

Disability and Rehabilitation in Late Colonial Ghana  
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**Abstract:** This paper analyzes disability and economic rehabilitation in late colonial Ghana (the Gold Coast), focusing particularly on a program for African soldiers between 1943 and 1947. The project, which attempted to reintegrate the rehabilitees into the existing workforce, failed within a few years of its inception. I argue that its failure occurred for three reasons: urban economic hardship, the rehabilitees' peasant backgrounds and the colonial doctrine of community development. Reinforcing this analysis is the fact that after independence, the Ghanaian government reversed the colonial conditions and achieved much better success.

**Key Words:** disability, rehabilitation, colonial Ghana

### Introduction

Between 1943 and 1947, the West African War Council (WAWC) and the government of the Gold Coast (colonial Ghana) developed a rehabilitation program for African soldiers disabled by combat injuries during World War Two. The West African initiative drew heavily on the British model of social orthopaedics, which sought to rehabilitate disabled individuals economically by reintegrating them into the existing workforce.<sup>1</sup> The model was "social" in that it defined social citizenship by participation in the labor market; to be a full citizen, that is, one had to be a productive worker. For the British state, expanding the workforce to include those disabled in combat was especially important during the World Wars because military recruitment triggered domestic labor shortages. During World War One, the British government relied on private charities to care for disabled soldiers. In the 1940s the state shifted gears, assuming direct control of the national rehabilitation program through the Interim Scheme of 1941 and the Disabled Persons (Employment) Act of 1944 (Cooter, 1993; Cohen, 2001). As we shall discover, the Gold Coast scheme envisioned a similar project of state-directed economic rehabilitation.

Centered in Accra the colony's biggest city, the Gold Coast rehabilitation program sought to retrain the ex-soldiers as productive workers, either by reintegrating them into the urban labor market or placing them in sheltered workshops producing items for sale. Initially, the Accra "Convalescent Wing" targeted soldiers from the Gold Coast Regiment of the West African Frontier Force, best known for its campaign in the Arakan province of southwest Burma (Bourret, 1960; Killingray, 1982; Jackson, 2006). By mid-1945, however, the Wing's patients included soldiers from the other British West African colonies (Nigeria, the Gambia, and Sierra Leone), as well as a handful of civilians (Spooner, 1945, May 15). However, after admitting several hundred trainees in 1944-5, the project faltered and the colonial government abandoned it in 1947.<sup>2</sup> Twenty-four years later, the post-independence government led by Kwame Nkrumah revived the rehabilitation program with more success, extending it to rural areas in addition to Accra and targeting 13,000 formally registered disabled Ghanaians.<sup>3</sup> Although Nkrumah's program deserves to be studied in its own right,<sup>4</sup> for our purposes it is most useful in

shedding additional light on the roots of the colonial failure. Our discussion therefore contains two strands. First, we shall assess the failure of colonial rehabilitation based on evidence from the 1940s, highlighting funding problems, poor economic conditions, and the colonial doctrine of community development as the main problems. Second, we shall use Nkrumah's program, which reversed many of the problematic colonial policies, to reinforce our argument about the failure of the 1940s and to demonstrate that rehabilitation could work under the right conditions.

#### Social Orthopaedics and Soldiers' Rehabilitation in the Gold Coast, 1943-47

##### Planning for Rehabilitation, 1943-44

In early 1943, the Colonial Office convinced the WAWC and the Gold Coast Government to build a rehabilitation unit for disabled soldiers at the Accra Military Hospital (the 37<sup>th</sup> General Hospital). Reflecting the social orthopaedics model, the WAWC insisted on limiting admission to soldiers with treatable disabilities in order to increase the chances of rehabilitees returning to the labor market (WAWC, 1943, January 16 and 28; Emberton, 1942). This approach reflected Britain's Interim Scheme, which classified disabled soldiers into three categories: those who could return to previous forms of employment, those who could be trained for a different form of employment, and those who could not return to any form of employment (Stanley, 1944, February 28). The British Government excluded the latter, often called "incurables," from the rehabilitation process. In the Gold Coast, Sgd. R. A. Hopple reproduced these categories in a slightly different form, classifying injured African soldiers as temporarily disabled, permanently partially disabled, and permanently totally disabled. Individuals in the first two categories would be taught a trade, while "permanently totally disabled" soldiers would be placed into long-term care or returned to their families. The trades would focus on artisans' occupations, to be pursued individually or in sheltered workshops, as well as clerical work suitable for government employment (Hopple, 1942).

