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# A History of Health and Psychiatry Services in Zimbabwe 1890-1980

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## Abstract

Colonialism and its associated practices of segregation and subjugation left a lasting impact on the lives of the Africans it aimed to 'civilise', despite its role in refining certain aspects of African innovation, particularly in healthcare and psychiatry. These practices influenced how Africans viewed mental health issues even after the end of colonial rule. Colonialism weaponised psychiatry and medicine, using them as systematic tools to undermine and replace African healthcare systems through the enforced adoption of Western culture and practices. Consequently, there is limited documentation on the evolution of medical and psychiatric practices in Zimbabwe from the colonial to post-colonial era. In line with post-colonial discourse, this paper traces the origins of colonial health and psychiatric services noting how they were shaped by segregationist policies. It aims to demonstrate how medical and psychiatric care developed under colonial rule within a segregated government framework designed to diminish African innovation and purpose. The paper employs a qualitative desktop analysis, examining primary archival sources on the development of medical systems in Rhodesia, secondary sources, and one-on-one interviews with key figures in the fields of mental health and African medical practice. Results show that health and psychiatric services from Rhodesia to post-independent Zimbabwe experienced numerous changes and challenges, as two systems with a common goal – to save lives – competed, with one culture promoted over the other.

**Keywords:** History, Psychiatry, Segregation, Post-Colonial Studies, Zimbabwe

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## Introduction

Healthcare services play a significant role in the wellbeing of any society, as such, healthcare practitioners and their practices are crucial to the success or failure of any given system in a society. Such a system existed in Zimbabwe during the pre-colonial era, where healthcare was egalitarian and highly valued with the system providing care to all, regardless of creed, profession, or social status(Moyana, 2022). However, with the Scramble for Africa and the subsequent annexation of Zimbabwe by the British South Africa Company (BSAC) on 12th September 1890, this once robust pre-colonial medical service began to decline due to the perceived superiority of the 'civilised' service promoted by the new administration (Ncube, 2012). As a result, while colonialism may have introduced certain benefits to African society, these were often implemented within the broader context of colonial exploitation and control, which had complex and sometimes detrimental effects on local communities (Ocheni & Nwanko, 2012). The Zimbabwean society was so deeply affected by colonialism that even after independence, its impact continued to be felt within the medical fraternity, particularly in psychiatry. This study aims to illustrate how medical and psychiatric care evolved under colonialism through a segregated government system, which in turn fostered African subalternity.

Colonialism sought to alter the situation not only politically and economically but also socially, including healthcare services. Under this system, Africans were not provided with the same level of healthcare as the European community, including mental health services. As a result, healthcare services were organised under a selective system that favoured Europeans over Africans through the enactment of discriminatory laws and practices. These laws marginalised Africans from accessing basic goods, services, fertile land, and efficient healthcare (Land Apportionment Act, 1930). Consequently, Africans continued to rely on traditional healthcare systems even when they had been criminalised under the Witchcraft Suppression legislation which had been passed in 1899 a few years after colonisation had been established up until 1923, when Health Services for both European settlers and Africans became a government responsibility. Prior to this, medical services were provided by missionaries, who had established hospitals and clinics, offering 1,471 beds for Africans, with 16 Medical Officers attending to them (Gear, 1960).

The primary state healthcare provider, Salisbury (now Harare) Hospital, was a makeshift hospital serving police officers, priests, European businesspeople, and

settlers. It was staffed by Dr F. Rand, with Mother Patrick and four Dominican Sisters assisting. Meanwhile, Bulawayo's Memorial Hospital, opened in 1895, was staffed by Europeans. Africans living near Salisbury Hospital received treatment for free, while those in Bulawayo paid a small fee, which later became mandatory for all state hospitals (Gelfand, 1976). In March 1895, Mother Patrick's efforts to expand Salisbury Hospital to serve a broader population were realised. The new 34-bed hospital had a perimeter fence, two gates, a mortuary, and two main wards accommodating eight patients each (Gelfand, 1964a). Maternal health services began as early as October 1894 in Umtali (now Mutare), where a small hut within the hospital complex was converted for maternity and other female patients, likely becoming the country’s first dedicated maternity ward (Crawford, 1957). The service expanded with the arrival of nurse Lizzie Hewitt in June 1894, who was trained in maternity health and became the first officially recognised midwife in Rhodesia (Gelfand, 1964b).

