,308 in 1968, 2, 033, 128 in 1969, 1,916,342 in 1970 and 1,217,357 in 1971. This then reduced to 647,613 in 1972, 354,904 in 1973, and higher with 1,037,130 in 1974. Nevertheless, the pattern up to 1971 at least was about a doubling of vaccination efforts from the previous fifteen years. By 1975 there were 57 teams of MFUs working in a system of 110 Hospitals, 54 urban health centres and 68 health posts.[589] In 1977, smallpox was declared eradicated in Ghana. The effectiveness of the smallpox campaign in Ghana also had wider consequences. According to Bhattacharya, the successes in Western Africa in the mid-1960s led to the profile of the fight against smallpox being raised in US administrative circles. To make the campaign global it was then extended to India, Pakistan and Bangladesh.[590] As well as Sudan, Burma and Nigeria, Frank Grant himself, now with personal WHO backing on the Smallpox expert committee, traveled to India to continue the eradication efforts.[591]

Measles was also widely vaccinated and decreasing in incidence in the late 1960s after the campaign began fully in 1967, but suffered setbacks in the 1970s. Large swathes of children in Ghana were vaccinated in the late 1960s and early 1970s, but after 1971 the numbers of cases began to rise again. During the Smallpox/Measles program, between 1967 and 1970 there were 7.3 million smallpox inoculations and 2

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[587] F. C. Grant, 'Smallpox Eradication in Ghana' *World Health Organisation* (1964)

[588] F. Fenner, D. A. Henderson, I. Arita, Z. Jezek and I. D. Ladnyi, *Smallpox and Its Eradication* (Geneva: World Health Organisation, 1988) p.1083.

[589] K. Ward-Brew, 'Ghana/medical officer at present responsible for smallpox eradication' *World Health Organisation* (1975).

[590] S. Bhattacharya, 'International Health and the Limits of its Global Influence: Bhutan and the Worldwide Smallpox Eradication Programme' *Medical History* 57.4 (October 2013) pp.461-462.

[591] Grant continued to work with USAID and WHO on Onchocerciasis, as well as on the Expanded Programme on Immunization (EPI) and many other projects. According to Fenner's volume on SEP, Grant was the WHO smallpox eradication consultant for Burma in 1970 and from 1965 had assisted I. Arita in Burma, Afghanistan, Mali and Nigeria, as well as working on the national programme in Ghana; Memorial and Thanksgiving Service for the Late Dr. Francis Grant (Funeral Brochure, 2002) pp.7-8, Personal Archives of the Family of F. C. Grant (Accra, Ghana); F. Fenner, D. A. Henderson, I. Arita, Z. Jezek and I. D. Ladnyi, *Smallpox and Its Eradication* (Geneva: World Health Organisation, 1988) pp.408, 432,

million measles immunisations.[592] Between 1971 and 1973, 1,276,643 one to four year olds were vaccinated against measles. In 1970 there were only 45843 cases of measles with 200 deaths but the same statistics show an increase to 94567 and 361 deaths in 1971 and 95529 with 273 deaths in 1972. These were not confined largely to the Upper Regions as the MFU surveys had suggested but were spread across Ghana.[593] Whilst this may be because of better recording, another set of data from a different source corroborates some similar rises. The rise itself, rather than the overall numbers may be more telling of an actual increase in incidence. The other set of date shows that 1971 there were 90223 cases of measles with 338 deaths, this rose to 95529 in 1972 with 273 deaths and 94918 in 1973 with 290 deaths. In the first three months of 1974, 36000 cases of measles were reported, this was 50 per cent more than the same period in 1972 and ten per cent more than that in 1973. By 1975 measles cases had risen to 140,821 with 384 deaths and in 1976 it was at 131,405 with 439, in contrast to only 275 and 313 acute polio cases in each respective year. Most of these were in children under 5, a study on the Greater Accra region from 1970 to 1972 of 26334 cases showed that 85 per cent of all cases were under 5.[594] By 1977, the Ghana Health Assessment Project placed malaria first in terms of disease burden and measles second. Between 1973 and 1982, Korle Bu recorded that 8.8 per cent of paediatric admissions were due to measles. Moreover, whilst measles was part of the Expanded Program of Immunization, in 1985 there was an epidemic with 64,557 cases. Measles was brought under some control, dropping back to 81, 788 in 1979 and only 31470 cases in 1981, returning to 79184 cases in 1982.[595] In general vaccination coverage was still low until 1993.[596] As the articles written by Ghanaian health workers at the time often showed, severe malnutrition and kwashiorkor occurred following these measles attacks.

Grant's attempt to tackle measles in Ghana by vaccination was not particularly successful long-term, though smallpox was eradicated. It is hard to know exactly why measles was not controlled given the effective programme tying it to smallpox eradication with the support of the CDC, USAID and the WHO. Part of the problem was redeployment of MFU units to other emergencies such as the September 1970-71

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[592] D. Newberry to E. G. Beausoleil, 'Memorandum: A Review of the Plan "A Primary Health Care Strategy for Ghan" and Recommendations for the Medical Field Unit Participation' (2 August 1978) I8/370/2GHA/R58, World Health Organisation Archives (Geneva, Switzerland).

[593] J. M. Blankson and Y. Asirifi, 'Measles and its problems as seen in Ghana' Health Service Planning, *Ghana Medical Journal* (June 1974) pp.134-140.

[594] 'Measles' 45 Weekly Epidemiological Rec. (8 Nov 1974) p.376 based on *The Ghana Monthly Epidemiological Bulletin* (May 1974).

[595]Annex 1 'Morbidity and Mortality in Ghana, 1978-1982' in 'Programme for Production of Vaccines in Africa: UC/RAF/83/088' (Ghana, 5th-15th May, 1984) I8/370/2GHA/R84, World Health Organisation Archives (Geneva, Switzerland); Annex II 'Cases and Deaths of Selected Communicable Diseases in Ghana, 1972-1981' in 'Programme for Production of Vaccines in Africa: UC/RAF/83/088' (Ghana, 5th-15th May, 1984) I8/370/2GHA/R84, World Health Organisation Archives (Geneva, Switzerland).

[596] W. K. Bosu, M. Essel-Ahun, S. Adjei and P. Strebel, 'Progress in the Control of Measles in Ghana, 1980–2000' *The Journal of Infectious Diseases* 187(Suppl 1) (2003) pp.S44-S45.

cholera outbreak, which broke up vaccine cycles. Unlike smallpox which could be eradicated with the surveillance and containment strategy, measles needed high coverage with a fully potent vaccine. Educational campaigns nationally also struggled because of lack of resources and staff. Another issue was also probably the increasingly realisation of the scale of the problem once surveys had been completed. It was found that measles was present continuously rather than in separate cycles as in England.[597] Moreover, given that colonial surveys had not recognised how much measles there was, combined with local assumptions about the normality of its prevalence in early childhood, meant that the battle against it was far harder than with yaws or smallpox which had been widely known. Colonial neglect of the disease meant that beginning the programme from scratch, even with the boost of placing it in tandem with smallpox eradication, was over-ambitious. This was probably a product of the extractive nature of the colonial state in the Northern Territories where measles was perhaps, as the MFUs had originally estimated, highest in the Upper regions. It was only when the nation-state fully incorporated the North into the development agenda and infrastructure that measles was given the place it desired. Geographies of neglect and extraction in colonial Gold Coast had long term consequences for inequality and high measles incidence in postcolonial Ghana.[598]

In the Ghanaian medical culture of the Yaws campaign, the neglected disease of measles and internationally backed smallpox eradication - Ghanaian Christianity and Christian missions figured influentially - but not in ways that were discontinuous with the past. Ultimately international health planning was one of the disappointments of a postcolonial development era that looked very much like the colonial development era; however, in this continuity was also success. The 1960s were the high point for WHO and USAID health planning in Africa, when postcolonial African national contexts were seen as ideal for international development programmes through national government strategies. In Ghana there had already been health planning in the first development agenda inaugurated in 1951 under the colonial state and Nkrumah as leader of government business. This had widened the scope and reach of MFUs that were ultimately responsible for SEP, it also, as chapter 2 has shown, ensured the growth of medical mission. The second development plan in Ghana began in 1959, ensured the further expansion of healthcare, particularly in the South, with the North to be focused on with the MFUs. This was added to with the third development plan in 1963/4. Crucially, where there was increased immunisation and health coverage from WHO-USAID cooperation through national structures in Ghana, it benefited from older colonial networks, identities and organisations such as the MFUs, missions and missionary identities. Specifically with immunisation campaigns, medical missions were a key factor in the effectiveness of international health intervention. For Ghanaian Christians and international health workers like Grant relied on their links to older medical

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[597] J. M. Blankson and Y. Asirifi, 'Measles and its problems as seen in Ghana' Health Service Planning, *Ghana Medical Journal* (June 1974) pp.134-140.

[598] On structural inequalities see J. D. Nott, 'Between Famine and Malnutrition: Spatial Aspects of Nutritional Health During Ghana's Long Twentieth Century, c.1898-2000' (Unpublished Doctoral Thesis, University of Leeds, 2016).

missions to execute their agendas. At the same time, that colonial neglect of a disease such as measles, had hangovers for postcolonial attempts to understand and control it.

Finally, Grant's collaborations with USAID did not stop with measles and smallpox but extended to elite medical education - a key concern of the US for influence within Ghana. In provision of high level medical education USAID sought to impose its own vision for development and it used Christian Ghanaian doctors as key contacts. USAID wished to co-opt elite development and ensure its survival amidst the competing priorities of Nkrumah's Ghana. That way they could influence possible fresh leadership away from Nkrumah. The complexities in these negotiations show further how Christianity, political and human development could mix in various ways. It also shows how in spite of political turbulence, the US and Christian Ghanaians continued to find in each other, helpful allies when the medical school was rebuilt after Nkrumah's downfall. Grant's Christian development vision, mimicking his Father's Methodist evangelism and Aggrey's missionary internationalism, was not the same motivation as USAID's narrative of modernization, but their outworking in health programmes and the medical school dovetailed well.[599]

Around 1960-1, the US began to offer funding for a medical school in Nkrumah's Ghana. According to the former medical officer, head of smallpox control and founder of the Gold Branch of the Red Cross, Percy Selwyn-Clarke, by January 1962 the cost with a hospital attached to the medical school, was estimated by the Americans to around 7 and a half million Ghana pounds with annual recurrent costs of around one million Ghana pounds.[600] Long-term, home-grown medical trained Ghanaians were a key ambition to ensure retention of the talent in which the government had invested and to display to the world black skins in the white coats of professional medical modernity.[601] This was as much about national identity as practicality. Thus, as the plans proceeded apace and tensions rose, the medical school hit both on the raw nerve of independent nationalist self-image and American Cold War fears.

The medical school was part of the plans of the US for the use of development aid to 'influence' Ghanaian politics away from drifting to the Soviets. Already by 1960, Nkrumah's socialist leanings were a key concern for American foreign policy makers and diplomats.[602] At its peak, the aid programme from the US was $66

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[599]Again, for the debate on the relation between development, Cold War strategy and US modernization theory see D. C. Engerman, N. Gilman, M. H. Haefele and M. E. Latham, *Staging Growth: Modernization, Development and the Global Cold War* (Amherst and Boston: University of Massachusetts Press, 2003); N. Gilman, *Mandarins of the Future: Modernization Theory in Cold War America* (The John Hopkins University Press, 2003); M. E. Latham, *Modernization as Ideology: American Social Science and "Nation Building" in the Kennedy Era* (Chapel Hill and London: The University of North Carolina Press, 2000).

[600] P. Selwyn-Clarke, 'A Ghana Journey: The Selwyn-Clarke Report' 1.1 *Medical Care* (Lippincott Williams and Wilkins, January-March, 1963) p.60.

[601] Interview with Author, F. Konotey-Ahulu, Harley Street, London (6 November 2016).

[602] 'Annex 1: UK-Ghana Economic and Military Ties' Sanitized Copy, Central Intelligence Agency (CIA) Office of Central Intelligence (18 December 1965) FOIA Policy - 17276 Plot to Overthrow President Kwame Nkrumah, Washington University Archives (Washington DC, USA) p.5; W. H. North interviewed by C. S. Kennedy (The Association for Diplomatic Studies and Training Foreign Affairs Oral History Project Foreign Assistance Series, 18th February, 1993).

million, but had dropped to $3 million by 1966 when the US wished to force Nkrumah out.[603] Still in 1963, with Nkrumah putting pressure on his relations with the West, the US were attempting to steer him back to the fold. In a US government report in 1960-1961, it was stated at the outset that the 'immediate US objective should be to halt the dangerous drift of Ghana toward the Bloc'. In the $37 million Volta project in Ghana, the US aimed to 'use the increased leverage provided by the Volta project to establish a close working relationship, not only with Nkrumah, but also with his younger officials'.[604] For example, even anti-western ministers could learn it to be worth their while to help the US as it could 'assist its friends in the Ghana Government, so that they are in an improved position to make their weight felt in high government and party circles'. In addition the hope was to 'influence the next generation of leaders' by emulating the Bloc and seeking 'out potential leaders' in schools, and 'cultivating them for the time when they may count'.[605]

The medical school was a key feature of this Cold War strategy, by 1963 it became the focus of increasingly tense relations with Nkrumah and how to manage him.[606] In same report as Volta and strategy in Ghana were discussed, the medical school was explained fully, both its motivations and costs. The author of the report explained that: 'Because of Nkrumah's personal interest in the project it is important that the US carry out its commitment to assist Ghana in the establishment of a medical school'. Until 1963 relations

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[603] Bridgewater, 'Ghana at 50: U.S.-Ghana Relations' (Telegram accessed on Wikileaks, released 28 February 2007); This was the fifth in a 'series of scene setter cables focusing on Ghana at 50'.

[604] Ambassador Trimble and R. C. Huffman, cc. Mr Gebelt, 'Proposed Department Position re.PL-480 Program for Ghana' (9 October, 1962) pp.1-2, Admin - Communications, Correspondence with Chief of Mission, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA).

[605] U.S. Programs in Ghana, pp.1-10, esp.7. (1960-1961) 14.A.1 Internal Security Assessment, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA).

[606] Again, for the debate on the relation between development, Cold War strategy and US modernization theory see D. C. Engerman, N. Gilman, M. H. Haefele and M. E. Latham, *Staging Growth: Modernization, Development and the Global Cold War* (Amherst and Boston: University of Massachusetts Press, 2003); N. Gilman, *Mandarins of the Future: Modernization Theory in Cold War America* (The John Hopkins University Press, 2003); M. E. Latham, *Modernization as Ideology: American Social Science and "Nation Building" in the Kennedy Era* (Chapel Hill and London: The University of North Carolina Press, 2000).

ebbed and flowed between optimism, tension, concern and outright hostility.[607] USAID even pushed out the Philadelphia group who wanted to contribute five times as many American personnel over 12 years which would cost $18.2 million in staffing alone.[608] According to one government letter from Oliver L. Troxels, charges d'affaires, to the ambassador, the economic value was minimal and instead USAID was useful a political strategy to gain an 'American presence' in Ghana.[609] However, in October 1963, the President, John F. Kennedy backed the medical school funding but also noted that 'This project also seems to me a particularly good example of why we should not make commitments before we know what they really involved'.[610]

However, 1963 and 1966, the medical school project was terminated and Nkrumah's relationship with the US went from bad to horrendous. Nkrumah feared the CIA and decided that the medical school was a hive of

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[607] Acting Secretary, 'Memorandum for the President, Subject: Relations with Ghana' pp.1-2 14.A.1 Internal Security Assessment, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA); From S. G. Gebelt to Ambassador Trimble, 'Possible Pressure on Government of Ghana' United States Government Memorandum (29 January, 1963) RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca. 1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA); O. L. Troxel Jr. (Counselor of the Embassy) to P. C. Narten (Officer in Charge, Ghanaian Affairs, Department of State, Washington, D.C.), The Foreign Service of the United States of America (Accra, 26 September 1963) POL - Political Affairs and Rel., 1-0 Positive and Negative Factors/Developments in Ghana, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA); SODEFRA were a French firm who were also building a textile mill in Tanzania: S. Adejumobi and A. O. Olukoshi, *The African Union and New Strategies for Development in Africa* (New York: Cambria Press, 2008) p.190.

[608] P. C. Narten to Ambassador Trimble, 'Medical School for Ghana: United States Government Memorandum' (1 Aug, 1963) POL - Political Affairs and Rel., 1-0 Positive and Negative Factors/Developments in Ghana, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA); W. C. Trimble and Mr Tasca, Medical School in Ghana (19 July 1963) pp.1-2 POL - Political Affairs and Rel., 1-0 Positive and Negative Factors/ Developments in Ghana, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA).

[609] O. L. Troxel (Charges d'Affaires) to W. C. Trimble (Department of State, Washington, D.C.)'Country Assistance Program Book' (18 November, 1963) Admin - Communications, Correspondence with Chief of Mission, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA).

[610] J. F. Kennedy (The White House, Washington, D.C.), 'Memorandum for D. E. Bell, Administrator for the Agency for International Development' (8 October, 1963) Health and Medical Care HLTH 9 Medical Education and Training RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA); W.C. Trimble to Mr Tasca, 'Trial of the Accused Ghanaian Cabinet Ministers' United States Government Memorandum (12 March 1963) pp.1-5 RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II, Maryland, USA).

their activity and was being used as a way of spying on him.[611] As a letter from G. Mennen Williams to the Assistant Secretary of the State Department put it in April 1963:

> We know that Nkrumah believes that the CIA had been actively plotting against him. Given his suspicious nature and tendency to reach emotionally, he may conceivably regard Negro American employees of our Government in Ghana as actual or potential CIA agents.[612]

Whilst the medical school was formally instituted in 1964, its foreign personnel and support was cut off. Even before Nkrumah kicked them out, Oliver Troxels, now counselor of the embassy, wrote in October 1963 to the Phillip Narten, officer in charge of Ghanaian affairs, in Washington that:

> Ghana has evolved under Nkrumah toward an increasingly unpopular dictatorship of the far left, to the point where we are unlikely to be able to exert any significant constructive influence and where it would be contrary to our long-term interest to be identified with the regime. At minimum we would withdraw from projects marginal to our interest as quickly as possible.

Within the next couple of years, the US would reduce aid to a bare minimum and rumours still abound as to the extent of their involvement in the coup against him in 1966. General Ankrah, who took over the armed forces after Nkrumah, had been in contact with the FBI regularly in the previous year.[613]

After Nkrumah had been ousted in 1966, USAID found alternative routes to helping form the medical school, this built on the work of long-term contacts like Frank Grant and Fred Sai. When in June 1964 the US sponsorship of the medical school was withdrawn, Frank Grant and Fred Sai continued the effort with other notable Ghanaian medics such as Dr Easmon, to continue the process of establishment.[614] Whilst

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[611] What is certain is that the state department was doing psychological assessments of Nkrumah; L. C. Beck to W. C. Trimble, 'Transmittal of Psychological Study of Kwame Nkrumah' United States Government Memorandum (27 November, 1963): 'Kwame Nkrumah Assessment Supplement: Juju' in Kwame Nkrumah: A Psychological Study (June 1962) POL 17, Diplomatic and Consular Representation, Ghana Ambassador: RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II (Maryland, USA).

[612] G. Mennen Williams to The Secretary, 'Steps to be Taken in Regard to the Recent Attacks Against American Negros in the Ghanaian Press - Approval Requested' Department of State Assistant Secretary (18 April 1963) RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 3112A, Records relating to Ghana, United States National Archives II, Maryland, USA).

[613] Federal Bureau of Investigation, U.S. Department of State, Communications Section, Urgent to Director 12 from New York 2P 'Proposed Assassination of Kwame Nkrumah' (11 June 1965) FOIA Policy - 17276 Plot to Overthrow President Kwame Nkrumah, George Washington University Archives, Washington D.C) ; Memorandum for Deputy Director of Central Intelligence (25 February 1966) FOIA Policy - 17276 Plot to Overthrow President Kwame Nkrumah, George Washington University Archives (Washington D.C., USA).

[614] Memorial and Thanksgiving Service for the Late Dr. Francis Grant (Funeral Brochure, 2002) pp.6-37, Personal Archives of the Family of F. C. Grant (Accra, Ghana).