Britain followed up the Interim Scheme with the Disabled Persons (Employment) Act, which established the right of disabled individuals to participate in the labor market "in a normal competitive environment" (Borsay, 2006, p. 135). The Act contained three components. First, it mandated training and resettlement schemes designed to assess the potential of disabled individuals for reintegrating into the labor market; second, it set quotas of disabled employees for employers; third, it provided for segregated employment at home or in sheltered workshops for individuals deemed incapable of participating in the mainstream workforce. To these ends, the Act called for the development of Rehabilitation Centers and Disablement Settlement Officers to manage the various schemes (Borsay, 2006). In May 1943, the Colonial Office began to pressure the WAWC to implement similar legislation in the Gold Coast. After nine months of discussions, the WAWC and the Gold Coast Governor finally committed to the project in February of 1944 (Stanley, 1943; Stanley, 1944, February 28; Courtland, 1943).

Despite public support from the Secretary of State for the Colonies (Stanley, 1943; Stanley, 1944, March 15), disagreements between the Colonial Office and West African officials delayed the scheme's implementation. For example, the Secretary of

State argued that the colonies had an obligation to “resettle” all disabled soldiers “in civil life,” including so-called incurables (Stanley, 1944, March 15). The Colonial Office also disliked the emphasis on crafts over standard wage employment (Stanley, 1944, May 16). In contrast, the Gold Coast Government excluded incurables and emphasized craft production. Other sticking points included military versus civil responsibility, staff shortages, and the production of artificial limbs. These problems were intertwined and they reflected the challenge of translating British wartime legislation to the West African colonies. For instance, in the United Kingdom soldiers deemed unfit for service were discharged within 28 days and turned over to the Ministry of Pensions, after which their rehabilitation became a civil responsibility. The War Office wanted the West African colonies to implement the same principle, but the Gold Coast Government argued that staff shortages would make it impossible. Unless the British Government funded the entire rehabilitation process, after 28 days, the Gold Coast would have to attempt rehabilitation through its existing offices, workshops, and technical schools. The Convalescent Wing would have to be discontinued owing to a lack of resources (Gold Coast Finance Committee (GCFC), 1944). Artificial limbs presented another hurdle. The West African Governments wanted them to be produced at the same standard as Britain’s, that is, prostheses with working joints made from metal rather than simple wooden peg legs.<sup>5</sup> To this end, an expert from the limb-fitting firm Hangars visited West Africa and concluded that West African limb-fitters would have to be trained by British experts. This was not possible, however, because of a shortage of British trainers (Shepherd, 1944).

Eventually, the West African vision prevailed regarding craft production and incurables, and agreements were reached to compensate for staff shortages in rehabilitation and limb-fitting. Most importantly, the War Office agreed to subsidize the construction of the Convalescent Wing. When it opened, patients would be discharged from the military after 28 days and the Gold Coast Government agreed to cover the costs of their subsequent rehabilitation. Regarding artificial limbs, Italian prisoners of war with limb-fitting experience would be sent from East Africa to train African limb-fitters at a new limb-fitting center. Britain would fund the Accra limb-fitting center but the Gold Coast would cover the Italians’ transportation costs. In addition, the British Government would bring one disabled African ex-soldier to Hangars’ workshop for training (Shepherd, 1944).