The colonial administration promoted Western medicine and health services, often denigrating African traditional healthcare in the so-called 'civilisation crusade'. Initially, Africans were not fully integrated into the healthcare system, including mental health services. Even after some level of integration, the services provided to Africans were not on par with those offered to Europeans. Instead of granting equal access to all, the state enacted discriminatory laws that marginalised Africans from accessing basic goods, services, and efficient healthcare (Rhodesian Government, 1930). It is, therefore, important to examine how health systems were used as tools for the political subjugation of the colonised through healthcare provision.

Colonialism sought to dismantle the belief and healing systems of the colonised, which had existed for centuries. One such tactic was the 'witchdoctor thesis', which contributed to the destruction of African culture. Colonialism utilised this tactic to psychologically subjugate the colonised, knowing that one's beliefs guided conformity to social order (Government of Southern Rhodesia, 1899). By destroying the traditional power base, the colonial system could impose its own beliefs and achieve social conformity. In this context, psychiatry became a proving ground for subalternity, as Frantz Fanon argued. Fanon highlighted how psychiatry, intertwined with the political and social conditions of colonialism, undermined the colonised person's sense of identity, culture, and traditions (Fanon, 1994).

Several pieces of legislation were enacted to erode the power and belief systems of the colonised, such as criminalising traditional medicine by labelling it witchcraft. The Shona and Ndebele, for example, believed that healing systems were intricately connected to their spiritual beliefs, which held their societies together (Rhodesian Government, 1957). In this context, traditional medicine served a dual purpose—addressing both spiritual and physical health. In African settings, medicine and religion could not be separated, and certain illnesses were sometimes seen as having religious undertones. Western medicine could not fully diagnose or treat such conditions, particularly mental illnesses, when they affected Africans (Cleetus, 2007). As a result, colonialism fundamentally changed how Africans perceived illness, especially mental health, as new forms of diagnosis, treatment, and healing often clashed with cultural and spiritual beliefs. This had a profound impact on the humanism of Africans as a people.

## Methods

The paper employed a qualitative data analysis approach. It also used structured interviews involving professionals and senior citizens who directly witnessed the events under study. This method was complemented by primary sources, including archival records of health services in Rhodesia, and secondary scholarly works focusing on decoloniality and mental health practices in Zimbabwe. In examining the effects of colonialism on health services, the paper adopts a subaltern perspective, analysing sources that document the systematic subjugation of Africans and their resistance to colonial systems of medicine and psychiatry in Southern Rhodesia. This approach aims to highlight the African experience, particularly how Western medicine and civilisation alienated them from their cultural and spiritual heritage. The study explores the profound impact this disconnection had on diagnosis and healing practices, even for those who sought care in mental hospitals.

## Subalternity in Health and psychiatry Services

On 1 October 1923, the British South Africa Company (BSAC) reign ended as Southern Rhodesia became a self-governing colony with a total population of 35, 900 Caucasians and 890,000 Africans (Palmer, 1977). With Europeans being numerically outnumbered by Africans, it became a necessity to curb African development by curtailing freedom of movement, property, education and above all their well-being which in this case was the indigenous health services (Government of Southern Rhodesia, 1929). This would enable the status quo in

power and avert any future insurrection as Wilson noted in his Native Affairs report that:

> ***The objects of our native policy … (are to secure) the development of the native in such a way that he will come as little as possible in conflict or competition with the Caucasian man socially, economically and politically (Wilson, 1923)."***

Resultantly, Africans became limited in everything, they could neither stay in the same surroundings with the Europeans nor could they continue with their way of consulting traditional medical health practitioners, *n'anga* in local language, who were dismissed and labelled as witch doctors. The European settlers could not fathom being at par with people they had civilised in this regard, the native commissioner in his 1903-05 reports mentioned that "wherever Caucasians are living, repugnance is shown to the invasion of their neighbourhood by natives for residential purposes" (Palmer, 1977). As a result of such comments, segregation by definition, became the practice of a social system which provided separate facilities for minority groups, which in turn with regards to Rhodesia cascaded to education, property, and the health delivery system (Masakure, 2020). The segregation system ensured that there was no equality and equity between the African who outnumbered the European ruling class when it came to health services, even though human life came first despite colour or race (Youe, 2002). As such, conditions in the hospitals of Caucasian were better off as compared to African hospitals especially psychiatric units.