Nkrumah's reputation had deteriorated, Grant, Sai and other key medics were able to continue networking internationally, unhindered by ideological agendas. Quickly after Nkrumah had gone, the medical school was taken up again by USAID.[615] USAID restored its close relationship with the medical school and had returned to being the point of contact for international staffing. In June 1969, the Ghanaian Times declared triumphantly that 34 doctors trained in the Ghana medical school had passed.[616] As with measles and smallpox, the concerns of local Ghanaian doctors, especially Ghanaian Christian doctors, facilitated international health programmes in spite of problems and political blockages in national infrastructure.

ii. FAMINE AND FOOD RELIEF: PL-480, USAID AND CATHOLIC MEDICAL MISSION

It was not only Africanising Ghanaian doctors but also new streams of medical mission funding that were linking to and shaping international health. Building on chapter 4, this section will show how Catholic medical mission became a key actor within this health landscape. In the context of the postwar expansion of Catholic internationalism and the incorporation of Catholicism into the American political mainstream in the early 1960s, USAID made strong links with Catholic medical mission networks in Ghana. It was not only immunisation but also in food aid in which USAID utilised missionary contacts. USAID funded Catholic and Protestant aid networks extensively to maintain and expand their role in Ghana amidst political turbulence. From 1959 onwards the Catholic Relief Services (CRS) in Ghana had been conducting a food programme with USAID, derived from the 'food for peace' programme Public Law 480 (PL-480). The CRS was a US Catholic aid organisation which was founded in 1943 but reformulated from the 1950s in line with the growth of the European Catholic groups such as MEMISA and Misereor.[617] PL-480 in many cases was the sale of cheap food, mainly wheat, which resulted in the stockpiling of huge funds used by the US government in a variety of ways. For example, in India some of that money was given to anti-malaria work, green revolution work and smallpox eradication because of the lack of WHO money.[618] As Nick Cullather has shown, Title I and III of food aid in Asia created a 'crucial source of investment in the industrial sector',

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[615] E. Gilliatt to File, 'Aid to the Ghana Medical School (University of Ghana) (Meeting of Mr. Ghebo, Registrar of the Medical School, Mr F. E. Gilbert and Miss Elinor Gilliatt on Monday, 12 August 1968 at Mr Ghebo's Office at Korle Bu' Memorandum (14 August 1968) FY69 Ghana Medical School, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 5179, Records relating to Ghana 1964-1975, United States National Archives II (Maryland, USA).

[616] '34 Ghana Trained Doctors Pass Out' *The Ghanaian Times* (27 June 1969) p.1, FY69 Ghana Medical School, RG0059, Department of State, Bureau of African Affairs, Office of the West African Affairs, ca.1960-1985, Entry# A1 5179, Records relating to Ghana 1964-1975, United States National Archives II (Maryland, USA).

[617] W. Bruchhausen, 'From Charity to Development: Christian International Health Organizations, 1945-1978' *Hygiea Internationalis: An Interdisciplinary Journal for the History of Public Health* 13.1 (December 2016) pp.117-118.

[618] S. Bhattacharya, 'Global and Local Histories of Medicine: Interpretative Challenges and Future Possibilities' in M. Jackson (ed.) *A Global History of Medicine* (Oxford: Oxford University Press, 2018) pp.258-259.

up to $400 million a year in India, whereas in Africa it was given for emergency relief.[619] In Ghana, PL-480 provided food commodities distributed through the CRS. After 1980 the US also funded the government of Ghana to produce a PL-480 programme more similar to that in India, with attendant development work using the revenue. This later phase of PL-480 after 1980 in Ghana added a supply of $12.7 million worth of wheat, corn and rice, funded by a loan. Under the programme the US gave a loan which was used to buy food from the US and any proceeds from the sale of those commodities was then put into a counterpart fund in Ghana which funded irrigation projects and the improvement of farm facilities. This amounted to around 85 million cedis giving the US a 68% share of this counterpart fund and a dominant role.[620]

Andrew Preston's *Sword of the Spirit, Shield of Faith* published in 2012 shows the significance of religion to American war and diplomacy, especially for the Cold War. Preston has built on Odd Arne Westad's thesis that the Cold War should be approached in a pluralist and internationalist way.[621] This is contrary to the restrictive frame of Anders Stephanson in which after 1963 there was not much Cold War of which to speak.[622] By contrast, Preston argues in his contribution to these debates in *Uncertain Empire* (2015) that alongside Westad's many Cold Wars which emerged across the world, historians should also emphasise the greater importance of American religion. Preston writes that: 'The ebb and flow of American religious conceptions does not explain the Cold War writ large; but it does help, in part, to explain one its primary components, American behaviour and motivations'. The resurgence of faith between the 1950s and 1970s fused with the ideological and geopolitical pressures of the postwar world - 'In the Cold War…politics became faith-based and faith became politically based'. Religious liberty, as it had been many times before in American history, returned to the 'heart of American foreign policy' when the Cold War reached its zenith in the late 1950s. However, this did recede in the mid 1960s with Vietnam War, especially as those on the side of the West were recognised to be at least as brutal as Communists in persecuting religious groups.[623]

As part of the greater inclusion of Catholicism in US political culture in the early 1960s, the CRS offered USAID a logistical solution based on global Catholic networks and imaginaries which had previously been held at arms length. Andrew Rotter argues that American Cold War concerns in the late 1940s and 1950s

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[619] N. Cullather, *The Hungry World: America's Cold War Battle Against Poverty in Asia* (Harvard: Harvard University Press, 2010) pp.257-258.

[620] A. Essuman-Johnson, 'Influencing a Country's Political and Economic Decision Making with Food: The Case of Ghana' *Research Review* NS 7.1 and 7.2 (1991) pp.45-60.

[621] A. Preston, *Sword of the Spirit, Shield of Faith: Religion in American War and Diplomacy* (Knopf, Canada: 2012); O. Arne Westad, 'Exploring the Histories of the Cold War: A Pluralist Approach' in J. Isaac and D. Bell, *Uncertain Empire: American History and the Idea of the Cold War* (Oxford University Press, 2012) pp.51-61.

[622] A. Stephanson, 'Cold War, Degree Zero' in J. Isaac and D. Bell, *Uncertain Empire: American History and the Idea of the Cold War* (Oxford University Press, 2012) pp.19-51.

[623] A. Preston, 'The Spirit of Democracy: Religious Liberty and American Anti-Communism during the Cold War' in J. Isaac and D. Bell, *Uncertain Empire: American History and the Idea of the Cold War* (Oxford University Press, 2012) pp.141-164.

'mirrored' American Protestants' worries about secularisation, evil communists and Catholics.[624] However, as Preston shows, from the early 1960s Catholics were incorporated (though still with some controversy) into the mainstream of American political culture, most apparently with JFK's election victory.[625] With this shift was a greater recognition of the potential for American Catholic networks to benefit development aid and foreign policy priorities.

For Ghana, partly as a result of the expansion of West German and Dutch Catholic aid, international Catholic medical mission networks were incorporated into USAID's imaginaries of development and state stabilisation. Through their links to worldwide Catholic mission, the CRS provided USAID with a logistical solution to creating state stability based on a national network of churches and mission clinics. Instead of giving aid directly to the Ghanaian government in order to ensure that it would not slide into communism, with all its attendant dangers, USAID could utilise Catholic networks with Title II. This was not restricted to the 1960s or only to Catholic charities, but more widely to NGOs; however, these would not have had the large networks that CRS had. Cullather shows that the Reagan Administration actually channelled 'a larger share of food aid through Title II of P.L. 480…to Save the Children, CARE and Catholic Relief Services, rather than through Title III to recipient governments…Title II did not generate a counterpart fund for capital projects as grants under title I and III did'.[626] The global Catholic network that directly linked the CRS with Misereor and with Catholic medical mission in Ghana, changed what was functionally and imaginatively possible for USAID development aid. CRS itself had reformulated in line with European Catholic organisational restructuring such as through Misereor and the liberalisations of Vatican II in the mid 1960s (which did not include birth control, it is worth noting).[627] CRS was shaped by changes in global Catholicism and, because of shifts in American political culture, USAID could link to these networks.

By late 1960s in several areas there was famine and starvation, CRS and USAID combined to tackle this issue with food aid. As John Nott has shown, as a result of starvation in Arabie and Nankon in 1968, the government pleaded with the Christian Council of Ghana to provide relief. The year before, the Catholic Relief Services had struggled to supply Bolgatanga with food during a famine. Again, as Nott's thesis shows, under Kofi Busia between 1969 and 1971 the food deficit increased, between 1963 and 1971 there had been a 38 per cent loss of food imports and the total output of staple crops had decreased massively. The World Bank showed in the Berg report how between 1969 and 1979 the total production of food and nonfood fell. As Nott argues, malnutrition became epidemic in the South where access was based on status in relation to

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[624] A. Rotter, *Comrades at Odds: Culture and Indo-US Relations, 1947-1964* (Cornell University Press, 2000) p.234.

[625] As Preston puts it: 'It is no small irony that one of the least religious presidents should have been the agent of such profound religious change'; A. Preston, *Sword of the Spirit, Shield of Faith: Religion in American War and Diplomacy* (Knopf, Canada: 2012) pp.502-503.

[626] N. Cullather, *The Hungry World: America's Cold War Battle Against Poverty in Asia* (Harvard: Harvard University Press, 2010) p.257.

[627] W. Bruchhausen, 'From Charity to Development: Christian International Health Organizations, 1945-1978' *Hygiea Internationalis: An Interdisciplinary Journal for the History of Public Health* 13.1 (December 2016) pp.117-134.

the cash economy, and hunger returned viciously to the North which had been systematically detached from the extractive colonial economy in which the Northern Territories functioned mostly as a labour reservoir. Political instability, corruption and environmental issues were exacerbated by long-term 'structural declines in nutrition security' relating to crop transition, the loss of precolonial social securities and the market dependency of the poor.[628] As the previous section has shown, measles can be added into this cocktail of malnutrition and related diseases. As the state decreased its capacity to provide services across the 1970s, the CRS saw increased attendance at its welfare clinics in tandem with nutrient provision.

The food commodities provided by PL480 came from the US Agricultural Trade Development and Assistance Act and were way of dealing with US food surplus as well as bolstering their international agendas. With the CRS, which were monitoring the nutritional status of Ghanaian children (for example, mapping a decline in nutritional status at their child welfare clinics in the early 1980s), USAID had a ready and analytical network for distributing aid in a context of severe deprivation.[629] All this was used to shape Ghanaian society; for example under Nkrumah they had withdrawn the aid. Title I was seen as an effective means of shaping political change within Ghana. In one USAID report from 1979 on Title 1 PL-480 they described how:

> One of the quickest and most appropriate ways to assist the GCG (Ghanaian Government) in implementing difficult policy changes of the stabilisation plan is through P. L. 480 Title 1.USAID's endorsement had been withheld for Title 1 programs in the recent past because it would have supported the government's country developmental politicals. Now that the new Ghana government is committed to establishing a more development-oriented policy framework, U.S. objections have been withdrawn and a sizeable initial P. L. 480 has been approved.

Through the CRS and then the Government of Ghana, USAID could influence the government when they wanted to. As with the medical school, but here through the CRS, PL-480 was envisioned as a way of manipulating governments and stabilising regimes, whilst also dealing with excess food stocks within the US. As one report on Title I explained, stabilisation through PL-480 would be successful by attacking inflation from the supply side 'in support of tough demand management' and increasing the supply of consumer goods in order to reduce social strain.[630]

Aid to the CRS could also be a way of bypassing the government when it did not act in accordance with USAID direction. The overall effect of PL480 across the 1970s was to help the 'most nutritionally vulnerable

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[628] J. D. Nott, 'Between Famine and Malnutrition: Spatial Aspects of Nutritional Health During Ghana's Long Twentieth Century, c.1898-2000' (Unpublished Doctoral Thesis, University of Leeds, 2016) pp.186-187, 265-270.

[629] J. D. Nott, 'Between Famine and Malnutrition: Spatial Aspects of Nutritional Health During Ghana's Long Twentieth Century, c.1898-2000' (Unpublished Doctoral Thesis, University of Leeds, 2016) p.283.

[630] FFPO W. M. Carter, P.L. 480 Title 1 (19 January 1979) pp.1-5, RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

groups' who were pregnant and lactating women, and children under five years old. As well as CRS and WFP, USAID also aimed to complement MIDAS and DRUHS work too.[631] By 1971, USAID were proposing giving a $20 million dollar loan to the Ghanaian government for economic development.[632] The next year, in 1972, the US Department of State suspended approval of aid programmes on account of the new regime that seized power in Ghana abrogating existing debt arrangements.[633] That same year in 1972 USAID gave $1,039,000 to CRS and $238,000 Church World Service for food programmes and maternal and child health. They were spreading their funding carefully and strategically depending on responsiveness to their agendas. In 1973 and 1974 respectively the Church World Service received $203,000, and the CRS funding was raised to $1,554,000 and then $1,543,000.[634] P. L. 480, the food and material aid program, by the beginning of the 1980s was giving between $15 and $20 million annually to Ghana. When relations with government were problematic, USAID took away funding; yet, through Christian medical and aid missions, they continued to impose their agenda on the country by sustaining funding.

Up to 1980, unlike in India, the main PL-480 programme had directly distributed food commodities free of charge through the CRS, using all denominations of missionary networks, Catholic, Protestant and Pentecostal, and government help. One of the consequences of Vatican II was more ecumenical work under Pope John XXIII's encouragement.[635] In Ghana the CRS was notable in using Catholic mission networks, and Evangelical and Pentecostal churches. CRS also worked with Government of Ghana agencies but only for help with transport and the ports, and this proved to be problematic with great losses of food in the ports. By 1983, the CRS in Ghana directly managed a network of 24 hospitals, 15 stationary clinics, 10 mobile clinics, 2 orthopaedic centres 2 primary health care projects and 2 family health care projects. This totalled around 400,000 in patients and 2.5 million outpatients annually.[636] In 1965, the US began supporting this food aid work, giving around a million dollars in support. In 1966 after Nkrumah fell this rocketed to around

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631 FFPO W. M. Carter, P.L. 480 Title 1 (19 January 1979) p.5, RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

632 Points Regarding Ghana's Economic Development: Ghana's Performance, J.D.S. Tempel (3rd December, 1971) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 347, Subject Files: 1969-1974, United States National Archives II (Maryland, USA).

633 Talking Points Concerning Ghanaian Repudiation of Selected Suppliers Credits p.2, FN 14 Ghana Debt (debt rescheduling) (Jan-Mar) Ghana 1972 (RG 0286 Agency for International Development, USAID Mission to Ghana/ Education, P 347, Subject Files: 1969-1974, United States National Archives II (Maryland, USA).

634 Ghana: New Resource Commitments by Area of Concentration Annex B RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 347, Subject Files: 1969-1974, United States National Archives II (Maryland, USA).

635 A. Preston, *Sword of the Spirit, Shield of Faith: Religion in American War and Diplomacy* (Knopf, Canada: 2012) p. 509.

636 K. Ward-Brew to Regional Director, 'AFRO - Memorandum: G-7 Primary Health Care: Catholic Relief Services' (25 August 1983) p.57, 'Economic Assistance to Ghana - Report of the Multi-Agency United Nations Mission to Ghana' G2/27/5/GHA, World Health Organisation Archives (Geneva, Switzerland).

7 million dollars, then reaching 14 million by 1968 and peaking at around 19 million dollars in 1968 - it would not be higher than this again until the mid-1980s - see Figure 1. In 1977 alone the amount had reach 9857 metric tons of food, worth about $3.9 million, distributed to 202,000 recipients. In 1978 aid rose again to $4.7 million worth of food to around 220,000 people. Through their cross country network of maternal and child health clinics, pre-schools and food for work programmes they were managing to get food from ports to over 400 feeding points. Added to all this was around $3 million of commodity losses, which amounted to around 38.6 per cent of the programme.[637]

By the end of the 1970s, USAID was effectively using the CRS to distribute huge amounts of 'emergency' food relief, but this was not without its problems. According to a USAID report, the Catholic Relief Services PL-480 Title II program in Ghana was directed toward 'maternal and child health, pre school feeding, food for work and school feeding'. These activities were 'designed and managed by Catholic Relief Services' but 'implemented in the field by many organizations including Missionaries and Government of Ghana agencies'. The CRS monitored the feeding programme, the Government of Ghana arranged port handling and transfer from the port, and USAID managed the process and donated the food. The CRS also sold the food packaging, for $43,800 in 1977, in order to produce funds for supporting distribution. During 1977 overall, USAID reported that the US Government had delivered 19,386 tons of food to the Catholic Relief Services 'for distribution throughout Ghana', this was duty free and exempt from taxation; moreover, the government of Ghana paid for the transportation. In the same report, USAID were increasingly angry at the CRS because $3 million of missing food commodities. In 1977, around 20 percent of the food shipped to Ghana was lost - 3908 tons valued at $1,589,400 in the port and port shortage. In 1977 they heavily criticised the CRS for 'very poorly managed' food distribution given the huge losses suffered. USAID proposed to charge them for any of the commodities not reclaimed and to terminate the programme unless there was significant change.[638] Without insurance CRS had to bear the losses.[639] In another smaller scale case, USAID found that CRS food was being sold in Achimota markets and so supplies to Achimota chaplaincy were immediately suspended.[640] In another case, food distributed at the Catholic mission at Walewale was deemed

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[637] U.S. Agency for International Development, 'Report of the Re-Examination of the Catholic Relief Service P. L. 480 Title II, Food Program in Ghana' (7 July 1978) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives, Maryland).

[638] U.S. Agency for International Development, 'Report of the Re-Examination of the Catholic Relief Service P. L. 480 Title II, Food Program in Ghana' (7 July 1978) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II, Maryland).

[639] FFPO: W. M. Carter (Food For Peace Officer) to Rev. W. M. Campbell (Program Director, Catholic Relief Services), 'Determination of the Value of Claims on P. L. 480 Title II Commodities' (24 January 1979) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

[640] W. Rastetter to Rev. J. T. Addy, 'Suspension of Food Program' (14 August 1978) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II, Maryland).

not fit for human consumption, similar issues with found at the Assemblies of God missions at Nasia and Tanga in 1980.[641]

The CRS did benefit from its mission network in improving management and capacity, but the scale of need dogged the organisation. The issue with losses and stealing was not permanent and the CRS managed to improve commodity accountability after an audit and also pursued loss claims against the government of Ghana for loss at the ports (though USAID noted firmly that this did not absolve the CRS).[642] In 1979 USAID gave $4 million worth of food commodities to the CRS reaching 250,000 people, again through maternal and child health, school feeding and food for work programs.[643] However, general lack of administrative capacity meant that the CRS could not supply 'nutritionally vulnerable groups' with significant short term aid.[644] This was not restricted to the North; in 1979 the CRS director wrote to USAID to explain that there issues with food distribution in Bolgatanga were actually more widespread:

> The problem at Bolgatanga Assemblies of God Mission is of country-wide in our program. Due to source of limitation on our School Feeding category, we programmed this centre for 400 recipients, but unfortunately 1500 recipients are being supported with the Title II food.

This statement also again emphasises that the CRS used Pentecostal (such as mentioned at Nasia) missions as well as Catholic ones to provide food. The mission network was not the issue, the problem was lack of CRS management itself, it was actually from the mission network that the CRS were building itself management. For example, in the same letter, the Director explained that the Rev. Father John at Tamale Catholic Mission had just assumed responsibilities over Catholic activities.[645]

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641 S. Sugri to Father-in-Charge, Catholic Mission, Walewale, 'Comments on Foodstuff Inspected at the Catholic Mission at Walewale' (27 July 1979) RG 0286 Agency for International Development, USAID Mission to Ghana/ Education, P 347, Subject Files: 1969-1974, United States National Archives II, Maryland); The Rev. Pastor, Assembly of God Church, Tanga to Ministry of Health, Environmental Health Division, 'Soy-Fortified Sorghum Grits Certificate of Assembly of God Church - Tanga' (29 June 1980) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II, Maryland).

642 U.S. Agency for International Development, 'Report of the Re-Examination of the Catholic Relief Service P. L. 480 Title II, Food Program in Ghana' (7 July 1978) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II, Maryland

643 I. D. Coker (Mission Director) to J. L. S. Abbey (Commissioner for Economic Planning) (18 January, 1979) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II, Maryland).