#### Implementation and Failure, 1944-47

With the arrangements secured, the project moved forward in the late summer of 1944. The Italians arrived in August, and on 4 September 1944, the Wing received its first disabled patients. Housed separately from the hospital, it contained huts, a gymnasium, running track and food store, as well as the artificial limb workshop. By 12 October, the Wing was fully functional, although the limb-fitting workshop had to produce inferior prostheses from local materials until the arrival of limb sets from Hangars in February of 1945. In the meantime, the Gold Coast Government sent a disabled soldier, J. B. Nelson, to Hangars for training (WAWC, 1944, August 1; WAWC, 1944, September 14; Jones, 1944; Burns, 1945). Back at the hospital, in a twist on the British system, as of January, 1945, the military agreed to discharge the disabled soldiers

with 28 days' pay as soon as they entered the Convalescent Wing. They were therefore supported entirely by the colonial government, receiving a full disability pension while undergoing rehabilitation (WAWC, 1945, 23-4 January). Two further developments occurred in March. First, the Gold Coast Government considered, but rejected, legislation mandating employment for disabled ex-soldiers after rehabilitation, on the grounds that it did not want to force them into the labor market. Instead, they would be assisted by Resettlement Advice Centers established for all ex-soldiers. Second, after 20 March, the Convalescent Wing began to accept civilian patients (WAWC, 1945, March 8; Robinson, 1945). More than two years after the WAWC proposed the Accra rehabilitation center; it finally had become fully operational.

The Convalescent Wing operated effectively for the first several months. However, on 20 May 1945, the Demobilization and Resettlement Committee of the WAWC reported that the returning soldiers intensely disliked the idea of rehabilitation, preferring to return directly to their homes after medical treatment. To address this problem, the Committee suggested bringing the soldiers' families to Accra in order to persuade more of them to stay for rehabilitation. This did not happen, however, and by late July there were only a handful of patients in residence. On 22 July, faced with a decision to cut European staff, the War Office proposed closing the Convalescent Wing. Henceforth, disabled soldiers would be treated in existing hospital wings, perhaps with some rudimentary arts and crafts training. On 7 August 1945, the Gold Coast's Commissioner of Labor agreed to close the Wing but not the limb-fitting workshop (WAWC, 1945, May 20; West Africa Command, 1945; Spooner, 1945, August 7). The following March, the War Office took over the building as its new headquarters and the colonial government moved the Italian limb-fitters (who had been freed officially on 24 August 1945) to Korle Bu hospital in central Accra, where rehabilitation facilities were established on much smaller scale (Gold Coast Italian Limb Team, 1946; Burns, 1945). A year later, the government closed the limb-fitting center and the remaining rehabilitation facilities (Gold Coast Legion, 1947).

Hundreds of rehabilitees passed through the Convalescent Wing at its peak between October, 1944 and March, 1945, but the numbers declined precipitously thereafter as the trainees graduated and very few new patients agreed to attend (Spooner, 1945, May 15). Unfortunately, we do not know what happened to the graduates, as there are no records and no indication that the colonial government followed up or even recorded where they went afterwards. It is almost certain, however, that most of the trainees simply returned home after rehabilitation, left to fend for themselves. As such, the colonial project must be considered a failure.

#### Kwame Nkrumah and the Revival of Rehabilitation, 1960-66

But this was not the end of the story, for the African government of Kwame Nkrumah revived the rehabilitation program after the Gold Coast became independent as Ghana in 1957. Nkrumah "discovered" disability shortly after independence when he began to gather and jail destitutes and beggars, only to find that many of them were disabled. Alarmed by this revelation, in late 1960, Nkrumah recruited John Wilson, Director of Britain's Royal Commonwealth Society for the Blind, to survey the state of

disability in Ghana and develop a comprehensive rehabilitation program. Wilson's recommendations prompted the revival of the colonial scheme and its extension to rural areas. Specifically, Wilson recommended an Industrial Rehabilitation Unit (IRU) and limb-fitting center in Accra, along with eight Rural Rehabilitation Units (RRUs) spread throughout the rest of the country. While the Government developed the Units, registration teams fanned out across the country to register disabled Ghanaians on a regional basis. By the end of 1963, over 13,000 individuals had registered officially (Adoo, 1964). There is no information on their backgrounds, but undoubtedly, more than a few ex-soldiers would have registered during these years.