Subalternity refers to the social, political and cultural marginalisation that occurs to an oppressed group of individuals with their ways of life being regarded as backward and unacceptable, with some instances such practices and beliefs being criminalised as was the case with Southern Rhodesia (Chikafa and Mangezi, 2024). The concept of subalternity, as developed by postcolonial theorists, may also refer to marginalised groups of people excluded from hegemonic power structures which determine access to specific services and rights. In the context of Zimbabwe's health services, subalternity profoundly shaped the development and perception of mental health care and traditional healing practices from the colonial period beginning in 1890 to the present day.

With the conception of the scramble and partition of Africa and subsequent colonisation of the space, the establishment of colonial rule in Southern Rhodesia, as it was known then, brought with it new Westernised biomedical models that were imposed upon existing indigenous healing systems and practices. This development led to such practices being undermined as Africans lost political

authority which at times reinforced traditional aspects of living. Such unequal power dynamics meant that the introduction of Western medicine created new hierarchies, with Western-trained doctors often given more authority and resources than traditional healers, who would later be criminalised under oppressive acts meant to destroy the indigenous knowledge base of culture as well as medical ingenuity. (Summers, 1994) further illustrates this by noting how resources were made available for European hospitals and clinics to be built and given autonomous authority to diagnose, prescribe medicine and treat both European and African without questions asked.

Cultural dissonance evident between Western medical practices and African traditional medicine showcases the secondment of African practices as inferior to Western forms of medicinal knowledge. A point Waite illustrates pointing out that Western medicinal practices were often at odds with African cultural beliefs and practices surrounding health and illness(Waite, 2000). In African society, sickness or certain events are associated with mysticism and must be dealt with accordingly. As such, the inability of Western medical practitioners to understand one's illness as being attributed to the patient as having done something which angered their ancestors or out of witchcraft meant that they were at odds with African customs and did not regard the culture as an important facet of medical treatment and recovery and in so doing discarded African culture and medicinal practices relegating it to witchcraft.

Furthermore, the establishment of colonial rule in Zimbabwe (then Rhodesia) in 1890 marked the beginning of a systemic marginalization of indigenous health practices. As(Mutambirwa, 1989) noted that colonial authorities viewed traditional healers with suspicion and often actively suppressed their practices, through the introduction of Christian beliefs and later criminalised the consultation and practice of traditional medicine. The introduction of Western biomedicine was accompanied by many attempts to delegitimise local healing traditions, creating a hierarchical system where Indigenous knowledge and practices were subordinated to European medical paradigms. In mental health circles, this subalternity was particularly pronounced as noted by Jacobs who highlighted that colonial psychiatry in Zimbabwe was deeply intertwined with racist ideologies, often pathologising African cultural beliefs and practices (Jacobs, 2014). As such, traditional healing practices were similarly subordinated during this period with Chavunduka observing that colonial authorities were on a political mission too, to discredit and criminalize traditional healers, often describing their practices as 'primitive' and incompatible with modern

medicine(Chavunduka, 1994). Such a suppression of Indigenous knowledge systems created a legacy of mistrust and tension between traditional and Western approaches to healthcare.

Further subalternity of Africans in the health and psychiatric field is illustrated through the inequity of resources allocated per race in Rhodesia during the colonial era. Colonial psychiatry played a particularly pernicious role in the subalternity of the African in colonial Rhodesia as it subtly criminalised mental sickness and African concepts of healing and psychiatry under the guise of civilisation (Jackson, 2006) noted that Colonial psychiatric institutions in Zimbabwe were often viewed as sites of social control and racial oppression, where African patients were often diagnosed based on racist stereotypes rather than sound medical principles This approach not only marginalized indigenous understandings of mental health but also pathologised resistance to colonial rule. Thus, mental health facilities, such as Ingutsheni Hospital established in 1908, were designed primarily to contain, and control rather than treat patients effectively using medical knowledge and considering cultural sensitivities of the patient. Furthermore, such an approach not only marginalised traditional understandings of mental illness but also created lasting stigma around mental health issues in Zimbabwean society which still plague the country to date.