644 FFPO W. M. Carter, P.L. 480 Title 1 (19 January 1979) p.2, RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

645 Rev. W. M. Campbell (Director) to W. M. Carter (Food For Peace Officer, USAID Mission/Ghana), 'Inspection Reports' (7 March 1979) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

After 1979 USAID also began a further PL-480 programme with the national government and exerted pressure through loans instead. Between 1979 and 1980 USAID began a different PL-480 model funded through the government, supplying loans for food amounting to $12.7 million dollars and creating a stockpile which financed irrigation and farming projects.[646] This was separate from the CRS Title I program because of 'sensitivity of the whole subject' - perhaps relating to what the CRS saw as government failure in their losses in the late 1970s. In 1979, PL-480 was classed by US officials as at the 'top of the list in per annum dollar of resource transfer'. In that year Title I had transferred $10 million, and Title II had transferred 4.5 million to the CRS and 0.8 million to the World Food Programme.[647] Title I, however, was not in food aid not in 'sales by the United States of food grains to Ghana on a concessional basis'.[648] In addition to this was further shipments of food labelled as Title III which directly aimed to influence Ghanaian government policy in coordination with the IMF. As one USAID report put it, Title III could be used to:

> …encourage governments to undertake new policy or reform programs not previously agreed to or instituted. Such new reform should flow from the analysis of the CDSS, the country's development plans and our overall A.I.D. strategy of equitable growth.[649]

In very direct ways Title III was a tool for encouraging the Ghanaian policy in the direction of AID priorities. Specifically Title III (and Title I) aimed to generate the use of 'local currency' and develop 'self-help measures', as well as improving 'nutritional gaps' and the 'basic food deficit'.[650] As well as improving self reliance and the availability of food, Title III also aimed to stabilise price, 'while maintain an incentive to agriculture'. Partly this was based on timing, Title III delivered food at the beginning of the lean season, in order to lower prices for the rural poor and simultaneously incentivise agriculture by providing a grain

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[646] A. Essuman-Johnson, 'Influencing a Country's Political and Economic Decision Making with Food: The Case of Ghana' *Research Review* NS 7.1 and 7.2 (1991) pp.45-60.

[647] FFPO W. M. Carter, 'Memo: Projects Worthy of Visit by U. S. Officials' (18 September 1979) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

[648] FFP W. M. Carter, I. D. Coker (Director) to G. Harley (Commissioner for Transport), 'Priority Berthing for U. S. Food Commodities' (31 August 1979) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

[649] 'Memorandum: USAID Title III' (22 August 1979) p.4, RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

[650] Auditor General, USAID Audit Report 3-641-78-6 'Report on the Examination of the Catholic Relief Services PL 480 Title II Food Program in Ghana' (7 July 1978) RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

security scheme.[651] Overall, after the 1980s these targeted development schemes, from PL-480 revenues, were more in line with those conducted in India - they provided for farming and irrigation projects. They were manipulating supply and demand as well as attempted to construct the ideal liberal Ghanaian citizenry that would help themselves.

Yet, given the heterogeneity of medical mission in Ghana, aid organisations did not only need to use the CRS or Catholic mission, they also could use the Salvation Army, expanding their medical mission work. The World Food Programme, Swiss and Canadian aid work supplied Ghana with milk powder, farming projects and vitamin tablets through the Salvation Army rather than through the CRS in the late 1970s through into the 1980s.[652] In previous food aid nurses at the clinics who distributed food around Begoro also 'instructed the women on how best to use it'.[653] The Salvation Army also gained food and medicine from the Christian World Service (USA) and Oxfam in the 1960s, and World Vision International (USA) in 1970.[654] However, in the late 1970s this grew massively with CIDA (Canadian International Development AID) funding. In 1983, 30 tons of milk powder was flown in by the Canadian air force, in addition to TEARfund providing a lorry for distribution. Moreover, the US and Dutch Salvation Army providing milk, water, penicillin and high protein biscuits. In more sustainable ways, CIDA had also provided funding for a young farmers project to improve nutrition and stop slash-and-burn methods. In the next year, the Salvation Army received more than 300 tons of food, including 200 tons of corn from the World Food Programme, 20 tons of tinned fish from CIDA and 3 tons of milk powder from Switzerland, 25 tons of dried fish powder from Norway and two container loads of food from the Netherlands. This was not directly to bypass the CRS, as the CRS and the Christian Council also supplied the Salvation Army. Yet, it does show that given the heterogeneity of mission, aid organisations could pick and chose where they supplied food aid and through which denominations they did it. In 1983 alone there were 2455 deliveries registered at Salvation Army clinics and 389026 outpatient treatments, large numbers because 'food encourages attendances for antenatal and postnatal care'. The Salvation Army, funded by SIMAVI of the Netherlands, also was helped to build a

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[651] FFPO W. M. Carter, P.L. 480 Title 1 (19 January 1979) pp.1-5, RG 0286 Agency for International Development, USAID Mission to Ghana/Education, P 348, Subject Files: 1978-1985, United States National Archives II (Maryland, USA).

[652] 'Major Mel Bond Asst. Public Relations Officer and Canadian Forces Officer re: Milk Powder Shipment to Ghana' The Salvation Army International Heritage Centre (London, UK); 'Ghana' *The Salvation Army Year Book 1981* (St Albans: Campfield Press, 1981) pp.130-131, The Salvation Army International Heritage Centre (London, UK); 'Ghana' *The Salvation Army Year Book 1982* (St Albans, Campfield Press, 1982) pp.126-127, The Salvation Army International Heritage Centre (London, UK).

[653] 'Ghana' *The Salvation Army Year Book 1963* (London: Salvationist Publishing and Supplies Ltd., 1963) pp.90-91, The Salvation Army International Heritage Centre (London, UK).

[654] 'Ghana' *The Salvation Army Year Book 1970* (London: Salvationist Publishing and Supplies Ltd., 1970) pp.121-123, The Salvation Army International Heritage Centre (London, UK).

nutrition centre at Wiamoase clinic. By the end of 1984 the Salvation Army had treated 450000 outpatients, their role in distributing food aid had allowed their medical mission work to expand.[655]

[655] 'Ghana' *The Salvation Army Year Book 1984* (St Albans, Campfield Press, 1984) pp.118-121, The Salvation Army International Heritage Centre (London, UK); 'Ghana' *The Salvation Army Year Book 1985* (St Albans, Campfield Press, 1985) pp.124-125, The Salvation Army International Heritage Centre (London, UK). 'Ghana' *The Salvation Army Year Book 1986* (St Albans, Campfield Press, 1986) pp.124-125, The Salvation Army International Heritage Centre (London, UK).

Image XII: ‘Major Mel Bond Asst. Public Relations Officer and Canadian Forces Officer re: Milk Powder Shipment to Ghana’ GHA 4, Image Courtesy of The Salvation Army International Heritage Centre (London, UK)

Image XIII: Receiving Milk Powder Shipment to Ghana, GHA 4, Image Courtesy of The Salvation Army International Heritage Centre (London, UK)

It was not only through missions, but also from missions, that food aid was being donated. In 1983 the Danish church gave $146,975 in food relief, and the Seventh-Day Adventist fed 1000 people and gave medicine costing $107,000. World Vision International, the Christian aid organisation, also supplied $235,000 worth of relief supplies. The Holy See also gave $10,000. In this missions and churches were linking into a wider international effort, with Sweden giving $1,035,879 in food and relief, UNICEF donating 227 tonnes of medicine ($177,247) as well as food items totalling $1,012,300. As usual West Germany and the Netherlands gave large amounts: the Germans donated $819,234 in food and relief and the Dutch provided the highest total amount of all organisations and nations with separate donations of $2,036,586 and $2,036,386. There was a spread of other nations also donating, with the third highest being Italy who donated $3,757,500. This was vital given that even the £100,000,000 loan the government had obtained from a commercial bank and the $40,000,000 requested from the World Bank for a general import credit was still recorded as not having been enough to deal with the ensuing crisis. This was unsurprising given that estimates at the time were of around 900,000 to 1.2 million people, mainly young men, entering the country and increasing the population by around 10 per cent.[656] In this context missions were only one element in a patchwork international response to the chaos.

Outside of the crisis, nutrition generally worsened through the late 1970s and early 1980s, even after structural adjustment and this period of intense foreign aid, it continued to decline. As so often is the case, the targeted emergency response to the famine was discontinued once 'normal' circumstances had resumed. Though PL480 food aid generally did increase in across the 1980s, according to records kept by CHAG between:

> …1975 and 1979 39% of children aged 12-23 months suffered from acute malnutrition, i.e. weight for age roughly less than 77% of the standard (WHO). This percentage is higher now due to the drought, bush fires and worsening economy. In 1980 the average index of food production per capita stood at 74 in comparison 100 in 1969-71. The daily per capita calorie intake was 88% of the requirements (FAO).[657]

As Nott shows nutritional status declined across Ghana in the late 1970s and early 1980s, and in rural Asante kwashiokor was a major concern. After Flight Lt. Jerry Rawlings first revolution in 1979, markets declined and went into almost complete collapse on the even of structural adjustment in 1983; this was dangerous especially for those who relied upon bought food. Up 1983 political instability combined with food

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[656] Annex 1, 'Emergency Assistance', K. Ward-Brew to Regional Director, 'AFRO - Memorandum: G-7 Primary Health Care: Catholic Relief Services' (25 August 1983) pp.25, 66-67, 'Economic Assistance to Ghana - Report of the Multi-Agency United Nations Mission to Ghana' G2/27/5/GHA, World Health Organisation Archives (Geneva, Switzerland).

[657] 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) pp.6-7, Annexes I-III, SOAS Library and Archives (London, UK).

insecurity to produce 'epidemic malnutrition'.[658] After 1983 malnutrition did endure and inequality grew, though the CRS did detect a return to the 1980 level by 1986. Generally however, there was still malnutrition with 64 per cent of children underweight in the North and 48 per cent in the South. Food aid could not keep up with the social effects of neoliberal reforms, however much they improved macroeconomic growth. As with measles, malnutrition remained divided along North-South lines, and again limited what foreign intervention could do. There was certainly some impact but again generally the colonial geographies of neglect and extraction continued to determine the shape and depth of malnutrition and famine in 1980s.[659]

[658] J. D. Nott, 'Between Famine and Malnutrition: Spatial Aspects of Nutritional Health During Ghana's Long Twentieth Century, c.1898-2000' (Unpublished Doctoral Thesis, University of Leeds, 2016) pp.190-200

[659] J. D. Nott, 'Between Famine and Malnutrition: Spatial Aspects of Nutritional Health During Ghana's Long Twentieth Century, c.1898-2000' (Unpublished Doctoral Thesis, University of Leeds, 2016) pp.226, 238.

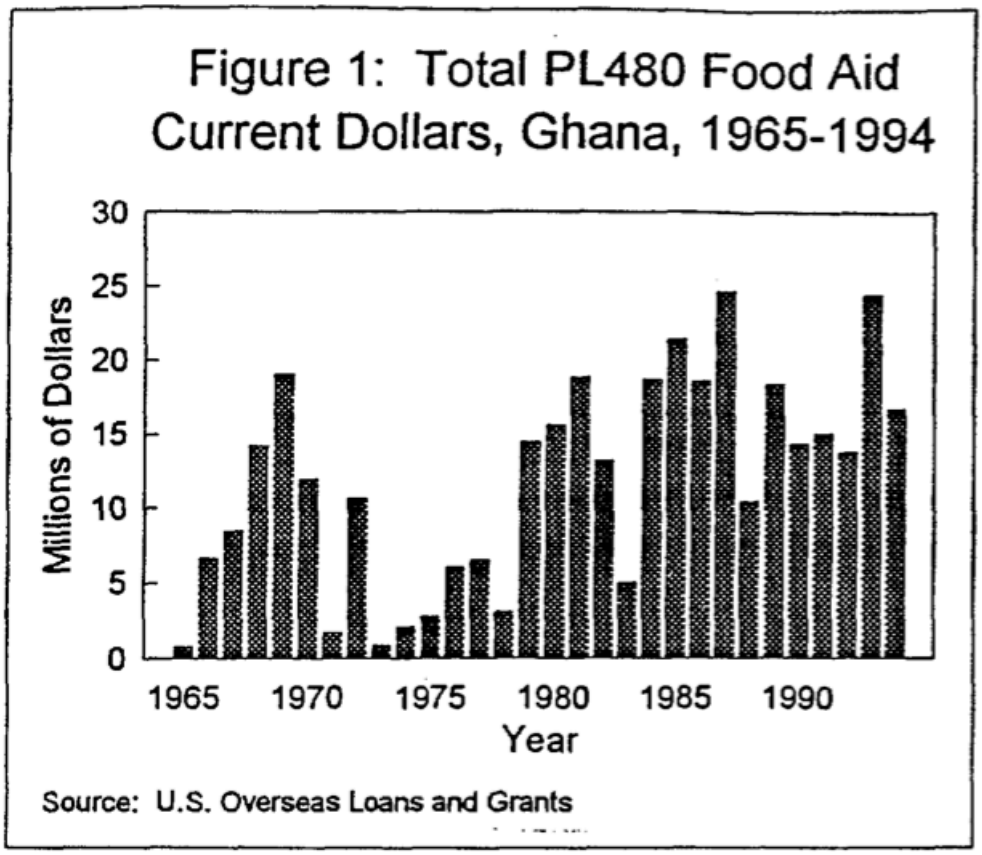

Figure I: J. Lieberson, B. Riley, M. Pillsbury and T. Cook, USAID Working Paper No.225 Center for Development Information and Evaluation: The United States Food Aid Program, Ghana Study (November 1996) p.36.

iii. CONCLUSION

As Warwick Anderson has argued a 'postcolonial approach' to health histories means recognising how 'modern science and biomedicine are put together, assembled, on the terrain that various sorts of colonialism have worked over'. Anderson contends that 'biomedicine is constitutively colonial: that it derives from colonial practices, becomes a means of managing the colonial aftermath, and functions always in a multiply contested contact zone'.[660] The history of international health in Ghana shows how complex, constructed and contingent networks negotiated and exchanged within specific contexts. This chapter has shown that long-term colonial geographies of extraction, neglect and structures of medical mission were key factors in what international health and development aid could do in postcolonial Ghana.

It was not only in the Ghana Smallpox and Measles Programme but across the 1950s to the 1980s, that mission and Christian connections were central to the strategies of US medical aid in Ghana. The effect of missions on USAID was, however, divergent between programmes and particularly organisations. Whilst Frank Grant used international health priorities to conduct measles vaccinations which he considered to be more important, the CRS opened up a global Catholic network and imaginary which shaped the way in which USAID used PL-480. For Grant, this work was related to long-term identities linked to Africanisation, evangelism and structural inequality. For USAID, with Cold War concerns, influencing and shaping an incredibly turbulent Ghanaian politics, needed the navigation of various missionaries, Christian Ghanaian and Christian aid organisations, especially when the national government was hostile. Success in these protracted non-governmental relations with Christian groups, enabled USAID to have a complex set of tools and levers for managing the Ghanaian state and Ghanaian healthcare. The Salvation Army was also a key actor in this landscape, acting as a hub for large scale foreign aid in the famines of the early 1980s. Catholic mission may have dominated but it was certainly not the only feature of Ghana's landscape of medical mission which international health organisations could utilise.

Within a larger shift in American political culture toward the incorporation of Catholicism in the early 1960s, global Catholic networks were becoming a more significant actor within US development work. As Misereor and MEMISA helped to expand Catholic medical mission across Ghana, through the CRS USAID linked into this network and used for their programmes. Whilst the postwar growth of Catholic medical mission was driven by West German and Dutch development narratives of restoration and claims to humanitarianism and suffering, it also figured in Cold War conflict through connections to the CRS and

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[660] W. Anderson, 'Introduction: Postcolonial Technoscience' 32.5-6 *Social Studies of Science* (Sage Publications Ltd., October–December 2002) pp.643-658; M. L. Pratt, Imperial Eyes: Travel Writing and Transculturation (London and New York: Routledge, 2008) p.7; G. M. Joseph, 'Close encounters: toward a new cultural history of U.S.–Latin American relations', in G. M. Joseph, Catherine C. Legrand and Ricardo D. Salvatore (eds.), *Close Encounters of Empire: Writing the Cultural History of U.S.–Latin American Relations* (Durham, NC: Duke University Press, 1998) pp.3–46 cited in Saavedra, 'Politics and Health at the WHO Regional Office for South East Asia: The Case of Portuguese India, 1949–61', pp. 380-400; W. Anderson, 'Where is the Postcolonial History of Medicine?' 72.3 *Bulletin of the History of Medicine* (Fall 1998) pp.522-530.

USAID. It certainly was not determined by these motivations but it was not entirely detached from them. Moreover, as the emerging international health community evolved from the late 1960s, the Catholic medical mission network was reconstructed and utilised for even more imaginaries of development in Ghana. Overall, whilst there were different development narratives and agendas at play within the health landscape in Ghana, shared aims allowed for connections and collaborations.

Finally, shared responses to the emergence of international health organisations was part of a process in which Protestant and Catholic medical missionaries in Ghana (Ghanaians, Europeans and Americans) began moving into closer coordination in the late 1960s. Adrian Hastings argued that there had emerged in the late 1950s a modern leadership of Presbyterian and Methodist African elites, particularly in Ghana. This was a group 'deeply committed to their Protestantism, nationalist through and through yet very moderately so in expression, mildly anxious to reassert the values of traditional religion and culture'.[661] In healthcare this Presbyterian and Methodist Ghanaian leadership had emerged in the 1960s with key individuals such as Frank Grant, Mary Grant, Fred Sai, Felix Konotey-Ahulu, Michael Baddoo and Kofi Annan (working in the WHO in the early 1960s) some of whom will be explored further in chapter 6. By contrast with the Protestants, as chapter 3 showed, the 'Africanisation' of the Catholic healthcare hierarchies remained limited by expatriate control in the 1970s. However, ecumenical shifts, work within international health organisations, cooperation through the Christian Medical Commission (CMC), membership in the Christian Health Association of Ghana (CHAG), and shared adherence to the Primary Health Care movement brought these groups into new relationships amidst different responses to decolonisation.

[661] A. Hastings, *The Church in Africa, 1450-1950* (Oxford University Press, 1994) pp.604-605.

Chapter 6

CATHOLIC MEDICAL MISSION, GHANAIAN CHRISTIAN DOCTORS AND PRIMARY HEALTH CARE, GHANA, c.1966-1983

A narrative of 'development' and subsequent 'disappointment' has marked the history of postcolonial Africa.[662] The hope and triumphalism of the early years after independence, giving way to the corruption and poverty of the 1970s and 1980s, followed by structural adjustment and neoliberal reform. The history of international health has been structured by this narrative. Ruth Prince describes the 1970s as when 'modernization faltered and the vision of public health pursued by the developmentalist state was downscaled', then the 1980s was marked by 'a decisive shift away from developmentalist African states as aggressive neoliberal policies pushed by Western donors promoted privatization of health services and a dominant model of voluntary provision by humanitarian NGOs'.[663] From the 1970s, Prince argues that interventions focused on emergencies and African states retreated from the 'health for all' goals pursued with the WHO in the 1960s and 1970s, and the Primary Health Care (PHC) goals of Alma-Ata declaration in 1978 were 'short-lived'. Kelley Lee ties the setbacks for PHC to neoliberalism and the power of the World Bank which ensured 'greater restrictions on public health spending'. Moreover, she argues that PHC was 'out of step' with the priorities of major donors such as the US which wanted to return to a focus on major diseases such as Tuberculosis.[664] Marcos Cueto has further shown how PHC was left behind for the less 'broad and idealistic' SPHC with the Rockefeller Foundation identifying more 'cost-effective health strategies' as early as the Bellagio Conference in 1979. This was backed by UNICEF under the leadership of James Grant from 1980.[665]

This chapter will challenge this periodisation and show how medical missions, especially Catholic medical missions, both figured within and continued PHC reforms, well into the 1980s. Vital to understanding medical mission is comprehending how their operation within national contexts was at variance or in conjunction with their international role, and how these matched up in different ways at different times. In the 1970s, medical missionaries were taking up PHC before it was adopted by the WHO, and missions had a role in driving its uptake in international health. On the ground in both Catholic and

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[662] On development and 'disappointment', including emphasis on the struggle of 'cultural and spiritual institutions' to survive and handle 'disillusionment' see F. Cooper, *Africa Since 1940: The Past of the Present* (Cambridge: Cambridge University Press, 2002) pp.91-132, esp.130.