Like their colonial predecessor, Nkrumah's Rehabilitation Units focused on economic integration. The IRU provided strengthening exercises and basic skills training as a springboard for specialized training in urban occupations. Skills training included carpentry, metalworking, and farm gardening, the products of which were sold to raise money for the Unit (Ghana Department of Social Welfare and Community Development [GDSWCD], 1966). The RRUs offered specialized training for village and town occupations as well as literacy and citizenship classes for peasant trainees. The RRUs' main goal was to produce "all-rounders" in peasant villages, self-supporting and capable of everything from farming and poultry raising to house construction and tailoring, but they also provided training for occupations in rural towns. Taken together, the IRU and RRUs achieved more success than the colonial scheme. For example, in 1963, 56 IRU graduates found jobs, mostly in manufacturing but also in retail and the hotel industry (GDSWCD, 1966). During the same year, a similar number of RRU graduates obtained wage employment in the smaller towns (Adoo, 1964). The graduates provided good publicity for the Rehabilitation Units, as in the cases of Richard Fodzi and S. R. Owusu, two physically disabled adults who became craft instructors at a middle school after graduating from the Ho RRU. Fodzi remained in his position, while Owusu raised enough capital to become an entrepreneur in Accra (Acquah, 1966). In 1966, the community development journal *Advance* published the stories of twenty-five more rehabilitation graduates of the IRU and RRUs. In addition to their programs at the Rehabilitation Units, they also received support from a variety of other sources, including the Korle Bu hospital, the Accra limb-fitting centre, the Ghana Cripples' Aid Society, and the Presbyterian Church. After graduating, all of the rehabilitees found productive employment in a number of occupations, including craft production, teaching, industry, and trade (Acquah, 1966). In contrast to the colonial program, these stories indicate that Nkrumah's initiative was much more successful.

### Concluding Remarks

The colonial rehabilitation model of the 1940s owed much to Britain's emphasis on economic reintegration. Under the British paradigm, rehabilitation sought to "normalize" ex-soldiers disabled from wartime injuries by reintegrating them into civil life through vocational rehabilitation. The British rehabilitation scheme targeted ex-soldiers with any form of physical disability, including but not limited to cartilage injuries, amputated limbs, blindness and paralysis (Great Britain Ministry of Pensions, 1942; Watson-Jones, 1942; Anderson, 2003). Under the rehabilitation model, the British Government did not consider disabled ex-soldiers true citizens until they became

productive workers. The British Ministry of Pensions and the Colonial Office expressed this idea explicitly during the discussions about the Accra Convalescent Wing. For instance, in 1942 the Ministry of Pensions told the WAWC that “rehabilitation aims at restoring patients to their full wage-earning capacity in the shortest possible time” (Great Britain Ministry of Pensions, 1942, p. 1). Two years later, the Colonial Office referred to this process as “resettlement in civil life” (Stanley, 1944, February 28, p. 1). The WAWC and the Gold Coast Government accepted this model, seeking to normalize disabled soldiers by retraining them as workers. The GCFC, for instance, referred to this program as “the process of returning the disabled man to civil life—a process which entails in cases where medical treatment is unable to fit a man to return to his previous occupation, a special training designed to equip the disabled man to live as full and as useful a life as possible” (GCFC, 1944, July 25, p. 1). This statement clearly linked civil life to economic productivity and rehabilitation.

As it happened, this vision was incongruent with the social background of the disabled ex-soldiers, most of whom had been recruited out of the rural peasantry. What chances would they have had in 1940s and 1950s Accra? Rehabilitation along British lines would have been difficult due to the peasants’ lack of formal education, and, for those who graduated, the poor state of Accra’s labor markets would have undermined their chances of success. Jobs were very scarce and the colonial governments did little to assist any soldiers, much less disabled rehabilitees. Furthermore, outside the highest ranks of the civil service, the jobs that did exist failed to provide adequate living standards. Consumer goods shortages and inflation meant that prices outstripped wages, which made it very hard for urban workers to make ends meet (Killingray, 2007; Cooper, 1996, 2002; Gocking, 2006). Sheltered workshops would not have provided an alternative because the average African urban citizen would have had little, if any, disposable income to spend on crafts. In short, rehabilitated peasants would have had an immensely difficult time finding gainful employment.