Despite the introduction of Western psychiatry practice during the colonial era and having significant negative implications for the mental health of African patients. With the influence of Western medicine often being laden with colonial ideologies, it is essential to recognise the benefits also that evolved from these practices, including the establishment of formal psychiatric institutions, the introduction of psychotherapy, and the increased awareness of mental health issues in African communities. One of the primary benefits of Western psychiatry during colonisation in Zimbabwe was the establishment of formal psychiatric institutions prior to colonisation, mental illness was often treated through traditional practices rooted in Indigenous beliefs. However, the colonial administration introduced Western psychiatric frameworks that led to the founding of institutions specifically designed to address mental health issues. In this instance, the establishment of the Harare Psychiatric Hospital provided structured care for individuals with mental health challenges (Marufu, 2018), creating a dedicated environment for treatment together with others such as Ngomahuru in Masvingo and Ingutsheni in Bulawayo (Jackson, 2006; Makuvaza, 2017). Such institutions often offered a level of care that was previously unavailable to many African patients though segregated, these

services included access to medication and therapies grounded in Western medical practices. Although these services were often not fully accessible to the entire population, they marked a significant shift in how mental illness was understood and treated in Zimbabwe.

Alongside institutional care, the introduction of psychotherapy as a treatment modality marked another significant contribution of Western psychiatry to African society. Traditional African healing practices primarily emphasised community and spiritual aspects of well-being, while Western psychiatry introduced a more individualised approach, focusing on the patient rather than the collective. During this period, therapeutic techniques like talk therapy were gradually integrated into psychiatric care. These methods provided African patients with a safe space to explore their emotions, thoughts, and behaviours, contributing to their psychological well-being (Chinyamurindi , 2020). Research indicates that patients who underwent psychotherapy developed stronger skills to manage the complexities of their situations, including the psychological stress brought on by colonial oppression. The coping mechanisms they acquired through therapy enhanced their ability to confront these challenges, ultimately improving their overall mental health (Moyo, 2021).

## Colonial and African traditional psychiatry services and practices

Mental health is important as any part of a nation's health curative and preventative services. Despite being an important aspect of health in Rhodesian society, it was not spared from racial discrimination as institutions catering for Europeans were better off than those offering mental health services to Africans. Historically, in Zimbabwe and most of Southern Africa, prior to the advent of Western influences, mentally ill people were well tolerated by their societies and cared for by family members. The traditional view of all illness, including psychiatric illness, was that it was caused by external phenomena such as displeased ancestral spirits (Musungo, 2019). Consequently, this external locus of control meant there was little stigma associated with being mentally ill as the illness was perceived to be from the Gods. At the same time, the Shona proverb of, "*Seka urema wafa*/ you can only scorn at disability in death," regulated stigma and mockery of those affected by mental illness (Interview, 2019). Indeed, sometimes there was an overlap between being mentally ill and being 'called' upon by ancestral spirits to be a *n'anga*. However, the coming of mental health facilities because of the introduction of allopathic health services, mental illness stigma became prevalent.

Since the space that the mental health services existed was divided along racial lines, mental institutions were open to all yet practising racial discrimination when it came to the services it offered. The prevalent social order of the colonial era had a great bearing on how the mental health system ascertained one's insanity and sanity. Because inter racial relations were forbidden, it became one of the yardsticks to label one as qualifying for mental treatment if they went beyond their race to find partners (Jackson, 2006). That is, one was 'insane' if a European had sexual relations with an African partner and vice-versa. With such a scenario determining one's sanity and insanity, there had to be institutions which managed such patients, this saw to the creation of specific hospitals dealing with mental health being established in Rhodesia in the 19th century.