[663] R. J. Prince, 'Introduction: Situating Health and the Public in Africa: Historical and Anthropological Perspectives' in R. J. Prince and R. Marsland (eds.) *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives* (Athens, OH: Ohio University Press, 2014) pp.1-27.

[664] K. Lee, *The World Health Organization (WHO)* (New York, NY: Routledge, 2009) pp.78-85.

[665] M. Cueto, 'The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care' 94.11*American Journal of Public Health* (2004) pp.1864–1874.

Protestant missions in Ghana, by the mid-1970s PHC was a key part of their work. Missions continued their national and international work in PHC detached from international transformations. This was made possible because, on the ground, they were able to weather the storms of neoliberalism and Ghana's decline.

The relationship between mission and development was reconstructed in the 1960s and 1970s by Christians in international health offering new models for performing older missionary ideals. Long-term medical missionary visions of human development were re-formulated and critiqued through the CMC and PHC. These offered an alternative to older forms of medical missionary practice, such hospital construction which was described in chapter 2. In doing so they re-expressed the historic relationship between mission and development as being based on flawed conceptions of theology, community and healthcare. For both Christian international health workers and missionaries, PHC reconstructed the relationship between mission and development in terms of international health norms, and reshaped international health in terms of new thinking within medical mission. [666]

The final section of this chapter will show how Catholic medical missions expanded PHC because they were prevalent, they were interested locally in this kind of work, they had continued funding in spite of economic problems in Ghana and because Misereor supported (and partly financed) the CMC. Furthermore, Catholics in Ghana had an unusually strong relationship with the CMC and with healthcare ecumenism. In spite of retrenchment in international health in the 1980s, the transition to PHC within medical mission development work continued beyond Alma-Ata into the mid-1980s at least. WHO continued to link to CMC and medical mission PHC activities through the 1980s. Medical mission provided another forum in which the WHO Director-General, Halfdan Mahler could continue his campaign for a holistic PHC. This was all in the face of the prevailing winds of retreat to Selective Primary Healthcare (SPHC) from the original PHC programme: member states immediately challenged PHC after Alma-Ata, donor agencies backed the technical solution focused 1979 Bellagio Conference, UNICEF supported SPHC by the mid 1980s and Mahler lost the support of the WHO bureaucracy.[667] Nevertheless, with the CMC and missionaries, Mahler's vision of the original PHC continued to be promoted it in contexts such as Ghana.

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[666] This new approach has been possible through the analysis of previously unexamined papers in the Misereor archives in Aachen, the National Catholic Secretariat private archives in Accra, the archives of the Medical Mission Sisters in Philadelphia and the archives of the World Council of Churches in Geneva. Comparing the caches in these various depositories enables the evidencing of historical arguments which go beyond the simplistic narratives of international organisations or national governments alone. It also offers the possibility of challenging common historical categories of 'development' which have not taken in account the complexity of the terms production across many contexts and by many actors, especially in the postcolonial period.

[667] N. Chorev, *World Health Organization Between North and South* (Ithaca: Cornell University Press, 2012) pp.82-85

i. SURVIVORS:
MEDICAL MISSION AND THE 'HUMANITARIAN HINTERLANDS' OF A FAILED STATE, c.1974-1983

Between 1979 and 1983 more than half of Ghana's doctors left the country.[668] As one UNICEF report show, 8.5 per cent of nurses left in 1982 alone.[669] Between 1960 and 1975 physicians in Ghana had increased from 383 to 1031, nurses from 1554 to 6153 and midwives from 130 to 4932, hospital beds had gone from 5787 to 12,973. In the 1970s many of these trends were quickly reversed. By 1975 already, per capita Ministry of Health spending had fallen from 5.8 cedis per capita in 1974-5, to 4.13 in 1975-6 and 3.27 in 1976-77 (this was against an average of 3.2 per cent population growth annually from 1970).[670] In 1988 the Ministry of Health developed a report on the problems in the health system in Ghana for the National Health Symposium. It opened with an explanation of the disaster of the years between 1979 and 1983, when Ghana began structural adjustment under the military leadership of Flight Lieutenant Jerry Rawlings. The picture was damning, the report described how:

> The long period of economic that preceded the beginning of the Economic Recovery Programme had a heavy toll on most sectors of national endeavour, but few suffered as much as the health sector…drug supplies all but dried up; communications between different levels of the health system virtually broke down; and almost no funds were available for essential maintenance of equipment and buildings.[671]

Moreover, the report argued that the damage was long-lasting, as morale suffered and middle management struggled to implement reforms.[672] As GNP spiralled downwards, declining every year save one between 1972 and 1984, Ghana's healthcare collapsed and food self-sufficiency plummeted. Between 1975 and 1980,

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668 'Issues, Problems, And Priorities of the Health System in Ghana: Background paper prepared by the Ministry of Health, for the National Health Symposium, State House, Accra, June 7-8, 1988' (Ministry of Health, Accra, 31 May 1988) p.1, Private Archives of the National Catholic Secretariat (Accra, Ghana).

669 UNICEF, Accra, 'Adjustment Policies and Programmes to Protect Children and Other Vulnerable Groups in Ghana' in G. A. Cornia, R. Jolly and F. Stewart (eds.), *Adjustment with a Human Face Vol II: Country Case Studies* (Oxford: Oxford University Press, 1988) pp.93-125.

670 Appendix 11 - Primary Health Care Strategy For Ghana - Ministry of Health, Report on the Primary Health Care Conference: The Role and Function of NGOs/Ghana (18-20 October, Madina, 1978) Sponsored by UNICEF, 4215.5.11 Other Organisations 11-12 NGO Primary Health Care, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

671 'Issues, Problems, and Priorities of the Health System in Ghana' Background paper prepared by the Ministry of Health, for the National Health Symposium, State House, Accra, June 7-8, 1988, Ministry of Health, Accra (May 31, 1988) Private Archives of the National Catholic Secretariat (Accra, Ghana)

672 'Issues, Problems, and Priorities of the Health System in Ghana' Background paper prepared by the Ministry of Health, for the National Health Symposium, State House, Accra, June 7-8, 1988, Ministry of Health, Accra (May 31, 1988) Private Archives of the National Catholic Secretariat (Accra, Ghana)

the government only allocated around 3% of its total budget (this compared to 25.5% for agriculture, 21.6% for transport and communication, and 12.6% for education).[673] Real monthly earnings also fell rapidly. In 1983, two million Ghanaians returned from Nigeria, adding to the pressure on food stocks from droughts, bush fires and low production. As the PNDC Secretary for Finance and Economic Planning put it in 1985:

> The economic difficulties of the late seventies and early eighties have had serious consequences for the living standards of many Ghanaians, especial on their health and nutrition state…The sacrifices involved have been in many cases, crushing.[674]

Using World Bank sources, the UNICEF report showed how for healthcare the expenditure per capita dropped from 84.9 in 1978/1979 to 47.2 in 1979/1980, then further to 35.8 in 1980/1981 and 22.6 in 1982. Education expenditure followed a similar pattern. Foreign exchange restrictions hindered the import of new equipment in hospitals and clinics. The supply of drugs, bandages, needles and other healthcare basics dried up, in some rural cases being entirely absent for months. Moreover, before this around thirty per cent of the population had access to formal health in 1977/1978. At Korle Bu Hospital in Accra, in 1979 they had an out-patient attendance of 198,000, in 1983 it was 117,000.[675]

The anthropologist James Ferguson has argued that the state's reduction by neoliberal reforms both exacerbated the current political crisis and continued a long history of exploitative colonialism. Ferguson argues, following the work of Christopher Clapham, that aid work actively sucked the life out of governments by offering better salaries and conditions. Then the state became 'hollowed out'.[676] Moreover, the 'privatization plan' was conducted by state officials in their own idiosyncratic ways, leading to the 'criminalization of the state' that Jean-Francois Bayart, Stephen Ellis and Beatrice Hibou describe.[677] Thus, in this picture, international health organisations were active participants in exploitation and in creating the 'separately administered enclaves' connected transnationally and in a point-to-point style. These were formed of oil companies and 'humanitarian hinterlands' - in a sense, both alike in structure. Looking back to the resource extraction methods of King Leopold's Congo, Ferguson argues that this is an advanced form of

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673 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) pp.1-9, SOAS Library and Archives (London, UK).

674 UNICEF, Accra, 'Adjustment Policies and Programmes to Protect Children and Other Vulnerable Groups in Ghana' in G. A. Cornia, R. Jolly and F. Stewart (eds.), *Adjustment with a Human Face Vol II: Country Case Studies* (Oxford: Oxford University Press, 1988) p.93.

675 UNICEF, Accra, 'Adjustment Policies and Programmes to Protect Children and Other Vulnerable Groups in Ghana' in G. A. Cornia, R. Jolly and F. Stewart (eds.), *Adjustment with a Human Face Vol II: Country Case Studies* (Oxford: Oxford University Press, 1988) pp.93-125.

676 J. Ferguson, 'Seeing Like an Oil Company: Space, Security, and Global Capital in Neoliberal Africa' *American Anthropologist* 107.3 (2005) pp. 377–382.

677 J. Ferguson, 'Seeing Like an Oil Company: Space, Security, and Global Capital in Neoliberal Africa' *American Anthropologist* 107.3 (2005) pp. 377–382.

globalisation and that post-independent Africa's development triumphalism was a short term blip. Instead local politics, combined with the international flows of resources, reign supreme. Chiefs, priests, Imams and community leaders acted as gatekeepers to foreigners which, as Bayart and Ellis have shown, they have been doing for centuries.[678]

In late 1970s Ghana, as in Ferguson's model, was forced to abandon a national infrastructure and the 'humanitarian hinterlands' of medical mission were almost all that was left.[679] Medical missions sustained their care under the emergency rule of a disintegrating Ghanaian state in the late 1970s and early 1980s. There were times in which missions were the only real access to biomedical healthcare that Ghanaians had. As was the case across the country, missions still lacked resources and had to beg, borrow and steal to ensure the continued running of their Hospitals. However, unlike many other aspects of the health infrastructure, they maintained their staff - the missionaries did not leave. As the mid-1980s UNICEF report 'Adjustment with a Human Face' showed, in many areas, mission hospitals were the only ones still running. Instead of the voluntary sector underpinning or enabling nationalist health services, they had become its only surviving feature:

> The situation in mission hospitals was much better because medical equipment was functioning more efficiently, drugs and medical supplies were more adequate, and the loss in health manpower was less.[680]

Whereas overall united attendances in Ghana almost halved from 7,613,624 in 1979 to 4,468,482 in 1984, the Catholic Hospital at Duayaw-Nkwanta had increased attendance in the same period - 40,000 in 1979 up to 49,000 in 1983. Moreover, UNICEF's statistics on malnutrition under 5s between 1980 and 1984 came from the Catholic Relief Services survey. Whilst Ghana's state and private healthcare was being wiped out, medical mission was surviving.[681]

The answer to why and how could medical missions be growing when health infrastructure in Ghana was collapsing all around, can be found by looking at the role of continued foreign aid, the stability of mission staff and the pattern of mission hospitals established in the 1950s and 1960s. As shown in chapters 4 and 5, medical missions were continually funded and supported by US, Dutch and German aid into the 1980s, when

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[678] J-F. Bayart and S. Ellis, 'Africa in the World: A History of Extraversion' *African Affairs* 99.395, Centenary Issue: A Hundred Years of Africa (Apr., 2000) pp. 217-267.

[679] J. C. Scott, *Seeing like a State: How Certain Schemes to Improve the Human Condition Have Failed* (New Haven and London: Yale University Press, 1998) pp.223-261.

[680] UNICEF, Accra, 'Adjustment Policies and Programmes to Protect Children and Other Vulnerable Groups in Ghana' in G. A. Cornia, R. Jolly and F. Stewart (eds.), *Adjustment with a Human Face Vol II: Country Case Studies* (Oxford: Oxford University Press, 1988) pp.101-102

[681] UNICEF, Accra, 'Adjustment Policies and Programmes to Protect Children and Other Vulnerable Groups in Ghana' in G. A. Cornia, R. Jolly and F. Stewart (eds.), *Adjustment with a Human Face Vol II: Country Case Studies* (Oxford: Oxford University Press, 1988) pp.93-125.

crisis hit, they had support. Whilst the drug drought hamstrung most hospitals in Ghana, the Christian Health Association of Ghana (CHAG) and other medical mission institutions were able to find foreign sources of drug supplies. CHAG brokered a deal with a Ghanaian state-owned pharmaceutical company to produce drugs for 'church-related hospital and clinics in Ghana from raw materials made available by the Netherlands Government'.[682] In 1983, funded by the Dutch government, GIHOC produced 40 million aspirin tablets, 50 million vitamin B-complex tablets, 5 million Anti-TB tables paedritic and adult, amongst millions of others drugs. The total cost of materials was 1.2 million cedis, this was at a time when the exchange rate was 2.75 cedis to the dollar, but the exchange rate later fell to 51 cedis to the dollar making local production very cheap.[683] As Patrick Twumasi wrote in his survey for the Catholic Health Secretariat in 1982, the cost of drugs was extremely high and revenues received by patients' fees and government grants and secondment schemes could not cover expenditure. By this point some of the initial congregations that started medical missions had declined and 'The income of local people, it must be stressed, has not risen proportionately, even though the present patient's fees charged are much higher than before'.[684] The range of external donors, in streams established in the 1950s and 1960s particularly, resulted in mission hospitals being able to side-step the economic crisis to some extent. Training and personal support, as well as resources, were available in mission hospitals because they had their origins, sources and networks outside of the context of a fragile nation-state.

Missions still relied on the local community and national government to support their work, politically, financially and physically. Twumasi notes that the struggles of impoverished Ghanaians adversely effected missions even with foreign support:

> important constraints are finance, lack of community support, difficulty in finding local building materials, lack of interest in working in rural areas and thus the difficulty in recruiting health workers, and to find reliable building contractors.[685]

Local negotiations were critical to missions being able to sustain their health institutions. One Medical Mission Sister at Berekum Hospital, Sister Suzanne Maschek, recalls how she had to bargain, travel and use

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[682] 'Visit to Ghana by R. Amonoo-Lartson' (25 May-6 June 1985) pp.5-6, Country Files, Ghana 1-6, Christian Medical Commission, 4215.3.10, Archives of the World Council of Churches, Geneva, Switzerland.

[683] 'Visit to Ghana by R. Amonoo-Lartson' (25 May-6 June 1985) pp.5-6, Country Files, Ghana 1-6, Christian Medical Commission, 4215.3.10, Archives of the World Council of Churches, Geneva, Switzerland.

[684] P. A. Twumasi, 'Catholic Health Policy and Organization of the Department of Health, National Catholic Secretariat' *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) pp.16-17, Private Archives of the National Catholic Secretariat (Accra, Ghana)

[685] P. A. Twumasi, 'Catholic Health Policy and Organization of the Department of Health, National Catholic Secretariat' *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) p.16, Private Archives of the National Catholic Secretariat (Accra, Ghana)

a ‘chit system’ at Sunyani to get drug supplies and food in the 1980s. Moreover, she emphasises how the continued subsidies from the government were critical and when they went on strike, no money was coming in any longer.[686] Whilst Twumasi shows, as CHAGs records demonstrate, foreign donors enabled medical missions to weather the storms of Ghana’s economic collapse and structural adjustment in the early 1980s; however, missions were not islands unto themselves or afloat only on foreign money. They had to broker deals with locals and gain access to supply chains that inevitably went through national channels as well as through USAID. When the government went on strike and there was no money, replacing those funding streams could be incredibly hard. Moreover, in a very local sense, the pain and struggle of Ghanaians, both Christian and non-Christian, effected how medical missions were able to operate, they effected staff and building contracts. They created black markets in which missions had to negotiate their way through to survive.[687]

Missionaries also continued to work in Ghana under adverse conditions because of long-term commitments, whereas Ghanaian doctors, Christian or otherwise, had more options and more routes out. Missions worked within the complicated exchange processes and black markets of impoverished Ghana in the 1980s, whilst many elite Ghanaian medical professionals did not wish to enter into these systems. Sister Sue emphasised that many of the Ghanaian doctors left the country in order to maintain their integrity. They did not want to accept bribes to ensure their children had food and uniforms. According to Sister Sue, it was not only obvious personal gain that drove the mass exodus of Ghanaian doctors, it was also moral distaste with the enforced financial practices of the black market and bribe culture of the early 1980s.[688] Crucially, whatever the reason for leaving, Ghanaian doctors had the option to leave to better climes, whereas expatriate medical missionaries had fewer routes out. Medical missionaries had morally and personally sacrificed as a collective body to ‘Africa’ and to the mission community or congregation that they lived with permanently. Medical mission, especially for MMS nuns, was a permanent covenant bond to a religious order and to God. The orders’ hierarchical control ensured that local discomfort was seldom the cause for leaving. By contrast, Ghanaian doctors were free to move in and out of different contexts and networks to benefit themselves and others when particular situations became stifling or seemingly impossible. Ghanaians had other networks in the West and around Africa in 1960s, this through their training abroad and the openness of the international community to foreign medics like Frank Grant (who too left Ghana for work at WHO Regional Office for Africa in Brazzaville in the last 1970s after frustration within working in national government).[689] Moreover, when European, Australian and American health systems wanted immigrant

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[686] Interview with Author, Sister S. Maschek, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 Nov 2016)

[687] Interview with Author, Sister S. Maschek, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 Nov 2016)

[688] Interview with Author, Sister S. Maschek, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 Nov 2016)

[689] Interview with Author, M. Grant, East Cantonments, Ghana (31 January 2016)

doctors, Ghanaian doctors had new options. Medical missions made their decisions about location by a different set of standards and norms of practice.

On the other hand, as for expatriate missionaries, for some Ghanaian Christian doctors sustaining healthcare development amidst difficulty was also a way of constructing the distinction between Christian and non-Christian. The most significant clash between healthcare professionals and government in this period for Ghana was in the 1977 Doctor's Strike; some forms of Christianity figured as a catalyst to protest in this conflict. As Roger Gocking has shown in 1976 the Ghana Bar Association called for a return to civilian government and demanded that a new constitution be drafted. In a joint move with the Bar Association, as part of the Association of Recognised Professionals, doctors went on strike. The military government responded with intimidation, and ejected doctors and their families from their homes.[690] In interview, one Christian doctor, Felix Konotey-Ahulu, describes how the strike separated the wheat from the chaff, it revealed who had real faith and who did not. In the strike, soldiers came into hospitals and beat up doctors. Therefore, for Konotey-Ahulu, in the general strike 'you knew immediately which clinicians in teaching hospitals were Godly'. Felix recollected how his brother-in-law, a chief surgeon walked from town to his patients in spite of the attacks.[691] These acts, Felix argued, showed when one could attach the word Christian to an 'individual' and not just institutions or a nationality. Felix put himself in that bracket and recalled how he too slept in the ward with the patients during the strike, in the face of whatever abuse came his way.[692] In situations of conflict and violence, the boundaries between true and false faith became more obviously revealed to Felix. Those who loved money or their own security higher than Jesus, no longer met the grade in his view. For some Christianity drove the protest against the government and, for Felix, gave it the passion necessary to speak truth to power.[693]

Local bonds of companionship as well as hierarchical control could be significant motivators for medical missionaries remaining in Ghana. The Salvation Army medical missionary Margaret Tucker who worked in the Boso rural clinic from 1964, went to open a clinic in Wiamoase in 1969 and loved living there with the community. She recalled how when hostile officials came, a local 'gong gong man' from the community went around banging the gong to let people know there was to be no clinic today and that she was hiding. Tucker explained how she 'had to beg people not to come near us' and then, as soon as the officials' car left,

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[690] R. Gocking, *The History of Ghana* (Connecticut: Greenwood Press, 2005) pp.175-176.