Beyond the colony’s poor urban economic conditions, the colonial philosophy of African development actually opposed the transformation of peasants into workers. From the mid-1940s, just as rehabilitation arose as a colonial project, the Gold Coast government was developing the notion of community development for the African population. Under this doctrine, communal African social structures were to be protected against the disintegrative effects of capitalist development, including “Westernization” and individualism (Cowen and Shenton, 1996; Grischow, 2006). This model had its roots in the earlier doctrine of indirect rule, in which the colonial state codified the power of chiefs as trustees over their communities (Phillips, 1989). Community development sought to modernize this system by absorbing the educated elite into village politics, but the goal of protecting African communities from modernization and individualism remained intact. Indeed, it intensified in the face of labor resistance and increasing African anti-colonial nationalism. Therefore, although community development sounded similar to rehabilitation in its drive to develop “the individual in society,” the doctrine defined “society” in terms of traditional African communalism rather than modern individualism (Hilliard, 1955a, p.27). In short, colonial development doctrine sought to block rural Africans from becoming wage laborers. Instead, “real West African progress” (Hilliard, 1955b, p.40) would occur only if individual Africans remained bound

to their communities as “subjects” of their chiefs rather than “citizens” of the nation (Mamdani, 1996). With its roots in capitalist labor regimes, economic rehabilitation directly contradicted this project.

Summing up, the colonial failure to translate British social orthopaedics to the Gold Coast occurred for a number of reasons, including funding and staff shortages, poor wartime economic conditions, and, especially, a doctrine of community development that opposed the transformation of “traditional” Africans into modern workers. The subsequent experience of Nkrumah’s disability program reinforces this argument, while showing that rehabilitation could succeed if these factors were reversed. Unlike colonial officials, Nkrumah did not worry about preserving traditional African communities against modernization and wage labor. In fact, he wanted to recruit 1,100,000 Ghanaians into the workforce as part of his drive for socialist industrialization (Ghana Office of the Planning Commission, 1964). Rehabilitation would allow Nkrumah to integrate disabled Ghanaians into this project, contributing to national development by unlocking their economic productivity. To this end, the Government absorbed rehabilitation into the paradigm of community development – the opposite stance of the colonial governments of the 1940s. Furthermore, Nkrumah did not face funding or staff shortages because, as of 1964, his government controlled £43,000,000 in reserves inherited from the British Government (Omari, 1970), which prior to 1957 had been held in London, unavailable to the colonial governments of the day. This was more than enough to cover the £165, 000 cost of the rehabilitation scheme (Wilson, 1961). In addition, the rehabilitees faced relatively better job prospects than the ex-soldiers of the 1940s, because Nkrumah created a host of state-owned factories, as well as a number of state farms (Omari, 1970). In short, Nkrumah’s successes of the 1960s shed light on the colonial failure, while demonstrating that rehabilitation could open the door to productive employment for disabled Ghanaians.

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#### Endnotes

- <sup>1</sup> This section is based on Borsay, 2005 and 2006.
- <sup>2</sup> Details of these events, which are discussed below, can be found in the Public Records and Archives Administration Department, Ghana (PRAAD), CSO18/5/23: Disabled Soldiers Rehabilitation 1941-4 and PRAAD/CSO/18/5/24: Disabled African Soldiers – Rehabilitation and Training of, 1944.
- <sup>3</sup> Ghana became independent from Britain in 1957.
- <sup>4</sup> See for example Grischow, 2011.
- <sup>5</sup> For a concise discussion of the historical development of prostheses, see Le Vay, 1990.