Despite having several healthcare service providers in Rhodesia and later Zimbabwe namely the Ministry of Health, mission hospitals and clinics which at times were supported with state grants, as well as the industrial medical services and private healthcare providers, few ventured in psychiatric services (Agere, 1980). To that end, the healing space could be used to drive forth state segregation policy regarding culture and practices of the mind. With major hospitals being segregated as early as 1903, the same was prevalent in the provision of mental health services for the two major races, with Europeans receiving better services and amenities which promoted recovery and offered therapy. A post-independence medical health services report of 1980, It was highlighted that, "white (European) patients had psychiatric units which were pleasant and colourful, therapeutic and a modern trend which promoted recovery" (Government of Zimbabwe, 1980, p. 15). Whilst Africans housed in the same asylum were subjected to uncomfortable conditions unfit for humans, the same report indicated that African standards at mental hospitals "were institutional, custodial in intent and punitive in stance" (Government of Zimbabwe, 1980 p. 15). Hence, Africans that sought treatment at such institutions would be in an incarcerated environment than a therapeutic one as opposed to Europeans with the same conditions they sought treatment from.

Such a result may be that since the state was the sole provider for mental curative healthcare services, no improvement was made for Africans seeking treatment at its hospitals as the system was segregated unlike in a mission hospital were Africans and Caucasians could be treated by the same doctor sitting on the same bench and using the same toilet. The history of Mental Health Services can be traced back to 1908 when the first lunatic asylum was opened at Bulawayo

and named Ingutsheni which when translated into English would be place of cover (Rhodesian Government, 1908). Like all state institutions, Ingutsheni was not spared from racial biases, Europeans had better conditions of services as compared to Africans. Further on, there tended to be a handicap for Africans as psychiatric services were centralised, that is they were in major cities and towns, hence inaccessible to all Africans who sought psychiatric services. A great disadvantage for rural folk who were in the periphery of such towns and cities, such a picture paints the inability of the health delivery system's failure to mainstream mental health services for Africans as they were accessed by a few. With this deficit of mental health services in light, Simson (1979) went on to present statistical evidence on the differences in the provision of health and mental health provision by noting that:

> ***The racial breakdown of general hospital beds given one bed for every 219 Europeans and one bed for every 525 Africans. In general, each racial group has its own hospitals and clinics, although some specialist services in central hospitals may be used by all races. (As in the case of Ingutsheni) With the exception of Mpilo and Harari hospitals which by law are exclusively African Hospitals (Simson, 1979 p. 49).***

It can be said that European hospitals, especially since the construction of Andrew Fleming Hospital an all-European hospital in Salisbury, European hospitals were far better equipped with trained personnel and modern technology than African hospitals. From the above, as much as there was provision of mental healthcare, it was inadequate for Africans as they were exposed to unequal treatment conditions and care. African institutions tended to be overcrowded (Agere, 1980). Europeans had diets and environments which lessened the pressure on their mental being unlike Africans who were largely mine labourers and farm workers, domestic workers, industry handypeople and groundsmen. Occupations which exposed them to higher levels of psychological load leading them to 'burnout' and requiring mental health services. Hence if an African went to the mental health facility, they were kept in so as not to cause harm to society or themselves instead of being cared for.

## Resistance to colonial psychiatry and associated health services

Zimbabwe, a country deeply rooted in rich cultural and spiritual traditions passed down through generations, has long embraced ancestral worship as a key aspect of daily life. Ancestral spirits are believed to play a vital role in guiding and protecting the living. As such, Zimbabweans traditionally sought relief from mental illness through spiritual means—appeasing ancestors, consulting

traditional healers, or using herbal remedies—before turning to hospitals or psychiatrists. Given this cultural background, the history of psychiatry in colonial Zimbabwe is intricately connected to broader struggles for racial and gender justice, self-determination, and national independence (Jackson, 1999).

With the establishment of Health Services in colonial Rhodesia, services were segregated along racial lines, often leaving Africans with few culturally sensitive options. In response, Africans sought alternative health services that respected both their spiritual beliefs and cultural practices. This silent resistance allowed them to retain aspects of their traditional healing methods, despite efforts to make them abandon their spiritual and social systems under colonial rule. Even though they were pressured to adopt Western approaches to worship, education, and healthcare, they did not entirely forsake the homeopathic systems of medicine that had been a part of their heritage for generations.