[691] Interview with the Author, F. Konotey-Ahulu, Harley Street, London (6 November 2015).

[692]As Mary Grant in interview noted, Felix was 'thick as thieves' with Frank Grant for both of them Christ came first. Interview with Author, M. Grant, East Cantonments, Accra, Ghana (31 January 2016).

[693] However, as Felix emphasises, it was not only Christians but also other doctors who went the extra mile, including a Hindu gynaecologist. This consultant slept 'on the fifth floor where babies were being delivered' in order to continue to deliver babies, without being brutalised by soldiers. It must be noted that these constructions of the boundaries of faith, Christianity and belonging were created in interview many decades after the event itself. Whilst there are probably traces of the past in these articulations, it is hard to divest these from later re-imaginings, nostalgia, information learnt after the events and the ordinary workings of memory; Interview with the Author, F. Konotey-Ahulu, Harley Street, London (6 November 2015).

the ‘clinic and waiting room filled up’. However difficult the political climate became and in this case clearly the government wanted to shut down her work, close relations of trust with locals could ensure that Tucker wanted to stay and was enabled to stay. In spite of this bond of loyalty, in 1975 Tucker was forcibly moved to Begoro by the Salvation Army leadership against her will. She describes how she ‘resented’ it, when she was in Wiamoase everything was ‘big bright and well established’ and yet she had to move. She remembered ‘saying to God, unless there’s a real purpose in this, stop it’. Tucker had to go anyway, feeling that it was ‘wrong’, and began to set up work through liaising with the chief’s wife about several disabled children in the area.[694]

Finally, it was for many the fundamental commitment to Jesus Christ and to evangelism, that ensured missions wanted to stay in Ghana. Tucker explained that it was not only locals that made her want to continually establish home wherever she was moved, it was also her faith:

> Our purpose was always yes always to spread the Love of God. In practice this meant that we were continually available.....24/7. People would come to the house once clinics were closed and would always be attended to...we attended the services and helped with Bible studies and young peoples group…Each day, at all the clinics the day would commence with staff prayers, then the staff themselves would conduct prayers with the patients. A thanksgiving prayer was offered after each child was born…Yes I know of numerous folk who became committed Christians because of the work and service of the clinics…there was SO MUCH need at that time and so few workers that each clinic was like a little oasis. Everyone was treated, those who could not pay did not pay but still had the same treatment.[695]

Personal relationship with God drove her dedication, this was performed and practiced through staff prayer, in which the group would have been united in their standpoint and aims. Fundamentally, it was belief that God was acting, moving and healing, that His love was transforming them and their patients that ensure long-term commitment in spite of the struggles with hierarchies. The sacrificial, faith-driven calling on many missionaries lives ensured that they wanted to stay; they had committed to the ecclesiastical hierarchies but even more so to God. Evangelism had hardly decreased by the 1980s, in fact it was a critical motivator in the reasons for medical missionaries continuing their work.

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[694] Interview with Author, M. Tucker, UK (23 September 2015)

[695] Correspondence with Author, M. Tucker (17 October 2015).

ii. CHRISTIAN MEDICAL COMMISSION AND PRIMARY HEALTH CARE IN GHANA, c.1964-1983

As a result of their sustained role amidst state failure, medical missions who valued PHC could continue working on it on the ground in Ghana, in spite of international retrenchment. Especially significant in this were Catholic medical missions in Ghana. PHC emerged from the concern in the second half of the 1960s, in the wake of the failure of malaria eradication, in the WHO and UNICEF to support national health systems rather than focus on disease eradication. In the 1970s there were attempts by the WHO to pin down a definition of primary health care, which had centuries-old connotations of community care and preventative medical work, in order to use it as a rallying cry for equity in healthcare. Socialist medicine and the Chinese barefoot doctors were used as contextual examples for a declaration which asserted health as a human right, which had social determinants, was the responsibility of Government and was 'not merely the absence of disease or infirmity'.[696] It also incorporated the use of traditional medical practitioners.[697] This section will show how through the Christian Medical Commission (CMC), its Ghanaian institution the Christian Health Association of Ghana (CHAG), and medical missions across denominations, were a key part of the creation, formation and sustaining of the PHC movement. Through the CMC and PHC movement, medical missionaries reformulated their conceptions of human development, medicine and community, with long-term effect.

Many Ghanaian Christian doctors such as Fred Sai, German Catholic medical missionaries in Ghana such as Margaret Marquart, medical thinkers like Kofi Appiah-Kubi and the Ghanaian Catholic Bishop Peter Sarpong, were key members of the CMC. The CMC was effectively the health wing of the World Council of Churches (WCC) and it had met all around the world since the mid 1960s to discuss how medical mission was going to change in the light of the end of colonialism and the significance of ecumenism. The WCC itself had roots in the 1930s concern to mobilise Christian democratic nations about nationalism and a key mode of that was through ecumenism, particularly Protestants working with Catholics. The CMC and at the German medical mission institution in Tübingen (founded by the Basel mission) between the 1960s and 1980s were the main setting for debate into Christian medicine and drew in theologians, doctors and ministers to discuss how to imagine, survey and advise the huge amount of mission hospitals that were having to adapt to the end of colonialism. It managed to set up many pilot projects and surveys in coordination with the WHO, particularly within PHC. Other key West African medics attended too, the Nigerian deputy director of WHO, T. H. Lambo, was a founding member and the Assistant Deputy Director of WHO, Sierra Leonean and ordained minister, John Karefa-Smart was simultaneously the CMC's Vice-

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[696] 'Declaration of Alma-Ata' *International Conference on Primary Health Care* (Alma-Ata, USSR, 6-12 September 1978) http://www.who.int/publications

[697] M. Jones and C. Liyanage, 'Traditional Medicine and Primary Health Care in Sri Lanka: Policy Perceptions, and Practice' *Asian Review of World Histories* 6 (2018) pp.157-184.

Chairman.[698] As for Ghana, by the late 1970s, the CMC was working with the Church Hospital Association (CHAG, which it had helped to set up), the Christian Council of Ghana and the National Catholic Secretariat.

Within the context of the CMC, Christian concepts of human development were reformulated through cross-denominational perspectives from all around the world - though they struggled to involve Catholics in these early days.[699] The CMC had debates involving voices as various as the Russian Orthodox theologian Metropolitan Anthony Bloom and the Anglican Bishop David Jenkins. Catholics were not heavily involved but representatives to the first commission meeting in 1968 were sent through a relationship built with SEDOS. Through the discussions the CMC's main innovation was the value of the holistic approach to healthcare, that the community could itself have healing properties, and that too much attention on hospital provision by past missions, missed this vital element of the expression of the Christian gospel. A key part of the CMC's aim was to break the boundary between formal medical mission practice and the life of the church community, but they went even further than this, attempting to redefine the social units for biomedical mission. Part of the reason for this was because, as the Finnish Medical Missionary J. Hakan Hellberg put it in a CMC meeting around 1967:

> The modern hospital supported by a functioning society with laws and regulations, transport, education, hygiene and health control is like the apex of a pyramid depending on the underlying structures. If we "export" this highly developed hospital, with its abilities to cure, to a country without these underlying structures, the hospital is a more or less distorted sign of God's healing power.[700]

Hakan Hellberg argued that Christian medicine had to move beyond the ways in which it had been so far conceived of socially. To confine it to the hospital, even in greater contact with the non-medically trained Church community, was to 'distort' the sign of God's healing power. God's healing was attained commonly in an institution such as a hospital which was inaccessible to most. This said much about the sign of salvation which medical missions offered. Thus, Christian medicine required understanding the communities already in a 'given area' in order to provide the 'total proclamation of healing and of salvation'. The biomedical dream of 'cure' had to be enriched in Christian medicine to encompass the 'having' and 'not having', now

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[698] J. C. McGilvray to T. A. Lambo, 'Consultation on the Subject of Health and Salvation' (12 July 1966) 4215.0.3 World Council of Churches: Christian Medical Commission. History of the CMC 1-9, WCC Archives (Geneva, Switzerland); '3. T. Adioya Lambo: Traditional Healing and Scientific Medicine: Some General Problems of Adjustment' Master File of Material for Consultation on Health and Salvation' (Tubingen, 1967) 4215.0.3 World Council of Churches: Christian Medical Commission. History of the CMC 1-9, WCC Archives (Geneva, Switzerland); 'John Karefa-Smart M.D. Vice-Chairman, Assistant Director-General of WHO, Evangelical and United Brethren' CMC of the WCC, 4215.1.1 World Council of Churches: Christian Medical Commission, Annual Meetings and Annual Reports 1-11, WCC Archives (Geneva, Switzerland).

[699] J. C. McGilvray, *The Quest for Health and Wholeness* (Gesamtherstellung: Breklumer Druckerei Manfred Siegel, German Institute for Medical Missions, Tubingen, 1981) pp.64-65.

[700] J. Hakan Hellberg, 'Curing or Healing?' (Group 1. Art. 2.) pp.1-9, 4215.0.3 World Council of Churches: Christian Medical Commission. History of the CMC 1-9, WCC Archives (Geneva, Switzerland).

and not yet, tensions of Christian 'healing'. This required going beyond the flock and the hospital.[701] For another CMC contributor, American Lutheran minister Martin H. Scharlemann, this did not exclude technological advance which as in all contributions to human health could be viewed as 'a kind of endowment intended to urge us all to participate with the communion of saints in anticipating and preparing for the prospect (eternity) that lies before us'.[702] But it did mean re-imaging how societies and cultures lived in dynamic relation to technological intervention and biomedical structures.

In built into CMC dialogue about development was the importance of community-level healthcare. This was more than simply ensuring that an individual patient had companionship, the idea was that the unique local communities of belonging themselves had primary importance when it came to the healing of the person. G. C. Harding argued that church groups had 'false collective identification', and that healing could occur by better attention to feelings of belonging:

> a feeling of togetherness, often amounting to collective hysteria, induc(ing) a welcome feeling of 'belonging' a feeling which ordinary membership of the congregation may not have been able to supply…Many of their followers are "healed" of minor disorders simply because they have lost their loneliness.[703]

Judging what counted as a true community, what was false and which community mattered for which particular problem of physical or social healing could be very complex in a world perceived to be full of porous borders, bad theology, cults, demagogues, insurgent rebellions and communism. The only way to deal with such issues in church formation was to continue attempting to explore the problem. In this, sociology was as important as medical science. How God interpreted what was a just community required anthropology as well as biblical insight.[704] As the Anglican Bishop Ian Ramsey summarised: 'the saving work of Christ must necessarily be… contextualised' and the deliverance experience of the hospital must symbolise salvation in every situation, without resorting to 'theological relativity'.[705]

The church congregation itself was proposed as a model community for healing. In order to exemplify the ideal society, Harding and Lambourne argued, the Church could function as an experimental group in

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[701] J. Hakan Hellberg, 'Curing or Healing?' (Group 1. Art. 2.) pp.1-9, 4215.0.3 World Council of Churches: Christian Medical Commission. History of the CMC 1-9, WCC Archives (Geneva, Switzerland).

[702] M. H. Sharlemann, 'Health: What is it?' (Group 1. Art. 2,) pp.9-13, 4215.0.3 World Council of Churches: Christian Medical Commission. History of the CMC 1-9, WCC Archives (Geneva, Switzerland).

[703] G. C. Harding (possibly also with M. Sheel, and D. Jenkins), 'The Meaning of Health in the Congregation' (Group 11. Art. 2 - Consultation on Health and Salvation, Tubingen, September 1-8) pp.1-5, 4215.0.2 History of the CMC 1-9, WCC Archives (Geneva, Switzerland)

[704] G. C. Harding (possibly also with M. Sheel, and D. Jenkins), 'The Meaning of Health in the Congregation' (Group 11. Art. 2 - Consultation on Health and Salvation, Tubingen, September 1-8) pp.1-5, 4215.0.2 History of the CMC 1-9, WCC Archives (Geneva, Switzerland)

[705] I. Ramsey, 'Summary' (Sunday September 3rd 1967) pp.1-3, 4215.0.2. History of the CMC 1-9, WCC Archives (Geneva, Switzerland).

enacting universal social health and wholeness.[706] There was a communal linkage between doctor and church that made Christian medicine distinct. This could function more prosaically too, with American Presbyterian minister Seward Hiltner suggesting that the distribution of materials about health in churches and the encouragement of member physicians.[707] Fred Sai added that the church must help governments provide total population health coverage, even with the danger of being manipulated. The call to help re-imagine and extend the limits of the churches' role in healthcare across diverse contexts - rather than modelling social or individual health from a hospital or church - was vital to both the theologian and the doctor.[708]

For the CMC, PHC embodied a new way of conceiving of medical mission and human development. In *The Quest for Wholeness* the CMC's most significant publication in 1981, their way of viewing and practicing community health was emphasised as their greatest legacy. The report summarised the CMC's most important work:

> While the Church had emphasized personal (individual) salvation, it was now coming to recognize that the uniqueness of the individual most frequently lay in his relationships in community. So, there was a need to recapture the Hebraic concept of corporate salvation and the Pauline version of it as the New Community Christ…(thus) solutions must always be developed within a local context.[709]

How exactly corporate salvation linked with local healthcare solutions was hammered out in practice by individual project makers. Crucially, this vision of holistic care expressed the complex theological discussions about salvation, community and the church, in ways that had direct relevance for PHC. They argued that medical mission had focused on individuals confined to hospital beds because historically they had imagined salvation as an individual process of returning to God. The CMC contended that by contrast, an improved model of salvation should reincorporate the Hebraic tradition of 'corporate salvation' with St Paul's vision of the community as a new creation in Christ. On this basis, an improved model of healthcare should attend to the local context, to the whole individual (as part of a community) and thus to primary health rather than secondary healthcare. Moreover, by this point Catholics were more closely involved in the

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[706] G. C. Harding and R. A. Lambourne, 'Health and the Congregation' (Group 11. Art. 2, Consultation on Health and Salvation, Tubingen, September 1-8) pp.40-46. 4215.0.2. History of the CMC 1-9, WCC Archives (Geneva, Switzerland).

[707] S. Hiltner, 'The Program of the Congregation in Relation to Health' (Group 11. Art. 2) pp.55-58, 4215.0.2. History of the CMC 1-9, WCC Archives (Geneva, Switzerland).

[708] H. Florin, F. Sai, A. Bloom et. al., 'The Theological Perspective: The Role of the Church in Health and Medical Services'pp.28-44, 4215.1.1 World Council of Churches: Christian Medical Commission. Annual Meetings and Annual Reports 1-11, WCC Archives (Geneva, Switzerland).

[709] J. McGilvray, 'The Beginning of the Christian Medical Commission: Its Emphasis on Community Health Care' *The Quest for Wholeness* (Herausgeber: Deutsches Institut für ärztliche Mission, 1981) pp.63-76.

CMC with Margret Marquart included as part of the Advisory Study Group for the work; later she was named as representing the Pontifical Council 'Cor Unum' of the Vatican to the CMC.[710]

The CMC's extensive work with the WHO on the PHC movement led by the Director-General Halfdan Mahler, testifies to the reach of their theologies of social salvation. As Socrates Litsios has argued CMC ideas directly influenced the WHO Primary Health Care Movement, as the WHO building was literally only down the road. Mahler even required WHO staff to read particular editions of the CMC's magazine *Contact*. Matthew Bersagel Braley also emphasises that the CMC had a major influence on the development of PHC.[711] Part of this was simply that key members of the WHO, such as T. H. Lambo, also worked within the CMC, as well as the closeness of Mahler and the leader of the CMC, James McGilvray. As a statement prepared for the Alma-Ata conference, for WHO and UNICEF and by the group of non-governmental organisations including the CMC, put it in 1978:

> Non-governmental organizations support the view that the promotion of primary health care must be closely tied to a concern for total human development. The totality of human development, and in fact, a holistic view of health encompasses the physical, mental, social and spiritual well-being of the individual…The integrated approach to human development embodies a concern for "people" rather than merely economic growth.[712]

Between the 1960s and 1970s, medical missionaries had an active role within and alongside international health organisations. As Litsios showed in his article on the CMC, from the earliest days of the PHC PHC movement in the WHO, the CMC was closely involved.[713] According to the only Priest to have a formal WHO role, Ted Karpf, the Director-General of the WHO between 1973 and 1988, Halfdan Mahler, was anti-religion until he dealt with the CMC. Mahler's flagship policy of PHC emerged out of the CMC debates from the early 1960s. In 1978 at the International Conference on PHC, the WHO, UNICEF and others committed to the Alma-Ata declaration which proclaim the urgent necessity of 'health for all'. According to Karpf, it was the CMC and missionaries that staffed this conference, as shown from CMC documents they were certainly a major played in the conference.[714] He went even further to suggest that WHO actually 'stole' the

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[710] 'Setting Our Priorities for Health: 1985 Meeting of the Christian Medical Commission' *Contact: A Bimonthly Publication of the Christian Medical Commission, World Council of Churches* (1985).

[711] M. B. Braley, 'The Christian Medical Commission and the World Health Organization' E. L. Idler (ed.) *Religion as a Social Determinant of Public Health* (Oxford: Oxford University Press, 2014) pp.298-318

[712] 'Non-Government Organizations and Primary Health Care' A Statement Prepared for the WHO/UNICEF - Sponsored International Conference on Primary Health Care (Alma-Ata, Kazakh, S.S.R., September 6-12, 1978) pp.3-5, 4215.5.11 World Council of Churches: Christian Medical Commission, Other Organisations 1-12, WCC Archives (Geneva, Switzerland).

[713] S. Litsios, 'The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach' Am J Public Health. 94.11 (November, 2004) pp.1884–1893.

[714] Interview with Author, Revd. T. Karpf, UK-New Mexico, USA (3 July 2017).

idea. Certainly, in the background document by Kenneth Newell on *Health by the People* there were comprehensive health projects in Venezuela, Iran and Niger, and one in in Jakhed, India, financed by the CMC.[715]

In Ghana, Fred Sai (who had been a key member of the the CMC debates) set up a project to express exactly what community medicine, PHC and social salvation could mean in practice. In many pilot medical projects around the world the CMC's donors and doctors re-imagined what community health meant in many settings. One of these was led by Sai at Danfa on the outskirts of Accra in the late 1960s and 1970s. Sai explained his vision behind Danfa to the Presbyterian Church of Ghana in 1971, after having lauded the past work of medical mission:

> …every health worker has to be a little bit of a sociologist, a social scientist, in that community, and he should be able to identify the strength and weaknesses of the community, hammer on the strength and minimise the weaknesses…We (the church) have hammered too much at the weaknesses of our colleagues in health care and not brought up enough of their strength…If there is a conflict let us send it to Tubingen and I will be there.[716]

In this speech, key ideas of the CMC about the value of community, the role of the church, the importance of ecumenical debate at Tubingen at the sociological categories that could facilitate better healthcare, are all registered. In his actual work at Danfa, Sai expressed this vision of health work in a wide-ranging project that combined family planning, with community development and the training of traditional birth attendants. The buildings constructed in the Danfa project were multi-purpose, serving as a venue for weddings as well as vaccinations. The vision was that the community, through owning the healthcare work, were contributing to collective belonging. Thus, a new form of medical mission in which salvation was imagined through the healing of social relationships as much as the individual physicality was being constructed literally in Ghana. Moreover, Sai continued a similar vision for healthcare later as President of the International Planned Parenthood Federation, UN program coordinator and Population Advisor to the World Bank.[717]

Given its ecumenical basis as part of the World Council of Churches, the CMC also set up ecumenical health organisations such as the Christian Health Association of Ghana (CHAG), these were considered to be directly tied to PHC. Both Catholics and Protestants were involved in CHAG. CHAG was originally an ecumenical organisation designed to enable medical missions to cooperate across denominational lines and to form a single lobbying power to formalise their relations with government. Its establishment was aided by

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[715] M. Arole and R. Arole, 'A comprehensive rural health project in Jamkhed (India)' in K. W. Newell (ed.), *Health by the People* (Geneva, World Health Organization, 1975) p.71, http://apps.who.int/iris/

[716] F. Sai, 'Essential Aspects of Medical Work with Special Reference to Church Medical Institutions' *Report of the Triennial Consultation of the Presbyterian Church of Ghana and its Related Overseas Missionary Societies held at the Presbyterian Church Offices, Accra, Ghana* (24-26 August, 1971) pp.44-50, Balme Library, University of Ghana (Accra, Ghana).

[717] F. Sai, *With Heart and Voice: Fred Sai Remembers* (Cambridge, UK: Banson, 2010).

the CMC who aimed to spread the initiative across Africa.[718] CHAG, with the Catholic Secretariat, was effective at brokering deals with government such as around hospital staff pay. CHAG was funded largely by MEMISA, Misereor, CIDA and Christian Aid.[719] Between 40 and 50 per cent of the costs were funded by the Ministry of Health.[720] CHAG helped to further institutionalise and give direction to the medical mission voluntary sector. According to Wodon, Olivier and Dimmock, this ensured that missions could 'be represented and negotiate together as a group'. As it was put in the CMC-led Tubingen meeting in 1967 in Legon, CHAG aimed to:

> …co-ordinate all church-related medical programs both Catholic and Protestant…(and) represent a united voice in negotiations with the government…churches should explore new avenues of service in community health as distinct from...the individualistic approach through curative medicine as practiced in hospitals.[721]

Crucially, this meant that CHAG encouraged the norms of community and social health that the CMC promoted, such as PHC. By 1985, CHAG had within it 14 PHC projects related to its institutions. In 1984 it argued that its Essential Drugs List, one of the key initiatives of CHAG, was directly related to its need to ensure PHC was effective.[722] Moreover, it had argued in 1983 that: 'Since PHC ultimately has to serve 70% of the Ghana this should become a very strong ecumenical activity with a separate department in CHAG'. CHAG with its PHC work was aiming to advance 'spiritual and pastoral care for personnel and patients' in CMC terms.[723]

From the 1970s onwards, amidst turmoil in Ghana, missionaries expanded their PHC programmes. By the late 1970s, Ghanaian government had become more haphazard with less clear priorities, as military dictatorship ousted Kofi Busia in 1972 and the religious and spiritual tastes of the new leaders such as General Acheampong were eclectic, heterodox and inconsistent.[724] Missionaries continued to receive funding

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[718] F. Dimmock, J. Olivier and Q. Wodon, 'Half a Century Young: The Christian Health Associations in Africa' MPRA Paper, *World Bank* (November 2012) pp.1-33.

[719] 'ICCO' (28 May 1985, DbB/ap) SOAS Library and Archives (London, UK).

[720] 'CHAG Relationships' *Christian Medical Commission: Programme on Getting Essential Drugs to the People Through Cooperative Pharmaceutical Services* (Ghana, 15 April - 11 May, 1983) p.25, SOAS Library and Archives (London, UK).

[721] F. Dimmock, J. Olivier and Q. Wodon, 'Half a Century Young: The Christian Health Associations in Africa' MPRA Paper, *World Bank* (November 2012) pp.1-33.

[722] 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) Annexes I-III SOAS Library and Archives (London, UK)..

[723] 'CHAG Relationships' *Christian Medical Commission: Programme on Getting Essential Drugs to the People Through Cooperative Pharmaceutical Services* (Ghana, 15 April - 11 May, 1983) pp.35-38, SOAS Library and Archives (London, UK).

[724] J. S. Pobee, 'Religion and Politics in Ghana, 1972-1978: Some Case Studies from the Rule of General I. K. Acheampong' *Journal of Religion in Africa* 17. Fasc. 1 (February 1987) pp. 44-62.

from the government but relationships were fractious. Missions focused on their own projects, rather than concerning themselves with reforming government. One of those foci was PHC. In Pascal Schmid's work on the Basel mission hospital at Agogo in Ghana, he has shown that they were producing PHC projects by 1978. Before this preventative healthcare was limited to maternal and child health. However, this did not curtail their highly curative and specialised hospital focus. Crucially, the new Dutch doctor in the mid-1970s and others in a generational shift were keen to promote more PHC which, they perceived as a 'happy coincidence' that this too is where the government wanted to focus. It was not financial struggles and dependency on the government, those these were occurring, but change in background and vision for medical mission that transitioned Agogo in favour of PHC.[725]

By the early 1980s the Salvation Army was, in all likelihood, also contributing to the growth of PHC. In 1981, 401694 people attended Salvation Army clinics in Ghana and they too were doing nutritional work, food preparation and hygiene demonstrations.[726] Where their work seems to have particularly matched the PHC agenda is how they were in 1982, describing what they were doing as holistic care: 'The Salvation Army is committed to the Total Person: physical as well as spiritual well-being'. Rather than meaning simply biomedicine combined with preaching, this was related in context to seed planting, community building, planting over 35000 trees and raising rabbits - all this through funding from CIDA (Canadian International Development Agency). Moreover, as the previous chapter has shown, the Salvation Army combined food aid and community development with their medical mission.[727] Whilst there is no direct evidence, or the explicit 'PHC' label given to Salvation Army activities here, these kinds of definitions and practices are related to those being which were being worked out in the CMC. For example, in a 1980 paper given at the Salvation Army in Ghana it states that 'Salvation is HEALTH - spiritual, physical and mental health'.[728] These were the exact terms of salvation for which the CMC had been contending since the mid 1960s. Whilst the Salvation Army were not always in comfortable relationship with these bodies, for example they suspended their membership regarding the WCC's $85,000 grant of food, clothing and medicine to the Rhodesian 'liberation families' (the Patriotic Front of Rhodesia), in general they were allied.[729] The CMC was vital in shaping the ways in which its member bodies envisioned community health care and they were also critical

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[725] P. Schmid, 'Mission Medicine in a Decolonising Healthcare System: Agogo Hospital, Ghana, 1945-1980' *Ghana Studies* 15/16 (2012/2013) pp.287-329.

[726] 'Medical Work', *60th Anniversary: The Salvation Army: Ghana Territory, 1922-1982*, The Salvation International Heritage Centre (London, UK).

[727] 'The Salvation Army is committed to the Total Person', Ghana Photo Collections, p.6, The Salvation Army International Heritage Centre (London, UK).

[728] 'Notes of Paper Given by Lieutenant William Clark at the SDA/SA Conference' (16-18 March, 1980) pp.1-2, The Salvation Army International Heritage Centre (London, UK).

[729] 'Memorandum: World Council of Churches', Commissioners Territorial Army (5 September 1978) The Salvation Army International Heritage Centre (London, UK); 'Council Regrets Pullout of the Salvation Army' (1978) The Salvation Army International Heritage Centre (London, UK).

in creating PHC with the WHO. It seems likely the Salvation Army were one of the key denominations influenced by their models.

iii. CATHOLIC MEDICAL MISSION AND PRIMARY HEALTH CARE IN GHANA, c.1967-1983

The most significant actor PHC, through the CMC and in CHAG in Ghana from the mid-1970s well into the 1980s were Catholic medical missions. Against prevailing international norms in the early 1980s, Catholic medical missionaries in Ghana especially supported the WHO Director-General Halfdan Mahler and expanded their PHC work in many regions and contexts (though this was not without challenge). Crucially, this section shows the dynamic relation that could exist between visions of development and medical mission practice when medical missionaries themselves moved between the various layers of international health. Though again, this was limited by changing international politics which were detached from missionaries' concerns about the theological basis of health and development.

From the late 1960s, ecumenical discussions between Catholic and Protestants flourished on the ground in Ghana, this began with the CMC meeting at Legon in Accra in 1967 that set up CHAG. Partly because of survey of all mission health institutions in 1966, Catholic, Protestants and government officials attended the conference in 1967. Following this not only were Catholics incorporated as key players in CHAG; moreover, Catholics from missions in Ghana became leaders within the CMC. By the 1980s Bishop Peter Sarpong had become one of the CMC's main Catholic consultant and Margret Marquart represented the Vatican for them. For decades previously Protestant ecumenism could be successful at grassroots level, David Maxwell has shown how ecumenical Protestant experience help to construct a broad sense of Luba Katanga identity in the late 1950s Belgian Congo.[730] Moreover, in many cases, the context of the mission field had resulted in the playing down of denominational differences; as previous chapters have shown there was hostility combined with pragmatic cooperation in the Gold Coast between Catholics and Protestants. In the 1970s, ecumenism achieved a different level in Ghana. In the 1970s an MMS missionary sister, Anne Louise von Hoene, became chair of the CHAG board.[731] By the 1980s, 69 per cent of CHAG members were Catholic health institutions.[732] With their links to the CMC and dominating CHAG, Catholics' took a major role in the expansion of PHC in Ghana.

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[730] D. Maxwell, 'The Creation of Lubaland: Missionary Science and Christian Literacy in the Creation of Luba Katanga in the Belgian Congo' *Journal of Eastern African Studies* 10.3 (2016) pp.367-392.

[731] Interview with Author, A. L. von Hoene, Medical Mission Sisters, Fox Chase, Philadelphia USA (9 November, 2016).

[732] 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) pp.1-9, Annexes I-III, SOAS Library and Archives (London, UK).

At the same, international ecumenism was critical - Misereor were funding many of the CMC conferences and Catholics were contributing to the journal *Contact*.[733] The wider inclusion of Catholics within international health was partly as result of the end of mandatory habit wearing and the encouragement to ecumenism through Vatican II in the mid-1960s. Misereor played a key role in the emergence of CMC ecumenism. For example, through CMC to the Christian Health Association of Nigeria (CHAN), Misereor donated 116,707.50 DM between 1974 and 1977.[734] Misereor also donated directly to the CMC throughout the 1970s and 1980s, for example they gave 50,000 DM for helping continue the CMC journal *Contact* in 1984 and a further 60,000 DM was given to the CMC for projects in 1985.[735] In Ghana the National Catholic Secretariat was also supportive, reporting in 1979 that they wanted to 'start now, not wait', to begin pilot projects and (in line with CMC thinking) begin these efforts 'within the concept of the healing ministry with Christian emphasis on the wholeness of man'. Moreover, they wanted to 'work effectively through identifiable Christian groups on the local level' and with CHAG at national level. For them PHC was about doing Christian ministry in a way that recognised localities 'particularly health priorities' and that worked with a community to 'recognise their health needs'.[736] The Ministry of Health wrote that the cost of PHC would be 'moderate and well within Ghana's means'. They concluded that:

> The cost of not instituting the Primary Health Care System will be the continuing high level of unnecessary sickness, disability and death of the people of Ghana.[737]

It was not only in international health circles but also in national governance and churches that PHC in the late 1970s was appearing to be the solution to a great many problems, particularly regarding communicable disease. Thus, in this case the Government provided impetus to the concerns missionaries had already developed. Furthermore, in 1981 MEMISA gave the 'first important drug donations' to CHAG.[738] When

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[733] Notably in relation to Ghana see P. A. Sarpong, 'Answering "Why" - The Ghanaian Concept of Disease' *Contact* 84 (April 1985) pp.5-11.

[734] 'Proposal Submitted Jointly to(…)Misereor for support funding of the Christian Health Association of Nigeria', Other Organisations, 'Misereor' 9, 4215.5.11 World Council of Churches, Christian Medical Commission (Geneva, Switzerland).

[735] 'Financial Assistance for the Period Contact, 1983-4', Other Organisations, 'Misereor' 9, 4215.5.11 World Council of Churches , Christian Medical Commission, Geneva, Switzerland; Eric Ram to Misereor, Other Organisations, 'Misereor' 9, 4215.5.11 World Council of Churches , Christian Medical Commission (Geneva, Switzerland).

[736] 'Report: Group 1: Topic: Primary Health Care' Report of the National Catholic Health Council Conference, Department of Health, National Catholic Secretariat (Nsawam, 21-24 Nov 1978) *Ghana - Bewilligungen 1959-1980*, Misereor-Archive (Aachen, Germany).

[737] 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) pp.1-9, Annexes I-III, SOAS Library and Archives (London, UK).

[738] 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) pp.1-9, Annexes I-III, SOAS Library and Archives (London, UK).

ecumenism broke down, as in the Agogo Ecumenical Nurses Training School in the mid-1980s, Peter Sarpong appealed to MEMISA to change their approach. When a Catholic Revered Sister was forced out of the Agogo school because her 'life there was like hell' with Presbyterians making her feel that she was on 'alien land', Sarpong wrote to MEMISA asking that they would also support a Catholic-only health programme. He asked that they make sure that all the eggs were not in the 'one basket' of the ecumenical 'healing community'.[739]

Catholics' work in PHC in Ghana was also the result of local and regional factors such as relations with anthropologists and the reading of particular books. Dutch Catholic medical missionaries, as noted previously, were reading works such as *Small is Beautiful* by E. F. Schumacher who was internationally significant in arguing for 'community development' models.[740] Local circumstances also ensured that PHC was an interest of particular missions from the mid-1970s. In interview Sr Mary Ann Tregoning described how at Berekum in 1976, generally there was interest growing in PHC before the WHO when one administrator noticed that one particular village had a lot of patients. With the Ministry of Health and social welfare they studied the village finding that it had adequate food but poor techniques and, a lot of malaria. Thus, they began simple clinics and nutrition demonstrations with the assistance of sanitation teams. After that they started training local midwives and community health workers.[741] Part of the reason for this early PHC work was also that a local anthropologist, Mike Warren, had encouraged the missionaries to start a programme to learn from traditional health and traditional midwives and vice versa. A non-Catholic, Warren had been a Peace Corps volunteer in the area and married a Nigerian. Around the mid-1970s he contacted the lay administrator (about whom Mary Ann was speaking) and who too was interested in, as Mary Ann put it, 'in doing more than the traditional ways of caring'. Around this time one of their Sisters became the first public health nurse in the region, before this there was only one doctor travelling about twenty miles to Drobo for a weekly clinic. Mary Ann emphasised how significant Warren and the administrator were in driving the initiative.[742]

In seminars, training programmes and new projects, Catholic medical mission in Ghana took up PHC intensely and promoted, through international health organisations' conferences, what they had already been doing in the mid 1970s, into the late 1970s and through into the 1980s. According to Sister Mary Ann, for

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[739] Revd. P. K. Sarpong to F. T. B. Pulis, Director, Department of Overseas Personnel Service, Memisa-Medicus Mundi (12 July 1986) Collectie 999, Nummer 361, Memisa Archives, Katholiek Documentatie Centrum (Nijmegen, Netherlands).

[740] D. Immerwahr, *Thinking Small: The United States and the Lure of Community Development* (Cambridge, Ma.: Harvard University Press, 2015) pp.88, 168.

[741] Sister Mary Ann Tregoning developed a maternity care program in Techiman, served as the health care coordinator for the Sunyani diocese and was on the board of the National Health Council; Interview with Author, Sister M. A. Tregoning, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 November 2016).

[742] Interview with Author, Sister M. A. Tregoning, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 November 2016).

missions in Ghana, PHC interest was in the 1970s 'bubbling up that whole time' then things 'coalesced' after Alma-Ata with a 'click', and rapidly there was 'so much going on…committees, community clinic attendants' and traditional healers.[743] The missions themselves increasingly were working together, with CHAG and setting up Diocesan health committees. At a seminar in Kintampo in 1978, amongst many others, Sisters and Catholic medical missionaries attended and took notes in order to put new PHC initiatives into practice. They studied how to build community leadership and maintain contact with key individuals. In 1978 the Catholics had a conference with USAID on Primary Health Care and Community Health Workers. PHC seminars included medical missionaries and practitioners from across the world discussing how PHC could be possible through mobilising groups and training teams. These projects which included Ministry of Health workers as well as missionaries, included support from CIDA and USAID.[744] At one PHC conference, sponsored by UNICEF in Madina in October 1978, there were representatives from Christian Health Association of Ghana, the Catholic Relief Services, USAID, Peace Corps, the Red Cross of Ghana and Social Welfare.[745] Catholics took a prominent role in discussions. For example, at Madina there was included a report on PHC promotion at Berekum where there had begun training and orientation of midwifery students with emphasis on the promotion of PHC, an under 5s clinic at the hospital itself and at 10 surrounding villages and immunisation programmes at the department of the hospital itself. There was also supervision of the new Drobo clinic, the Sampa Government Health Center, the Seketia Health Post weekly, the Seikwaa Dressing station fortnightly and the other Clinics at intervals when possible. Moreover, the Drobo clinic was able to extend services of the under 5 clinic to three outstations. Finally, Berekum was managing the coordination with the activities the Medical Field Units, the Environmental Health Units and the Leprosy Services. Under the banner of international health seminars on PHC, Berekum lauded what it had already been doing with regard to the initiative, with government, for the previous few years already.[746]

Catholic medical missionaries by 1981 were training those who trained PHC workers. Though PHC was falling out of favour in international health circles, in favour of the more circumscribed SPHC, in Catholic medical mission it continued apace. In Nsawam in 1981 a large group of Sisters trained those who were task with teaching 'village health workers in the skills of leaders, group dynamics and the use of codes'. The aim was that these trainers should also be able to 'train the Village Health Worker to use the Psycho-Social method in the Community Health Education Programme'. These programmes were not at all secularised but

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[743] Interview with Author, Sister M. A. Tregoning, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 November 2016).

[744] Interview with Author, Sister M. A. Tregoning, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 November 2016).

[745] Primary Health Care Conference, National Women's Training Centre, Madina (October 18-20, 1978) in National Catholic Secretariat Private Archives (Accra, Ghana).

[746] 'Holy Family Hospital Berekum: A Report on Some Involvements in Primary Health Care Promotion', Primary Health Care Conference, National Women's Training Centre, Madina (October 18-20, 1978) in National Catholic Secretariat Private Archives (Accra, Ghana).

began with an explanation of the relationship between the church and PHC which registered key concepts from the CMC:

> Health care was considered by Christ as part of development process aimed at improving the "quality of life". It is a essentially a community struggle in which the sick person, with the aid of the human community can be restored physically and psychologically to health to enable him to become an active agent and subject of his own development….Primary Health Care is increasingly being accepted as strategy for achieving this objective…The Church should build awareness among the Community that by making purposeful attempts to link health programmes with Community development programmes and on the efforts of the Community itself, the Church will seek to ensure that the "quality of life" of the Community is improved….In conclusion the Church is perhaps the only organization which is based at the very grass roots of the Community and whose selfless, disciplined and well trained leaders have influence with their members and the society of which they are a part. This influence can be the basis for active participation by the people in Primary Health Care.[747]

PHC was imagined as a Christian development project in the form of the CMC, not a way of simply reducing costs or aligning with international health trends or coping with a failing state, but of promoting Christ's ministry to humanity, to the whole community and to the whole human. The CMC vision for human development had direct effect on the way in which Catholic conceived of development on the ground in Ghana. Practically, support from USAID was critical in this Catholic PHC being possible, Mary Ann mentions how they 'supported PHC right from the beginning, very instrumental in getting immunisation out all over the country, provided the foodstuffs. vaccines, coolers'. As Mary Ann noted, there was 'never enough' in those years but 'generous donors' from Europe, Misereor, the Netherlands and the US made it possible to continued.[748]

Contrary to what Marcos Cueto has shown for Latin America, in Ghana by 1982 many Catholic medical missions were growing their PHC work rather than retracting it.[749] The Catholic health institutions in 1982 provided many mobile clinics, immunisation, preventative health work, family planning advice, nutritional support, travelling nurses, community health teaching and village health work. In addition to this there was also a great deal of PHC activities, labelled as such by Catholic records themselves, which begun in 1982 across Catholic medical mission in Ghana. Whether this labelling denoted a specific adherence to the PHC movement as opposed to continuation of older community activities renamed, is often unclear. However, there is some sense that when described as PHC, the initiative was new and was shaping Catholic health by

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[747] Report: Primary Health Care, Training of Trainers Workshop at Nsawam (23rd-27th August, 1981) in National Catholic Secretariat Private Archives, Accra (Ghana).

[748] Interview with Author, Sister M. A. Tregoning, Medical Mission Sisters, Fox Chase, Philadelphia, USA (10 November 2016).

[749] M. Cueto, 'The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care' 94.11*American Journal of Public Health* (2004) pp.1864–1874.

the particular PHC international movement. For example, St Martin's Hospital at Agoryesum described 'primary health care' it did in the surrounding villagers and separately explained its plans for a 'Primary Health Care programme' in the next five years to train primary health care workers. Furthermore, at Abease Primary Health Care Centre in Sunyani diocese, there was the usual clinic activities of TBA training and VHW teaching, as well as family planning advice. From this there was a plan to extend 'Primary Health Care to villages within 10 and 20km' but which was struggling against issues with isolation, personnel, water problems and transportation.[750] Again the capitalised 'PHC' suggests that the programme was in line with the kind of models laid out in PHC pilot projects in the 1970s, especially work with TBAs, which would have generally been new to Catholic missions given their historic rejection of traditional belief systems. This is not to say the distinctions were cut and dry but that there were some separate visions from older practices.