Resistance to being treated in a mental hospital was high among Africans due to the way mental health and illness had been perceived in their society before colonisation. In the pre-colonial setting, mental conditions like dementia, which primarily affected adults and the elderly, were not treated through hospitalisation. Instead, individuals with such conditions were allowed to co-exist within their communities, serving as living reminders of their life and experiences. This contrasts sharply with the Eurocentric approach, where those with symptoms such as delusions or memory loss were often admitted to institutions, which was perceived as a form of punishment (*Interview*, 2018).

The African psychiatric system recognised that mental illnesses were a natural part of life, common, and did not warrant the stigma that colonialism imposed. An illustrative analogy is the concept of '*mhengera mumba*' or "one who is insane but lives among normal people in a house setting" (Interview, 2019). Africans preferred an integrative approach to mental health care rather than the isolative system of colonial mental hospitals, where patients were treated as inmates. This is not to say that outpatient care did not exist, but the widespread fear of being incarcerated in mental asylums deterred many from seeking formal psychiatric help. As a result, families avoided presenting relatives exhibiting symptoms of mental illness out of fear of isolation.

One key aspect of African resistance to European psychiatry was the incorporation of African Independent Churches into their healing systems. These churches, under the guise of prayer, provided an alternative to consulting traditional healers or *n'anga*, which had been outlawed under the Witchcraft

Suppression Act. According to Mokgobi, colonialism had imposed a Western worldview that sought to determine the validity of African traditional healing, even though the two systems were often intertwined (Mokgobi, 2014). As such, any healing approach outside the European framework was welcomed. African Independent Churches led by figures like Andreas Shoko, David Masuka, and Samuel Mutendi became sanctuaries for those seeking relief from both general illnesses and mental health conditions (Daneel, 1970).

The churches provided a safe space for those who would have otherwise consulted traditional healers, explaining the causes of illness in ways similar to the *n'anga* before they were outlawed. While European hospitals focused on clinical treatment, African churches emphasised spiritual healing, drawing parallels with the spiritual consultations of *n'anga*. According to Daneel, the Holy Spirit in these churches served as a substitute for ancestral spirits in the diagnosis and treatment of diseases (Daneel, 1970). Even when Africans visited Western hospitals, they often employed a dual consultation system, seeking both a Western diagnosis and an interpretation of the illness through traditional or spiritual means to find a comprehensive healing solution.

Despite legislation and mechanisms discouraging Africans from using homeopathic systems for mental health treatment, many continued to consult traditional practitioners. These practitioners were believed to provide not only satisfactory explanations for the causes of illness but also remedies that could prevent recurrence. Discriminatory practices in health services persisted, and these were exacerbated by the Rhodesian Front government's Unilateral Declaration of Independence (UDI) in November 1965. In response, Africans turned to armed insurrection to address inequalities, not only in medical services but across society (Evans, 2007).

As a result of the conflict, the health services in war-affected areas were severely disrupted. However, the two main African liberation forces—the Zimbabwe African National Liberation Army (ZANLA) and the Zimbabwe People's Revolutionary Army (ZIPRA)—anticipated this and designed a sophisticated healthcare system. This system served both combatants and civilians, blending homeopathic elements of traditional medicine with Western practices. The medical personnel from these military wings would later form the core of the Zimbabwe National Army's Corps of Medicine, with prominent figures like Brigadier General Felix Ngwarati Muchemwa and Lieutenant Colonel Stanley Urayayi Sakupwanya serving as its first Medical Directors (Ministry of Information, Media and Broadcasting Services, 2018).

An interesting aspect of the resistance to Western medicine during the liberation struggle in Zimbabwe was how people in conflict zones, both semi-liberated and fully liberated, accepted Western treatments when administered by medics from the revolutionary armies. Under the leadership of Herbert Ushewokunze the ZANLA Medical Service (ZMS), ZANLA medics did not solely rely on allopathic remedies. They were also trained in Indigenous medical knowledge systems, which incorporated animism and the use of nature to offer both therapeutic and spiritual relief to combatants and civilians in the war zones (Nyakudanga, 2019). As the war progressed, ZANLA introduced refresher and advanced courses in medicine that blended traditional and Western medicines.

Provincial, Sectorial, Detachment, and Sectional Medical Officers were frequently withdrawn from the front lines to report on major health challenges affecting combatants and civilians. Strategies were devised that were both culturally and medically appropriate to address these issues. ZANLA cadres, many of whom had been sent to Scandinavian and European countries for training in primary healthcare, obstetrics, and gynaecology, applied their new skills while also incorporating local Indigenous knowledge. This approach was crucial in filling gaps left by the disruption of formal medical services due to the war (Huni, 2018).

The guerrilla army medical corps, thus, became an alternative medical system, practising a dual approach that integrated traditional and Western medicine. This understanding of cultural sensitivities helped overcome the aversion many Africans felt towards colonial medical and psychiatric practices. With their combined knowledge of medicine and psychiatry, ZANLA medics were able to manage a variety of cases affecting both the army and the civilian population. Combatants and civilians suffering from traumatic shock or "Shell Shock," often displaying disorientation and psychosis after combat engagements, were repatriated to rear clinics for psychiatric treatment, as front-line facilities lacked these services. In the interim, traditional African medicine men were consulted, who would use remedies such as snuff or dagga sprinkled on the ground to ensure safe passage for those being repatriated (Mavhunga, 2015).

The dual system is validated in the *Battle of Mavhonde* documentary, where Colonel Masenda recalls an incident where a disoriented cadre had to be disarmed and repatriated to the rear for psychiatric care. Those injured at the front were usually treated at Percy Ntini Camp, within the Chimoio Circle (*Battle of Mavhonde*, 2017). This example illustrates the flexibility and resourcefulness

of the guerrilla medical corps, which became a lifeline for those affected by both physical and mental trauma during the liberation war.

As a result of the war, people resorted to the Indigenous Knowledge Systems (IKS) due to the closure of schools, clinics, and hospitals. Many consulted the *n'anga* covertly for ailment remedies, contraceptives, and mental health services. These they would easily get since in every African village or settlement in a war zone herbalists and *n'anga*, were present. Guerrillas fighting in the war of liberation were in most cases deployed far away from clinics and hospitals. In some cases, they provided medical care to the civilian populace in their areas of operations. ZIPRA guerrillas were known to employ the services of 'Izinyanga' (traditional healer) even though they had a medical system within their organisation headed by Dr Bango. ZIPRA cadres consulted the African Indigenous medical service for treatment of ailments ranging from persistent headaches, stomach aches due to poisoning, fits, injuries, dizziness bomb shock and possession by evil spirits (at times this would be diagnosed as psychosis) (Mavhunga, 2015). In such situations, traditional healers were handy in dispensing medical services not only to guerrillas but also to civilians as well.

Gordon Chavunduka notes that the *n'anga* was not only revered as a prophet, religious guide, or political advisor but a healer of sicknesses too (Chavhunduka, 1978). Crawford substantiates how African medicine was not for therapeutic use alone, a result which saw many Africans still consult *n'anga* despite visiting clinics or hospitals for medical attention. Highlighting that, medicine in African terminology was used not only to cure disorders of the body including mental ailments, but to also achieve any end that requires for its success control over forces which would otherwise be uncontrollable, in this case spirits which caused the illness (Crawford, 1957).

Traditional medicine remained a pivotal arm of medical health service provision as it kept running even in the least accessible areas of the plateau during the war. In this regard, it was abhorred by European medicine practitioners who saw it as a dangerous system aimed at spreading diseases than curative services to the African populace. This came from some of the practices that the African traditional healers used in curing sicknesses ranging from the continuous use of sharp objects on several individuals whilst applying '*nyora*' which were tiny incisions made on the skin and covered with medicine to be absorbed through the open skin and into the blood stream (Interview, 2019). The sucking of boils and scraping of moles and spitting sputum on patients faces. Such acts, despite their therapeutic healing properties were resented by allopathic practice and

outlawed under the Witchcraft Suppression Act of Rhodesia 1957, which forbid the practice of sorcery related practices and witchcraft.

## Impact of colonialism on post colonial health and practices

Colonialism in Africa left an indelible mark on various facets of African society, including mental health. In Zimbabwe, formerly known as Southern Rhodesia, the colonial administration imposed Western psychiatric practices, neglecting indigenous mental health paradigms. Under British colonial rule, Western concepts of mental health were introduced to the Zimbabwean populace, and British authorities frequently dismissed indigenous understandings of mental illness, often labelling traditional healers as 'witch doctors' and sidelining their practices. Psychiatric institutions established during this time mirrored British models of health and psychiatric practices, focusing on containment rather than cure, and often serving as tools for social and political control. African patients were frequently mistreated and deemed culturally and intellectually inferior due to the racial prejudices embedded within the colonial mindset (Keller, 2007).