In 1982, there were many PHC programmes beginning or extending in Catholic health institutions in Ghana. At Apam Catholic Hospital there were also plans to begin health education work combined with PHC within the five years from 1982. At Breman Asikuma, there was a survey begun in order to implement PHC, as well as training of VHWs for 3-4 years and digging wells across a number of villages as part of a 'long term project'. At St Dominic's Hospital in Akwatia there was already PHC teaching with VHWs and TBAs taught to 'improve upon their traditional services'. At Akim Swedru in Accra there was PHC teaching as well with family planning advice and TBA teaching. There was PHC work already started at Holy Cross Mobile Clinic in Tamale and it was starting at Wiaga in the Navrongo-Bolgatanga diocese. There was also a primary health care teaching through extension services from Holy Family Hospital in Techiman. This was being grown on the basis that: 'The need is concerned with the patients total care and not just with their diseases. They feel part of the community and are responsive to their needs and desires'. Moreover, this statement, which fit very well with PHC's holistic models was tied to 'Building a sense of Christian Community and care'.[751] PHC functioned well with evangelistic visions for biomedicine - especially those which envisioned stretching out beyond the hospital.

Direct evangelism was the part of the target of PHC reforms actioned by the National Catholic Secretariat and by Catholic medical missions in Ghana. In a report on a Misereor fund for PHC from the National Catholic Secretariat in 1980, attended by Misereor delegates, one piece noted that a PHC training workshop would be held to make 'the healing activities and influence our priests more effective'. In other cases, whilst the overall intent of PHC was evangelistic, specific Gospel-health links were separated in specific events, apart from biomedical training. For example, at the conference, in a list of health training, village visits and rural classes there was a meeting with the 'Berekum District Catechist Society' in which they would be

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[750] P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) pp.143, 146, 156, Private Archives of the National Catholic Secretariat (Accra, Ghana)

[751] P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) pp.45, 51, 78, 83, 167, 171, 225, 243 Private Archives of the National Catholic Secretariat (Accra, Ghana).

trained to see the 'relation of health to the Gospel'. In the first two meeting eighteen catechists attended. The goal in the long-term was to 'establish a means of linking health education and the Church's role in healing/ concern for her people. Link health workers - - catechist - - parishiners (sic) - - sick persons'.[752]

This is not to say that Catholics did not struggle on the ground in their efforts to make PHC ideals a reality. PHC was not perfectly executed in Ghana, there were many issues such as local community intransigence and lack of cooperation because of scarcity. There were problems mobilising local communities. At the Assim Foso Catholic Hospital there were plans to extend PHC, to train a greater number of village health workers (VHWs), to train traditional birth attendants (TBAs) and to complete a 'district profile and to prepare a Village Health Workers Manual'. The issues were not actually in funding or in international support (though they struggled to get a reliable contractor and building materials) but crucially with 'seeking the co-operation of the villages in primary health care work'. PHC had invasive aspects and required community belief systems and health work to become more intermixed with Christian biomedical practice. This meant that a strict division or a pluralist approach to health in which the community itself could pick and choose its responses to illness or to pregnancy was less possible. PHC involved a further extension of power into Ghanaian lives and this, in Assim Foso at least, was resisted. At St John's Clinic in Akim Ofoase there was also PHC work planned for the following five years which again was finding uncertainty regarding local community participation: 'the only problem is whether the people will be willing to accept it through their own active participation and involvement'. St Mary's Clinic in New Drobo also noted that PHC had issues with 'lack of interest of villagers' as well as petrol shortages and bad roads, all this was linked to the 'difficult times'. In addition, given the significance of close relations with local communities to make PHC effective some of the problems harked back to when missions depended far more on local communities.[753] For example, at a PHC project from Berekum, one incident was recorded in which the Sister in charge, Sister Camillus, infuriated an Ashanti community to the extent that they tried to harm her by traditional means. The MMS found that 'some of the patients had put the juju' on her and when she left to go on an annual holiday, they attributed it to their power.[754]

There were also resources issues, conflicts and a lack of missionary staff who were keen to work outside of established clinics and hospitals. There were difficulties with mobilising missionaries themselves. In other cases, such as at St John of God Hospital in Duayaw Nkwanta, the issue with setting up PHC was that there were not enough staff who wanted to work in places where 'modern facilities are lacking or non-existent', their report explained that 'there are no good schools and there is a lack of recreational facilities. There is

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[752] 'Primary Health: Projects/Activities of the Members of the DHC, Diocese of Sunyani' Report of National Catholic Health Council Meeting (4-7 November 1980) *Ghana - Bewilligungen 1959-1980*, Misereor-Archive (Aachen, Germany).

[753] P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) pp.40-41, 90-93, 172-178 Private Archives of the National Catholic Secretariat (Accra, Ghana)

[754] PHW Project Notes 7 (1966-1971) pp.9-15, RG15, Medical Mission Sister Archives (Philadelphia, USA).

also a lack of appropriate housing'. In contrast, to the kinds of rural mission in the extreme Northern Territories explored in chapter 2, PHC for Catholic missions in 1982 was difficult because of its reliance on local communities who did not have the resources to support staff who were used to working in hospitals. However, for Holy Family Hospital at Berekum, the problem was not unwilling staff but 'the exodus of skilled personnel to other countries' as well as issues with water, roads, electricity and communication but these were not problems specific to PHC. The mobile clinic at Kandiga in Navrongo-Bolgatanga diocese also noted lack of petrol hindering its PHC efforts.[755] Similarly, the two PHC projects that the CRS was running in 1983 had to be curtailed and training suspended as a result of the refugee problem.[756] Finally, between Catholic health institutions and individuals there could be divisions and conflict. For example, the Dutch Catholic missionary Sjaak Van Der Geest recalls contrasting attitudes to abortion and birth control. Ghanaian girls would avoid Kpandu hospital where they would be given a long sermon by Marquart, by contrast, some 'enlightened nuns' tried to help people and others were hostile. In the Catholic hospitals where Dutch lay doctors who were 'agnostic' and not practicising Catholics there was a more 'relaxed' attitude though it was concealed.

PHC could be crowded out by long-term established patterns increasingly draining funding from new initiatives or it could force missions to adapt their historic theologies. As the Ministry of Health wrote, 70% of Ghanaians could not access the service and needed PHC.[757] In the same report as PHC was lauded, the National Catholic Secretariat accepted 1 million DM from Misereor to ensure that urgent staff housing would be built.[758] Some PHC projects were produced, such as at Berekum, but in situations where mission hospitals were already stable. In other cases, the priority was simply to sustain the services already being provided. On the other hand, some missions adapted in spite of difficulties. Older theologies around the dangers of traditional medicine could be eclipsed in favour of continuing PHC within limited resources. For example, the Catholic Bishop Lodunu of Keta-Ho Diocese in 1982 argued that PHC should be intensified even though resources were strained. He explained that this meant that Catholic health institutions needed to co-operate with traditional healers to meet the needs of the people. Working with traditional healers was one of the early challenges to historic missionary medicine made in the debates of the CMC. Fred Sai at the Presbyterian

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[755] P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) pp.162, 197, 293, Private Archives of the National Catholic Secretariat (Accra, Ghana)

[756] Annex 1, 'Emergency Assistance', K. Ward-Brew to Regional Director, 'AFRO - Memorandum: G-7 Primary Health Care: Catholic Relief Services' (25 August 1983) pp.25, 66-67, 'Economic Assistance to Ghana - Report of the Multi-Agency United Nations Mission to Ghana' G2/27/5/GHA, World Health Organisation Archives (Geneva, Switzerland).

[757] 'Appendix II: Primary Health Care Strategy for Ghana' Ministry of Health, Report of the National Catholic Health Council Conference, Department of Health, National Catholic Secretariat (Nsawam, 21-24 Nov 1978) *Ghana - Bewilligungen 1959-1980*, Misereor-Archive (Aachen, Germany).

[758] 'Group III: Proposal Re. Misereor Funding' Report of the National Catholic Health Council Conference, Department of Health, National Catholic Secretariat (Nsawam, 21-24 Nov 1978) *Ghana - Bewilligungen 1959-1980*, Misereor-Archive (Aachen, Germany).

conference in 1971 had challenged them by arguing that traditional healers did the work of God in looking after the dying in places where medical missions could not venture.[759] In 1982, in debates over funding for PHC, these CMC theologies were being supported in order to make PHC work and continue to improve efficient local community healthcare.[760] Concerns about medical missionary survival and choices around adaptation shaped the extent to which PHC was possible.

All this Catholic missionary PHC work challenged prevailing norms in international health in the 1980s. After Alma-Ata the attitude to medical missions within international health soured. Whilst their national role in Ghana and PHC ministry was being strengthened, medical missions' influence on international health policy, such as in the WHO, was curtailed. The high point of medical mission power in these contexts was the Alma-Ata declaration in 1978. After this, they were pushed to the peripheries of international health organisations. Instead, the CMC and missionary organisations truncated their role in international health to single-issue campaigns. Most importantly, in the 1980s they shifted from promoting PHC to AIDS policy and using medical mission contacts across Africa to tackle the emerging AIDS crisis. In the 1980s there was a rupture between international health organisations and the medical missions. According to WHO Priest, Ted Karpf, in the 1980s following the decline of PHC into Selective Primary Health Care after the Alma-Ata declaration, medical missions organised under the CMC began to split from the direction of the WHO. Karpf recalls how WHO tried to nationalise the principles proclaimed at the PHC conference in 1978. He emphasised the power of Northern Europe, particularly the 'secular' Norwegians, Danish, British and French alongside the US, in bolstering new nations rather than international initiative. Such new nations were imagined to hold back the spread of communism, could function within the nation-state system and could remain under the same structures of influence that presided in the late colonial world. The Germans and Dutch remained absent from this. In Ghana, in which the role of medical mission certainly did not diminish, those receiving German and Dutch aid, recall being heavily involved in PHC work.[761]

At the same time, the ability of medical missionaries and the CMC to continue their PHC work in the 1980s suggests limits to the significance of this transition away from it. In his article on the shift from PHC to SPHC, Marcos Cueto argues that PHC had much of its basis in the work of the CMC, particularly from its members Carl Taylor and John Bryant. However, the challenge was partly to its idealism, especially from the new head of UNICEF, James Grant. Under Grant's leadership: 'UNICEF began to back away from a holistic approach to primary health care…Grant believed that international agencies had to do their best with finite

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[759] F. Sai, 'Essential Aspects of Medical Work with Special Reference to Church Medical Institutions' *Report of the Triennial Consultation of the Presbyterian Church of Ghana and its Related Overseas Missionary Societies held at the Presbyterian Church Offices, Accra, Ghana* (24-26 August, 1971) pp.44-50, Balme Library, University of Ghana (Accra, Ghana).

[760] P. A. Twumasi, *Survey Report Health Services in Ghana: National Catholic Secretariat January-April 1982* (April 1982, Department of Health, National Catholic Secretariat, Accra) p.25, Private Archives of the National Catholic Secretariat (Accra, Ghana)

[761] Interview with Author, Revd. T. Karpf, UK-New Mexico, USA (3 July 2017).

resources and short-lived local political opportunities'. Grant's father was a doctor at the Rockefeller mission hospital in China and in some senses, this alternative vision came out of another, adaptationist model of medical mission. With Halfdan Mahler, the DG, not having the support of the WHO bureaucracy, his crusade for PHC floundered.[762] However, whilst this was the picture in the highest echelons of international health power, it misses what was happening on the ground. Given that Catholic missions in Ghana had their own streams of funding, and in their nutritional efforts (part of PHC) were supported by USAID, they were able to continue their own version of PHC without UNICEF or WHO backing. As the preceding chapters in this thesis have demonstrated, international health could be limited both in its interventions and its retractions by the processes already in motion within national and denominational contexts. The original impetus given to the Catholic missions in the late 1970s could not simply disappear. The lack of resources was certainly an extreme issue, but vision and ideas had less to do with international health politics in Geneva than historians often suggest. Moreover, in the CMC itself until they were forced into focusing on the AIDS crisis, there were a number of PHC projects jointly worked on with UNICEF and the WHO well into the 1980s.[763]

Outside the visible centres of power, in smaller international health organisations and on the ground in Ghana - PHC and ecumenism was alive and well. In 1981, the joint WHO/CMC Standing Committee agreed to study PHC in Zimbabwe.[764] In 1982 there was another standing committee meeting in which PHC in Southern Africa, Andean countries and Anglophone West Africa was discussed, with the former CMC member, with Hakan Hellberg attending as a representative for the WHO.[765] In 1984 the WHO/CMC Standing Committee on Primary Health Care agreed that there would be immunisation efforts, pharmaceutical programmes and in India guinea worm reduction.[766] Whilst these initiatives may not seem like hallmarks of PHC, the ones discussed in the WHO/CMC Standing Committee in 1986 were far more closely aligned. They agreed to jointly financed seed money (possibly with the World Bank and UNDP) country projects in Sierra Leone, the Marshall Islands, Togo and Guinea Bissau, amongst others, with district

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[762] M. Cueto, 'The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care' 94.11*American Journal of Public Health* (2004) pp.1864–1874.

[763] CMC/WHO Meeting on Collaboration in Strengthening District Health Systems Through PHC (July 23 1986) 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland); Minutes of the WHO/CMC Standing Committee (20th April 1990) 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

[764] WHO/CMC Standing Committee (4th March 1981) 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

[765] Minutes of the CMC/WHO Standing Committee Meeting (April 20 1982) 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

[766] Report of the Meeting Between the Christian Medical Commission (CMC) and WHO (12 March 1984) 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

level committees consisting of church, government and WHO representatives.[767] In a joint statement with Halfdan Mahler in 1986 they emphasised the ongoing commitment to 'health for all as a basic human right… embodied (in the) promotion and support of health systems based on primary health care'. This was followed by a commitment to a framework for a review including joint government/WHO/CMC teams.[768] The CMC also continued with the WHO, in Ghana they funded and developed a hospital called Nazareth with fourteen surrounding clinics which combined spiritual, social and physical healing, and elaborated PHC aims within this specific context.[769] The final recorded meeting of this Standing Committee that, as the records suggest, continued to support PHC was in 1990 when the 'spiritual aspect of healing and wholeness' was emphasised. However, in this meeting the WHO representatives:

> admitted that they were well able to make technical statements, but that often they were trying to tackle the problem with the wrong tool. It was felt that CMC might have the right tool, and that care (rather than intervention), coping with suffering and dying, and spiritual healing were more essential.[770]

After this the records suggest some curtailing of the WHO/CMC closeness with regard to meeting on care and PHC. It seems that the CMC directed its attention to the AIDS crisis, to essential drugs and even to Polio eradication.[771] Activities reports and annual meeting reports of the CMC show a similar trajectory, from year-on-year attempts with WHO, the NGO group and UNICEF to start and survey PHC, to a slow down in the late 1980s (with the exit of Mahler from WHO). Yet, the long continuation in the records up until this point should challenge, even in a circumscribed way, the bigger picture of the 'failure' of PHC. Instead it seems that on the ground and within its original architects' groups, PHC was continuing to have effect on international and national health.

Catholic missions' ability to continue working in PHC was also at variance with the Ghanaian state, who paid lip service to PHC but were unable to actually execute it. Whilst this chapter has argued that missions cannot be categorised in the same manner as NGOs that contributed to the struggles of African states in the

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[767] CMC/WHO Meeting on Collaboration in Strengthening District Health Systems Through PHC (July 23 1986) 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

[768] Agenda Item 1: CMC Standing Committee of 19 March 1987, 'Joint Statement on the Occasion of the Meeting Between Dr Halfdan Mahler, Director-General, WHO, and Dr Emilio Castro, Secretary-General, World Council of Churches (4 November 1986) 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches, (Geneva, Switzerland).

[769] Country Files, 1-7 Ghana, 4215.3.10, Christian Medical Commission, Archives of the World Council of Churches, (Geneva, Switzerland).

[770] Minutes of the WHO/CMC Standing Committee (20th April 1990) 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

[771] 4215.5.15 1-21 World Health Organisation, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

1980s, it has also shown that they were bound up with its long-term structural weaknesses. PHC was, in many ways, a luxury that some missions were able to afford, whereas the Ghanaian state simply was unable to even entertain. As one medical missionary put it reluctantly in interview: 'the government supported it (PHC) in theory', i.e. in theory alone.[772] Whereas the streams of USAID (which was pro-PHC from the beginning) going to Berekum allowed them to produce PHC in the early 1980s, funding was not similarly available to the Ghanaian government in rural areas. The formal voluntary sector strengthened its ties with each other in the 1980s around PHC and ecumenism, and continued to draw from foreign funding, whereas the military government of Ghana had less capacity or perhaps interest in innovating.

PHC also struggled within Ghana's overall economic decline and the long history of structural inequalities in Ghanaian healthcare. Unfortunately there are not the statistics to show whether Ghanaian's health actually benefited from the continuation of PHC or how much health improved generally. Throughout the 1970s, malaria, tuberculosis and many other diseases were increasing by tens of thousands each year. Measles rose from 94.870 in 1971 to 131,405 1976, infectious Yaws from 12,747 in 1971 to 71,765 in 1976, TB from 5605 in 1971 to 6174 in 1976, Pertussis (whooping cough) from 14,664 in 1971 to 22348 in 1976, and malaria from 75, 062 in 1971 to 443,410.[773] It must be noted this could be the result of far better detection of diseases rather than actual rise in incidence. However, given the size of the rises, particularly malaria, at a time when the state was struggling to hold surveillance on even its own employees and capital hospitals, it seems likely that these were real increases rather than hugely skewed by better recording. Other health indicators are also not available. Whether the trends suggested by communicable diseases were turned around or not in the 1980s is a question that sadly cannot currently be answered. However, given the decline in state and private health institutions and the exodus of doctors and nurses, missions locally may have had much success with PHC but the overall picture was probably one of continued problems into the 1990s. Pascal Schmid corroborates this conclusion on PHC, showing that by 1990 rural infant mortality was still double that of urban infant mortality, and that more than seventy per cent of Ghanaians lived over eight kilometres from any healthcare facility.[774] In Bawku in the 1970s, child welfare figures were increasingly annually with 98692 attendances in 1975 and 117717 by 1980. Antenatal cases went up from 24247 in 1975 to 31937 in 1980 and deliveries also improved with 196 in 1975 to 416 in 1980. Though at the same time,

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[772] Interview with Author, Anonymous.

[773] Appendix 11 - Primary Health Care Strategy For Ghana - Ministry of Health, Report on the Primary Health Care Conference: The Role and Function of NGOs/Ghana (18-20 October, Madina, 1978) Sponsored by UNICEF, 4215.5.11 Other Organisations 11-12 NGO Primary Health Care, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

[774] P. Schmid, *Medicine, Faith and Politics in Agogo: A History of Health Care Delivery in Rural Ghana, ca. 1925 to 1980* (Lit Verlag GmbH & Co. KG Wien, Zürich, 2018) p.316.

their access to vaccines was irregular.[775] Locally, where there was medical mission, PHC provision could show signs of biomedical coverage and some suggestions of successful improvement in health.

iv. CONCLUSION

Medical missions sustained their role in the Ghanaian state and in international health into the 1980s. They were able to continue their formal state voluntary sector role in spite of economic difficulties and the exodus of Ghanaian doctors. Thus, medical missions continued to promote and practice PHC in spite of dominant international health actors turning away from the model. Crucially, in contrast to previous chapters' analysis of medical mission and development, medical missionaries on the ground in Ghana directly deployed the new conceptualisations of community, humanity and healthcare that were in-built into PHC because of their active involvement in the CMC.