One prominent example of colonial influence was the racial segregation in mental health facilities, with distinct sections for Europeans and Africans. African patients were typically confined to poorly resourced sections of hospitals or entirely separate, inferior facilities (Jackson, 2006). This approach not only stigmatised mental illness but also reinforced racial hierarchies entrenched by colonial beliefs. Furthermore, the colonial emphasis on Western medical practices marginalised traditional healing approaches, resulting in a persistent mistrust between biomedical practitioners and traditional healers today, which often hinders the development of integrated healthcare approaches that could benefit patients (Mundeta & Maradzika, 2019). This ongoing divide has limited access to diverse treatment options and may impede the acceptance and understanding of mental health services among Zimbabweans, many of whom continue to place trust in traditional healing methods.

## Conclusions

This paper examined how colonial medical services were designed not to improve African health systems while undermining and discrediting African individuals, beliefs, and traditional practices related to illness and recovery at the same time. Through segregation and discriminatory practices, colonial authorities reinforced the subaltern status of Africans. The goals of colonialism extended beyond a supposed 'civilising mission'; colonial policies and actions were also structured to erode African social, political, and economic agency,

relegating Africans to an inferior status. This subjugation was evident in healthcare, where African healing practices were criminalised to prevent any potential competition from indigenous methods of healing, despite the ingenuity and effectiveness of these systems. The development of healthcare and psychiatric services in Southern Rhodesia was thus structured to serve European interests over African needs. While the colonial system was largely repressive and dismissive of African cultural needs, it did introduce some new therapeutic practices that were of benefit to African patients.

The paper noted that the subaltern status forced upon indigenous health practices during the colonial era has had lasting consequences on Zimbabwe's healthcare system, particularly in the fields of mental health and traditional healing. Although some steps have been taken to reclaim and integrate these marginalised knowledge systems, the legacy of colonial power structures continues to influence contemporary perceptions and practices. Moving forward, addressing this historical subjugation was regarded as essential for building a more equitable and effective health system that genuinely serves all Zimbabweans. Decolonising psychiatry in Zimbabwe will require a shift towards more inclusive, culturally relevant, and holistic practices that respect and integrate indigenous knowledge systems. By fostering further research and developing innovative policy approaches, Zimbabwean society can establish a mental healthcare system that meaningfully addresses the needs of its population.

The paper also pointed out how colonial medical services were in competition not to improve but rather denigrate, undermine, and discredit African persons, the medical systems and beliefs of illness and recovery through segregation which elaborated subalternity of Africans. Illustrated was that the aim of colonialism was not solely to deal with civilisation, but also sought to undermine African competition socially, politically, and economically through discriminatory legislation and actions which second rated Africans to nonhumans. Healthcare services and systems of healing of Africans became criminalised to avert competition of methods and mechanisms of healing by African whilst denying ingenuity of and effectiveness of African traditional healing systems. The development of healthcare and psychiatry services in Southern Rhodesia was made in a way to always benefit the European more than the African. However, it was submitted that the system, though largely repressive and inconsiderate to the cultural needs of the African patient, brought in new forms of therapy which were innovative and beneficial to the African patient. Despite this, the

subalternity imposed on Indigenous health practices during the colonial period has had lasting effects on Zimbabwe's health system, particularly in the areas of mental health and traditional healing. While there have been efforts to reclaim and integrate these marginalized knowledge systems, the legacy of colonial power structures continues to shape perceptions and practices.

Moving forward, addressing this historical subalternity will be crucial for developing a more equitable and effective health system that truly meets the needs of all Zimbabweans. Decolonising psychiatry in Zimbabwe necessitates a shift towards more inclusive, culturally relevant, and holistic practices that respect and integrate indigenous knowledge systems. By engaging in further research and developing innovative policy approaches, Zimbabwean society can foster a mental health care system that genuinely addresses its population's needs.

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