Particularly significant in PHC work were CHAG and Catholic missions, given their growth and sustained funding shown in the previous two chapters. By the 1980s, over two-thirds of the members of CHAG were Catholic. Through the Misereor-backed CMC and the success of ecumenism in Ghana, Catholic medical mission was creating PHC across Ghana. They were not heavily involved in the earliest stages of CMC discussions but Catholics were part of CHAG from 1967 which led to a much greater role in the CMC. Thus, Catholics in Ghana took an active though nuanced role in the formation of PHC, though this was complicated by divisions around key issues and because of difficulties with resources in the lean times. For international health, the consequence of their work was that Mahler had another forum in which to encourage PHC and realise some of its potential in the face of prevailing trends. Whilst the emergence of international health did not determine the expansion of Catholic medical mission in Ghana, which was related to postwar West German and Dutch visions of development, through CHAG and the CMC it did shape the way in which it was imagined and practiced. In the lean times of Ghana in the 1980s, medical missions were a vital feature of the health landscape, they had survived, they had renewed and they had adapted, but they were also heterogenous still; missions were spread in particular areas and in particular ways, as a result of long-term processes of colonial and postcolonial development.

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[775] Annual Report of the Bawku District Medical Programme 1980, Country Files, 1-7 Ghana, 4215.3.10, Christian Medical Commission, Archives of the World Council of Churches (Geneva, Switzerland).

CONCLUSION

Not only did medical missions in Ghana weather the storms of decolonisation, but the postwar and postcolonial world also offered new streams of funding, new national agendas of humanitarianism and new opportunities for development work. There were structural continuities in medical mission between 1919 and 1983 but there were also significant changes currently not represented within histories of internationalism, medicine or development. In bringing together the historiographies of international health, development, the colonial state and its various structures (as well as colonialism more broadly defined) and medical mission, this thesis has posed new questions as well as formulated fresh categories of analysis. These new research aims and methods have led to the examination of previously unexplored rich archival stores and to the production of original arguments within these historiographies. Most importantly, it has been argued that there was a huge growth in Catholic medical mission beginning in the late 1950s with funding from West German and Dutch Catholic aid organisations. This built on the historical legacies of colonial medical mission but it was not defined by their patterns. It had long-term ramifications for US development aid and international health organisations in Ghana. Following Vatican II and shifts in American political culture, Catholic medical mission in Ghana had significant ramifications for USAID food aid through the Catholic Relief Services and the continuation of the Primary Health Care movement against dominant trends in international health. By 1984, the Christian Health Association of Ghana (CHAG), which was created by the CMC to represent the formal voluntary sector of medical missions, was 69 per cent Catholic.[776]

This thesis has challenged common periodisations of international health by analysing the complexity, survival, adaptation and fresh formations of medical mission and its healthcare development in Ghana between 1919 and 1983. Anne-Emmanuelle Birn has argued that international health can be parcelled up into stages of 'success' as defined by international health organisations.[777] Furthering this method in her work on smallpox eradication she has argued that Halfdan Mahler viewed smallpox success as a deterrent to PHC success, and that there was an uncomfortable coexistence of these ideologically opposed standpoints in his reports.[778] By contrast, this thesis emphasises the dangers of such over-generalisations, as there are national, regional, international and, even, local strands in what is now regarded as global health, all of which get diminished and ignored when historians dabble in pre-determined over-generalisations that presume the weakness/inability of local actors to create many trajectories of action within complex international and global health programmes. Thus, this thesis has nuanced the presiding historical narrative in which

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[776] In 2012, CHAG was still 70 per cent Catholic; J. Olivier, M. Shojo, Q. Wodon, 'Faith-inspired Health Care Provision in Ghana: Market Share, Reach to the Poor, and Performance' MPRA Paper No. 45371 (November 2012); 'Gh.27: Ghana: CHAG's Efforts in Health Care' (August 1984) pp.1-9, Annexes I-III, SOAS Library and Archives (London, UK).

[777] A-E Birn, 'The stages of international (global) health: Histories of success or successes of history?' *Global Public Health* 4.1 (2009) pp.50-68.

[778] A-E. Birn, 'Small(pox) success?' *Ciência & Saúde Coletiva* 16.2 (2011) pp.591-597.

international health was founded by colonial organisations alone and functioned mainly through long-term networks of tropical medicine. It has shown how forgotten or neglected transnational, multinational and regional missionary networks and institutions could act in ways not determined by the dominant aspects of the emergence and 'strategic adaptation' of the international health community or by the Cold War concerns of nation-states or by colonial pasts or by networks of tropical medicine. The Cold War and international health shaped Catholic medical mission through organisations such as the CRS, USAID, CHAG and the CMC, but they did not determine it. Moreover, colonial structures shaped what was possible for Catholic medical mission in the form of historic inequalities, the formal voluntary sector and historic traditions of mission; yet, again, Catholic medical mission was not determined or driven by these legacies. Instead, Catholic medical mission was formulated through new processes of humanitarianism, development and evangelism, at its various layers, which manifested in the postwar restoration of West Germany and Holland. Reframing the historical category of international health requires attention to these processes outside of its classic articulations.

The analytical concept of international health can be further complicated by showing how the connection between medical mission and development has been constructed, disseminated and experienced in a variety of ways. USAID expanded its global horizons in relation to changes in Catholic medical mission and, with WHO sponsorship, USAID financed smallpox and measles control in Ghana because key Ghanaian actors had evangelistic visions for tackling diseases neglected during colonialism. USAID was not monolithic but was complicated by new actors and changing conceptions of development and medical mission at its various levels. Moreover, categories of space, the body and governance, which formed how international health organisations like USAID imagined their work and structured their programmes, were fluid, contested and subject to historical change. Catholic medical mission itself was not monolithic but changing amidst decolonisation, Africanisation, international reforms, national and regional political battles, and local internal divisions. All this was within the long history of denominational rivalries and cooperations, the varying concerns of medical missions, their shifting identities and their relations with many actors. The complexities of USAID, WHO and Catholic medical mission, and the ways in which they related in Ghana, show the importance of analysing international health within its many contexts, in order to challenge fundamental assumptions about its operation.

As a result of its persistent and evolving role between 1919 and 1983, medical mission in Ghana often figured in contested norms of modernity, international governance and nationality. Depending on the context, and the concerns of African nationalists, international health organisations, West German political leaders and missionaries themselves, the relation between medical mission and development could be reimagined in a variety of ways which were often in tension. The connection between mission and development was identified with evangelism and proselytism, spiritual support for colonial rule, technical solutions and scientific expertise for postcolonial modernisation, a site for postwar European humanitarian reconstruction and an expression of shared human suffering. Even within the same transnational missionary network there could be a variety of conflicting interpretations, narratives and claims on medical mission and its

development work. Medical mission and development also featured in political battles over the norms of Ghanaian sovereignty, the reach of the state, its claims to provide for its citizens and its claims to modernity. Medical missionary culture shaped these debates and helped to form key categories in the construction of postwar and postcolonial national identity, both in Ghana and in Europe. As for the international governance, medical mission contributed to how the individual and the community in development were defined.

Grand narratives about modernity and nationhood which motivated the organisation of large-scale medical mission in Ghana were uncoupled frequently from the concerns of the missionary actors who produced the healthcare itself. Missionaries' lived experiences, their perspectives and their organisational dynamics were frequently detached from abstract debates about development, voluntarism and nationality. As Emma Hunter puts it in her work on ideas of freedom in Tanzania: 'apparent uniformity at the level of words and concepts can hide the multiple and contested meanings developed in local contexts'.[779] The possible relationships between mission and development, and the political positions with which they were identified, were the subject of intense contests in colonial and postcolonial Ghana. Power comes from many directions and moves in many directions, and in the fights over who had the power to construct the missionary relationship with development, many actors had a stake at different points in time. Policymakers' visions of development could be far from the realities and aims of medical missionary activities. This was notable in the cases of the Catholics under Guggisberg, Scottish Presbyterians and SDAs in the 1950s in the formal voluntary sector, the PCG and Catholics' Africanisation in the context Nkrumah's modernisation, Misereor and German humanitarian concerns and their missionary beneficiaries, and USAID's Cold War concerns with Frank Grant's Aggrey-tradition of Africanisation and Methodist evangelism. Medical missionary norms sometimes had little bearing on the evolution of key categories in national and international healthcare, governance and ethnicity. Yet, at the same time, missions could utilise these gaps and shape international health by their own concerns. Especially with the Seventh-Day Adventists in the 1950s voluntary sector, medical missions under Nkrumah under the 1960s, and Frank Grant with USAID and WHO, medical missionaries adapted their work and lay claim to certain narratives and programmes in order to reshape international health and development by their own faith-motivated concerns.

In other ways, some medical missions' visions did match up with governments, policymakers and some parts of international health; therefore helping more obviously in the construction of key development categories. Medical missionary thinking could map directly onto the development models of colonial governments, nation-states, international health organisations and NGOs. This was particularly the case with the Presbyterians and the interwar colonial state, Gold Coast Governors and medical mission hospitals between the 1940s and 1950s, the Catholic Relief Services with USAID from the early 1960s, and Ghanaian Christian doctors, the CMC and Catholic missions with the PHC movement. In these cases medical missions' organisational structures, their networks, their debates, their racial narratives and their social conceptions

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[779] E. Hunter, *Political Thought and the Public Sphere: Freedom, Democracy and Citizenship in the Era of Decolonization* (Cambridge: Cambridge University Press, 2015) p.10.

contributed to the shape of development and international health at the time. These roles did not always produce the effects for which medical missionaries might have hoped but missions were empowered with an active place in the practical and imaginative formations of international health and development. Whilst there were many underlying conceptions of development and complex rival traditions, this corroborates and extends Packard and Cooper's thesis (along with those of Hunter, Hodge, Hödl and Kopf) that the concept of development could be one in which diverse and contradictory interests could come together within one amorphous concept.[780] Medical missionaries, Ghanaian communities and chiefs, Christian Governors and Christian Ghanaian doctors could be agents in the construction of development in partnership with international and national health. This was a dynamic relationship, with some key individuals straddling the divide between mission and international health. These relations were neither stable nor consistent, and public narratives could conceal or reveal complicated local rivalries and resource limitations. This was a process with huge significance for Ghana between 1919 and 1983.

This thesis has also built upon and nuanced the emerging literature of the history of global health. In recent years, historians of global health have been interrogating Africa as a site of international public health interventions, which have increased since the 1990s (though actual health outcomes often have not) and which have strong continuities with colonial pasts. Ruth Prince in 2014 described Kisumu in Kenya as place in which bodies and health are tied to 'global assemblages of medicine' where a grid of services, resources and opportunities interlock with government, and deepen dependence. She argued that this connection to the global and development is imagined 'not as a process encompassing the national collective but as an opportunity for individual social and geographic mobility'.[781] In 2015 Paul Wenzel Geissler similarly argued that the African state is at times an ephemeral figure, not monolithic and predictable but weak amidst other forms of global governmentality.[782] In Tamara Giles-Vernick, L. A. James and J. R. Webb's edited volume on Global Health in Africa in 2013, their work shows how the issues that Prince and Wenzel Geissler discuss have roots in long-term, persistent interventions by NGOs, international health organisations and medical researchers.[783] Moreover, they emphasise that Africa is still a site of human experimentation. This thesis has

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[780] E. Hunter, 'A History of *maendeleo*: the concept of "development" in Tangayika's late colonial public sphere' in J. M. Hodge, G. Hödl and Martina Kopf, *Developing Africa: Concepts and Practices in Twentieth-Century Colonialism* (Manchester and N.Y, Manchester University Press, 2014) pp.87-108; F. Cooper and R. Packard, 'Introduction' in F. Cooper and R. Packard (eds.) *International Development and the Social Sciences: Essays on the History and Politics of Knowledge* (Berkeley: University of California Press, 1997) p.7 cited in J. M. Hodge and G. Hödl, 'Introduction' in J. M. Hodge, G. Hödl and Martina Kopf, *Developing Africa: Concepts and Practices in Twentieth-Century Colonialism* (Manchester and N.Y, Manchester University Press, 2014) p.2.

[781] R. J. Prince, 'Navigating "Global Health" in an East African City' in R. J. Prince and R. Marsland (eds.) *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives* (Athens, OH: Ohio University Press, 2014) pp.208-230.

[782] P. Wenzel Geissler, *Para-States and Medical Science: Making African Global Health* (Durham, N.C: Duke University Press, 2015).

[783] T. Giles-Vernick, L. A. James, J. R. Webb (eds.) *Global Health in Africa: Historical Perspectives on Disease Control* (Athens, O.H.: Ohio University Press, 2013).

built upon this research by showing the long-term processes that led to development being construed not only as a term for the national collective by Ghanaians, but as an opportunity for individual and social geographic mobility, and for religious advancement. The state in Ghana has been both bolstered during economic struggle and also weakened amidst the types of governmentality practised by the international networks and institutions analysed. The deepening dependence Prince describes is not a short term product of a mixed set of interventions in Ghana, but a continuous track of structural and cultural change in which the global is a constant feature of the grid of medical services, resources and opportunities in Ghana since the 1920s. The government of Ghana may try to project homogeneity and a national health system, but ultimately medical missions, in terms of data collection, surveying and service delivery, have unintentionally created alternative sites of citizenship with global imaginaries, through offering an alternative to secular provision. These global imaginaries have their roots in historic mission traditions and identities, and shape the way in which development is practiced and how modern medical care, and the healthy and unhealthy body, are envisaged in Ghana. At the same time, nuancing the work of Stephen Feierman (et. al.) and Vihn-Kim Nguyen, this thesis has argued that with medical mission and Christian medicine, Ghanaian actors have effectively manipulated global health programs and refocused them on local priorities; in this case global health has not been a consensus or type of sovereignty which has excluded African voices in its creation.[784]

Attention to the complex histories of medical mission and its relation to development is important if current international health organisations are to recognise the complex contexts of its interventions. In the 2014-15 Ebola crisis, international health organisations failed to fully comprehend the vital role that faith communities and religious organisations needed to play in order to build trust and stop the epidemic spreading. As Sally Smith and Katherine Marshall have argued: 'Despite religions' deep-rooted health and social roles…national governments and international actors were late to appreciate the vital roles of religious actors in addressing Ebola and supporting health systems'.[785] Marshall and Smith go on to argue that Catholic and Protestant aid organisations and churches were rapid in reacting to the crisis but international health coordination with their efforts was 'restricted'.[786] The Christian Health Associations (CHAs) in Sierra Leone and Liberia were also able to mobilise volunteers, import medical supplies and organise training but failed to consolidate their relations with the government leaving hospitals and clinic under-supported.

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[784] Feierman et al., argue that power imbalances have led to blockages in global health; however, in the case of medical missions and Christian medicine in Ghana, this thesis has shown how Africans have been able to circumvent programmes supposedly created in the global north, for their own concerns and priorities. This also nuances Vihn-Kim Nguyen's arguments about the denial of sovereignty to Africans resulting from the power of 'therapeutic citizenship' in global health regimes. By contrast, as has been shown in through the history of medical mission and Christian medicine in Ghana, African actors could be a part of creating global health regimes as well as being subject to them; see S. Feierman, A. Kleinman, K. Stewart, P. Farmer and V. Das, 'Anthropology, Knowledge-Flows and Global Health' *Global Public Health* 5.2 (March 2010) pp.122-128; V.K Nguyen, *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS* (Durham, N.C: Duke University Press, 2010).

[785] K. Marshall and S. Smith, 'Religion and Ebola: Learning From Experience' *The Lancet* 386.10005 (2015) p.e24.

[786] K. Marshall and S. Smith, 'Religion and Ebola: Learning From Experience' *The Lancet* 386.10005 (2015) p.e24.

Churches and faith communities were able to quickly distribute health messages and engage with the issues such as funeral practices that were causing the disease to spread. The WHO working with these local experts was critical to Ebola's control.[787] Considering how in Ghana medical missions and churches have been necessary to maternal and child health, smallpox and measles control, medical education, food aid through PL-480 and PHC, their neglect is a major lucuna in international health thinking. Moreover, given that the voluntary sector of medical mission has been a sustained part of state provision since the outset of development planning, it is even stranger to occlude them. Whilst missions did not secularise, it seems that international health perspectives see only the secular, instead of fully comprehending the complexity of medical history in Africa.

In the future, historical research could further benefit understanding in national and international health by detailing exactly what have been exact health outcomes of particular medical mission practices and the religious conversion of Africans. This thesis has broadly mapped some of the results for Ghanaian healthcare and disease incidence of medical mission; it has shown the fall and rise in infant mortality in relation to missionary maternal and child health in the 1930s and their hospital building in the 1950s. It has commented on the limitations of PHC to transform completely key patterns in Ghanaian health inequalities in the 1970s and 1980s.[788] This thesis has also shown the effectiveness of some missionary aims when combined with national and international health concerns, especially in disease campaigns such as against smallpox and measles in the 1960s and 1970s. However, how Ghanaian patients were shaped by faith-based healthcare or the normative agendas of Christian medicine has not been covered. Studying linkages between religion and health in Uganda, with regard to patient characteristics and health outcomes, has been begun by Shane Doyle, Felix Meier zu Selhausen and Jacob Weisdorf but is yet to published. This is an important step in analysing whether Christian converts were healthier, whether Christian patients had better health than non-Christians and whether missionary propaganda had extensive effects.[789] Building on this analysis and that of Pascal Schmid on the Agogo hospital, it would be an important advancement in the scholarship to study what were the health effects of Catholic conversion in particularly regions, networks and hospitals in Ghana.[790] Furthering the argument of this thesis on the significance of Catholic medical mission in Ghana, answering these questions would contribute to a deeper understanding of the incentives behind African Catholicism and the roles that Catholic medical missions and churches played in national and international health.

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[787] K. Marshall and S. Smith, 'Religion and Ebola: Learning From Experience' *The Lancet* 386.10005 (2015) pp.e24-e25.

[788] See also P. Schmid, *Medicine, Faith and Politics in Agogo: A History of Health Care Delivery in Rural Ghana, ca. 1925 to 1980* (Lit Verlag GmbH & Co. KG Wien, Zürich, 2018) p.316.

[789] S. Doyle, F. Meier zu Selhausen and J. Weisdorf, 'Who came to the Clinic? Patient Characteristics and Heath Outcomes in a Ugandan Mission Hospital, 1908-1970' (Unpublished Research Project) http://www.sussex.ac.uk/profiles/361513/research

[790] P. Schmid, *Medicine, Faith and Politics in Agogo: A History of Health Care Delivery in Rural Ghana, ca.1925 to 1980* (Lit Verlag GmbH & Co. KG Wien, Zürich, 2018)

It is clear that twentieth-century medical missions changed Ghana but to what extent they changed the United States or Western Europe is also yet to be studied. This thesis has shown the divisions in the perspectives on development between medical mission's originators and its donors, and the lived experiences and motivations of its actors. Whilst the cultural encounters between medical missionaries and Ghana shaped conceptions of community, medicine and development, it is yet to be studied in-depth how much the effects of medical mission 'reverberated' back on Europe, as the German President, Heinrich Lübke had hoped in 1964. Whether or not Misereor did help to unify East and West Germany, and whether the contribution did consolidate the restoration of a humanitarian national identity or shared suffering with Europe, would be a worthwhile investigation. In David Hollinger's work on *How Missionaries Tried to Change the World but Changed America*, he argues that returning missionaries promoted multiculturalism, anticolonialism, critiqued Protestant hegemony and advocated pluralism in American life.[791] Medical missions on returning from Ghana (which many eventually did) as anthropologists, managers, teachers, parents and doctors probably did change the way in which Europe and the United States conceived of postcolonial change. Christian Ghanaian doctors also challenged conceptions of African identities, Empire, faith, race and medicine in the places to which they travelled. There are many stories yet to be told about the lives and after-lives of twentieth-century medical missions, and their global and local effects.

[791] D. A. Hollinger, *Protestants Abroad: How Missionaries Tried to Change the World But Changed America* (Princeton: Princeton University Press, 2017).

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4215.0.3 Christian Medical Commission: History of the CMC: 1-5 Tübingen II; 6-7. Background material; 8. Reports on healing; 9. Book and press release

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4215.5.11 Christian Medical Commission: Other Organisations 1-4 Institut Panafricaian de santé communautaire; 5. ICCO; 6. IDT; 7. League of Red Cross; 8. MAP Internatinal; 9. MISEREOR; 10. Missions boards; 11-12 NGO Primary Health Care

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